Lee, Kyong

From: Hoffman, John K.
Sent: Friday, December 08, 2017 1:06 PM
To: Doran, Mary; Jenkins, Dan
Cc: Hursey, Teresa; McGady, Shawn
Subject: Re: HB 40 Question; TIME SENSITIVE

Makes perfect sense, Mary, thanks.

From: Doran, Mary
Sent: Friday, December 8, 2017 12:53:44 PM
To: Hoffman, John K.; Jenkins, Dan
Cc: Hursey, Teresa; McGady, Shawn
Subject: RE: HB 40 Question; TIME SENSITIVE

John,

While I cannot confirm at this time whether the system will be fully prepared to process/reimburse on January 1, 2018, providers will be reimbursed for the abortion services provided on or after that date.

Make sense?

From: Hoffman, John K.
Sent: Friday, December 08, 2017 11:29 AM
To: Jenkins, Dan
Cc: Doran, Mary; Hursey, Teresa; McGady, Shawn
Subject: Fw: HB 40 Question; TIME SENSITIVE

Dan Mary —

Can you confirm that the Department is prepared to make provider reimbursements under the provisions of HB40 on Jan. 1? Thanks.

John

From: Kantas, Christopher
Sent: Friday, December 8, 2017 11:05:10 AM
To: Hoffman, John K.
Subject: FW: HB 40 Question; TIME SENSITIVE

John,
Can you get me an answer on this ASAP, please?
Thank you!
Chris

From: Schuh, Patty
Sent: Friday, December 08, 2017 11:03 AM
To: Kantas, Christopher <Christopher.Kantas@illinois.gov>; Lucci, Michael <Michael.Lucci@illinois.gov>; Bold, Rachel <Rachel.Bold@illinois.gov>
Cc: Englehart, Hud <Hud.Englehart@illinois.gov>; Tomev, Elizabeth <Elizabeth.Tomev@illinois.gov>; Wilson, Nicole J.

<Nicole.J.Wilson@illinois.gov>
Subject: RE: HB 40 Question; TIME SENSITIVE

I presume EOD is end of day … too late.

Need ASAP pls.

From: Kantas, Christopher
Sent: Friday, December 08, 2017 10:57 AM
To: Lucci, Michael <Michael.Lucci@illinois.gov>; Bold, Rachel <Rachel.Bold@illinois.gov>
Cc: Schuh, Patty <Patty.Schuh@illinois.gov>; Englehart, Hud <Hud.Englehart@illinois.gov>; Tomev, Elizabeth <Elizabeth.Tomev@illinois.gov>; Wilson, Nicole J. <Nicole.J.Wilson@illinois.gov>
Subject: RE: HB 40 Question

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Sent: Friday, December 08, 2017 10:49 AM
To: Bold, Rachel <Rachel.Bold@illinois.gov>; Kantas, Christopher <Christopher.Kantas@illinois.gov>
Cc: Schuh, Patty <Patty.Schuh@illinois.gov>; Englehart, Hud <Hud.Englehart@illinois.gov>; Tomev, Elizabeth <Elizabeth.Tomev@illinois.gov>; Wilson, Nicole J. <Nicole.J.Wilson@illinois.gov>
Subject: Re: HB 40 Question

Chris, please take first pass on this.

Sent from my iPhone

On Dec 8, 2017, at 10:33 AM, Bold, Rachel <Rachel.Bold@illinois.gov> wrote:

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> Rachel Bold
> Communications
> Office of the Governor

207 State House, Springfield IL 62706
C: (217) 993-1865

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> 207 State House, Springfield IL 62706
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>
>

Lee, Kyong

From: Amy Meek <ameek@ACLU-il.org>
Sent: Wednesday, December 06, 2017 2:51 PM
To: Norwood, Felicia
Cc: Hursey, Teresa; McGady, Shawn; Doran, Mary; Lorie Chaiten
Subject: [External] RE: MCO Model Contract and HB40 implementation
Attachments: 2017-12-06 ACLU Letter to Dir Norwood re finalized model contract.pdf; 2017-03-09 ACLU Letter to HFS re MCO RFP 2018-24-001.pdf; 2017-09-15 ACLU Suggested Exceptions re RFP 201824001ExceptionsForm.pdf; 2017-09-19 ACLU Cover Letter to Felicia Norwood re MCO RFP Contract Exceptions.pdf

Hi – I apologize that I didn't include our previous comments (see attached).
Thanks,
Amy

From: Amy Meek
Sent: Wednesday, December 06, 2017 2:46 PM
To: 'Norwood, Felicia'
Cc: 'Hursey, Teresa' ; 'McGady, Shawn' ; 'Doran, Mary' ; Lorie Chaiten
Subject: MCO Model Contract and HB40 implementation

Good afternoon,
Thank you for sharing the finalized MCO Model Contract with us. Our comments are attached. Please let us know how we can be of assistance with implementation moving forward.

Amy Meek
Staff Attorney, Women's and Reproductive Rights Project
Pronouns: She/Her/Hers
ACLU of Illinois
150 N. Michigan Ave., Ste. 600, Chicago, IL 60601
312.201.9740 x341
ameek@aclu-il.org
www.aclu-il.org

THE
ROGER
BALDWIN
FOUNDATION
OF ACLU,
INC.

SUITE 2300
180 NORTH MICHIGAN AVENUE
CHICAGO, IL 60601-1287
T: 312-201-9740
F: 312-201-9760
WWW.ACLU-IL.ORG

DELIVERED VIA EMAIL AND U.S. MAIL March 9, 2017

Lynette Schafer
Illinois Department of Healthcare and Family Services
Division of Medical Programs
Bureau of Managed Care
201 South Grand Avenue
East Springfield, IL 62794
HFS.Procurement@illinois.gov

Re: State of Illinois Medicaid Managed Care Organization Request for Proposals 2018-24-001

Dear Ms. Schafer:

I am a staff attorney in the Women's and Reproductive Rights Project of the Roger Baldwin Foundation of ACLU, Inc. ("ACLU" or "ACLU of Illinois"). I write to raise questions and concerns regarding the State of Illinois Medicaid Managed Care Organization Request for Proposals 2018-24-001 ("the RFP"), including the draft Model Contract between HFS and contracting managed care organizations ("MCO" or "Contractor") set forth in Appendix I of the RFP ("the draft Model Contract").

The ACLU of Illinois is a nonprofit organization dedicated to securing freedom, liberty, equality and justice. The ACLU's Women's and Reproductive Rights Project seeks, through litigation, public education, and administrative and legislative advocacy, to ensure that all in our society have access to the full range of reproductive health care options. The ACLU has a long and proud history of defending religious liberty and believes that the right to practice one's religion, or no religion, is a core component of our civil liberties. For this reason, the ACLU routinely brings cases designed to protect the rights of individuals to worship and express their religious beliefs. At the same time, the ACLU vigorously protects women's rights and reproductive freedom. To that end, we have been conducting an investigation of Medicaid coverage of reproductive health care services, including abortion care, in Illinois. We have, among other things, gathered documents through Freedom of Information Act ("FOIA") requests to the Illinois Department of Healthcare and Family Services ("HFS") and information about the experiences of patients in the Medicaid system who face barriers to access to essential reproductive health care.

As set forth below, the RFP and draft Model Contract raise critical issues about coverage for such care, including creating harmful barriers for patients who participate in the Medicaid program. We urge HFS to address these issues to ensure that all enrollees in MCOs selected for contracts under this RFP have adequate access to medically necessary covered services as required by state and federal law.

1. **The Draft Model Contract Language Regarding "Right of Conscience" Creates Refusal Rights Beyond Those Contemplated by the Health Care Right of Conscience Act.**

Section 5.6 of the draft Model Contract purports to incorporate rights under 745 ILCS 70/1 et seq., the Illinois Health Care Right of Conscience Act ("HCRCA"), by permitting any contracting MCO to "choose to exercise a right of conscience by refusing to pay or arrange for the payment of certain Covered Services."[1] The draft Model Contract allows a contracting MCO to do so simply by notifying HFS in writing of the "services that the Contractor refuses to pay, or to arrange for the payment of."[2] This contractual provision expands the right to refuse to participate in payment for services beyond that which is provided for in the HCRCA.

Contrary to the draft Model Contract, the HCRCA only permits a health care payer to refuse "to pay for or arrange for the payment of any particular form of health care services that violate the health care payer's conscience" if the health care payer's objection is "*documented in its ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents*" (emphasis added).[3] The draft Model Contract must therefore be revised to properly incorporate the terms of the HCRCA by requiring an objecting Contractor to submit to HFS formal corporate documents that demonstrate that the health care services at issue violate the health care payer's conscience.

2. **HFS Must Create Procedures to Ensure That Enrollees Can Access Covered Services When Their MCO Objects Under the HCRCA.**

HFS must take steps to ensure that Medicaid enrollees have adequate and timely access to covered services, as required by law, even when their MCO refuses to cover such services because of an objection covered by the HCRCA. As the Illinois General Assembly recently affirmed in an amendment to the HCRCA that went into effect on January 1, 2017, it is "the public policy of the State of Illinois to ensure that patients receive timely access to information and medically appropriate care," even in the face of conscience objections to such services.[4]

We appreciate that the draft Model Contract requires that, when a contracting MCO refuses to be involved in payment for health care services under the HCRCA, it must notify potential, prospective and existing enrollees at certain times specified in Subsection 5.6.2., and that such notice must include information about how an enrollee can obtain information from HFS regarding those covered services. However, we do not believe that this is adequate notice. Patients often do not know that they will need a particular service in advance and thus could not choose an MCO based on the notice that is currently required. We urge HFS to specify in the contract that the MCO must follow specific procedures that will enable an enrollee to access services when their MCO will not pay for, or arrange for payment of, such services. We also urge HFS to ensure that such information is available to enrollees at all times by requiring that the contracting MCO include this information in its enrollee handbook.

---

[1] Subsection 5.6.1 of the draft Model Contract.
[2] *Id*.
[3] 745 ILCS 70/11.2 to 70/11.4.
[4] 745 ILCS 70/2.

3. The Draft Model Contract Misstates the State's Obligation to Cover Abortion Care for Patients Enrolled in State Medical Assistance Programs.

Since 1994, Illinois has been under a court order (*Doe v. Wright*) requiring the state's medical assistance programs to provide coverage for abortion services necessary to protect a woman's health.[5] This requirement addresses the gap in Medicaid coverage created by the Hyde Amendment, which bans the use of federal Medicaid funding to cover abortion services except in cases of rape, incest, or life endangerment. Such bans on insurance coverage for abortion are heavy-handed intrusions into a decision that is best left to a woman and her family.

Even though the 1994 court order, among other things, enjoined HFS regulations to the extent that they failed to cover abortions necessary to protect a woman's health, HFS has never updated its regulations to reflect this decision. Outdated regulations, combined with confusing instructions, conflicting paperwork requirements, and other needless obstacles to coverage, have made it so difficult for providers to obtain Medicaid reimbursement for medically necessary abortion services that the Guttmacher Institute recently concluded that Illinois may be in violation of this longstanding court order.[6]

As Illinois has increasingly sought to shift Medicaid enrollees into MCOs, it is particularly important that MCOs have an accurate understanding of what services are covered under Illinois Medicaid. The RFP emphasizes that a contracting MCO must ensure that "providers understand billing requirements" and must "provide billing education to providers," which includes offering clear and accurate guidance to providers regarding the scope of covered services.[7]

Nonetheless, the draft Model Contract misleadingly describes the scope of covered services for abortion by repeatedly citing outdated state and federal regulations that provide that abortion services are only covered when necessary to save a woman's life.

First, Section 5.1 of the draft Model Contract states that "Covered Services shall be provided in the amount, duration, and scope as set forth in 89 Ill. Adm. Code, Part 140, and in this Contract" but fails to acknowledge that these regulations include a subsection (89 Ill. Adm. Code 140.413) which has been enjoined because it unlawfully provides that abortion services shall be covered "only in those cases in which the physician has certified in writing to the Department that the procedure is necessary to preserve the life of the mother."

Second, Subsection 5.5.1 of the draft Model Contract, which purports to explain the limitations on covered services for abortion care, is misleading and inaccurate. This subsection states:

> Contractor may provide termination of pregnancy only as allowed by applicable State and federal law (42 CFR §441, Subpart E). In any such case, Contractor shall fully comply with the requirements of such laws, complete HFS Form 2390, and file the completed form in the Enrollee's medical record. Contractor shall not

---

[5] *Doe v. Wright*, No. 91 CH 1958 (Ill. Cir. Ct. Dec. 2, 1994).
[6] Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, Guttmacher Pol. Rev., Vol. 19 (2016), *available at* https://www.guttmacher.org/sites/default/files/article_files/gpr1904616_0.pdf.
[7] Subsection 5.2.8.2 of the RFP.

provide termination of pregnancy to Enrollees who are eligible under SCHIP (215 ILCS 106).

This subsection fails to explain that abortion services are covered by Illinois Medicaid where necessary to protect the health or life of the pregnant woman, or in cases of rape or incest. Moreover, the outdated federal regulation (42 CFR §441, Subpart E) this subsection cites as "applicable . . . law" would limit coverage for abortion services solely to situations in which a woman's life is in danger.[8] Finally, the guidance offered in this subsection regarding abortion service coverage for enrollees eligible under the State Children's Health Insurance Program ("SCHIP" or "CHIP") raises a number of concerns, including that it conflicts with the Illinois CHIP State Plan. The Illinois CHIP State Plan specifically provides that enrollees who are eligible under SCHIP may enroll under Medicaid in order to obtain coverage for abortion services.[9]

HFS has included this misleading and inaccurate language in its contracts with MCOs, as well as in its Managed Care Manual for Medicaid Providers, in the past. As a result, most MCOs provide their enrollees and providers with similarly misleading and inaccurate guidance about the scope of abortion service coverage under Illinois medical assistance programs. The ACLU of Illinois reviewed enrollee handbooks and provider handbooks provided by MCOs for Integrated Care Programs ("ICPs") and Family Health Plans ("FHPs") in Illinois, and found that only a few accurately set forth the scope of Illinois Medicaid coverage for abortion services. Most MCO handbooks simply reprint the language of Subsection 5.5.1 verbatim, without attempting to explain to enrollees or providers what services are actually required to be covered. Indeed, several MCO handbooks imported the restrictions of the federal Hyde Amendment without acknowledging that Illinois medical assistance programs must cover abortion services when necessary to protect a woman's health.[10] These issues put Illinois patients enrolled in Medicaid at risk and deny them their legal rights to access medically necessary health care.

We urge HFS to correct this misleading contract language and provide full and accurate guidance to MCOs and providers regarding the extent of required coverage for abortion services under Illinois medical assistance programs.

4. HFS Must Ensure that Contracting MCOs Meet Network Adequacy Requirements and Quality Assurance Standards for Abortion Services as part of Comprehensive Reproductive Health Care.

Finally, we urge HFS to take affirmative steps to ensure that contracting MCOs have adequate provider networks and quality assurance standards to offer access to all covered services, including abortion services. The RFP and the draft Model Contract recognize that, as required by state and federal laws and regulations, a contracting MCO must build a provider

[8] In 1993, federal restrictions on abortion coverage were amended to include coverage in cases of rape and incest as well as to preserve the life of the pregnant woman. A 1994 federal court decision ensures that Illinois follows this federal law. *Planned Parenthood v. Wright*, No. 94 C 6886, 1994 WL 750638 (N.D.Ill. Dec. 6, 1994).
[9] Illinois CHIP State Plan (2002), at 30, available at https://www.medicaid.gov/CHIP/Downloads/IL/ILCurrentStatePlan.pdf.
[10] Some MCOs have instituted reporting or documentation requirements in cases of rape or incest that even deny or impede coverage for abortion services covered under federal Hyde Amendment restrictions. Such requirements conflict with the Illinois Medicaid State Plan and violate federal law. *See Elizabeth Blackwell Health Ctr. for Women v. Knoll*, 61 F.3d 170, 181 (3d Cir. 1995).

network and meet quality assurance standards to ensure adequate access to covered services for all enrollees. The RFP requires that MCOs submit information about their provider networks, including proposals for how they plan to recruit providers, build their networks, and monitor compliance with network adequacy standards.[11] The draft Model Contract provides detailed requirements for network adequacy and quality assurance standards to ensure access to care for family planning and reproductive health services,[12] as well as to care provided to pregnant women,[13] but does not address the need for an adequate provider network or other measures to ensure access to abortion services when necessary to protect the health or life of a pregnant woman, or in cases of rape or incest. Access to these covered services is critical to ensure that pregnant enrollees facing a health-endangering or life-threatening condition, or who are the victims of rape or incest, can access the care they need.

We note that the RFP asks MCOs to explain how they would address the needs of a potential Medicaid enrollee in an example vignette featuring a pregnant woman who has two children under the age of 5; she has schizophrenia and her "medications will need to be reduced during her pregnancy, potentially reducing their effectiveness."[14] The vignette does not specify whether the hypothetical enrollee has decided to carry her pregnancy to term, raising the possibility that she could decide to preserve her health by terminating her pregnancy, in the face of the real and substantial risks to her health posed by reducing her medications during pregnancy. In evaluating each RFP submission, HFS should evaluate whether the responding MCO identifies and addresses the possibility that a pregnant enrollee might decide to terminate her pregnancy in order to preserve her health, and whether the responding MCO offers adequate provider networks and coverage to provide such an enrollee with adequate and timely access to covered abortion services. Unfortunately, in the course of our investigation, we have become aware of women who have needed hospital-based abortion care to address a serious health condition but whose MCO did not contract with a single hospital that provided abortion care. We urge HFS to ensure that that does not continue to happen by requiring true network adequacy.

Thank you for the opportunity to raise questions and concerns regarding the RFP and the draft Model Contract. Please do not hesitate to contact me if you would like to discuss these issues further.

Sincerely,

[redacted]

Amy Meek
Staff Attorney, Women's & Reproductive Rights Project
Roger Baldwin Foundation of the ACLU of Illinois

cc: Representative Greg Harris

[11] Subsections 4.2.6 and 5.2.8 of the RFP.
[12] Section 5.8, Attachment XI ("Quality Assurance"), and Attachment XXI ("Required minimum standards of care") of the draft Model Contract.
[13] *Id.*
[14] Subsection 5.2.2.1 of the RFP.

STATE OF ILLINOIS
EXCEPTIONS TO CONTRACT TERMS AND CONDITIONS

The Roger Baldwin Foundation of ACLU, Inc. ("ACLU of Illinois") submits the following suggested exceptions for incorporation into the final version of the Model Contract issued pursuant to the State of Illinois Request for Proposal ("RFP") (Reference Number: 2018-24-001). These suggestions relate to concerns detailed in our March 9, 2017 letter to the Department of Healthcare and Family Services ("the Department"), about ensuring that enrollees have adequate access to medically necessary covered services as required by state and federal law. For additional background on these concerns, please refer to the March 9, 2017 letter (enclosed).

	CHANGES TO STANDARD TERMS AND CONDITIONS
Section or Subsection No.	State the exception, specifying the section or subsection number and the desired language, using terms such as "add," "replace," "delete," etc.
1.1.79 (page 17)	The full spectrum of reproductive-health services includes abortion care, yet there is considerable confusion about the extent of abortion coverage under Illinois Medicaid. Other states (such as New York) clearly state in Medicaid handbooks and contracts that abortion is part of the range of covered family planning and reproductive health services. Therefore, we suggest adding the underlined text (and deleting the strikethrough text) in the definition of Family Planning as follows: "**Family Planning** means a full spectrum of family-planning options (all FDA-approved birth control methods) and reproductive-health services, appropriately provided within the Provider's scope of practice and competence. Family-Planning and reproductive-health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy, terminating pregnancy, or ~~to improve~~ improving maternal health and birth outcomes."
5.5.1 (page 68)	This subsection offers a description of abortion coverage under Illinois Medicaid that is incomplete and potentially misleading, as the Model Contract does not explain when abortion is covered and directs Contractors to Illinois regulations (89 Ill. Adm. Code 140.413) regarding abortion coverage which have been enjoined by court order (*Doe v. Wright*). This subsection's guidance is also inaccurate with respect to SCHIP enrollees, as the *Doe v. Wright* order applies generally to state medical assistance programs and is not limited to Medicaid; furthermore, it conflicts with the Illinois CHIP State Plan, which permits individuals eligible under SCHIP to enroll under Medicaid to obtain coverage for abortion services. We therefore suggest replacing the text of Subsection 5.5.1 with the following underlined text: "Abortion (termination of pregnancy) is a covered service when the abortion is, in the medical judgment of the attending health care provider, necessary to preserve the woman's health or her life, or when the pregnancy is the result of rape or incest. A medical judgment that an abortion is necessary to preserve a woman's health may consider all factors — such as physical, emotional, psychological, and familial health and the woman's age — which are relevant to the patient's health

	and wellbeing. In any such case, Contractor shall complete HFS Form 2390, and file the completed form in the Enrollee's medical record. Enrollees who are eligible for assistance under SCHIP (215 ILCS 106) may enroll under Medicaid in order to obtain coverage for abortion services."
5.6.3 (page 69)	We suggest adding the following underlined text (and deleting the strikethrough text) in this subsection to ensure that Enrollees receive timely access to medically necessary Covered Services, in accordance with the Health Care Right of Conscience Act, 745 ILCS 70/1 *et seq.*: "Such notice shall include information on how ~~an Enrollee~~ Potential Enrollees, Prospective Enrollees and Enrollees can obtain information from the Department explaining how to access ~~regarding~~ those Covered Services subject to this section 5.6."
5.6.4 (page 69)	We suggest adding the following underlined text (and deleting the strikethrough text) in this subsection (and additional subsections set forth below) to ensure that Enrollees receive timely access to medically necessary Covered Services, in accordance with the Health Care Right of Conscience Act: "As set forth in section 5.32, all Provider agreements entered into by Contractor must include a list of any Covered Services that the Network Provider refuses to permit, perform, or participate in because of a conscience-based objection, and document the Network Provider's written access to care and information protocols that are designed to ensure that conscience-based objections do not cause impairment of Enrollees' health and that explain how conscience-based objections will be addressed in a timely manner to facilitate Enrollees' access to Covered Services. Contractor must require Network Providers to inform Enrollees of their condition, prognosis, legal treatment options, and risks and benefits of the treatment options in a timely manner, consistent with current standards of medical practice or care. If any Network Provider is unable, because of a conscience-based objection, to permit, perform, or participate in a Covered Service that is a diagnostic or treatment option requested by the Enrollee, ~~exercises the right of conscience,~~ Contractor must require such Network Provider to notify the Enrollee that the Covered Service will not be provided and, upon request by an Enrollee, refer or transfer the Enrollee to, or provide written information to the Enrollee about, other Providers who Contractor reasonably believes may offer the Covered Service the Network Provider refuses to permit, perform, or participate in because of a conscience-based objection. Contractor also shall require Network Providers in such an event, and if requested by the Enrollee, to provide copies of medical records to the Enrollee or to the Provider designated by the Enrollee in accordance with Illinois law, without undue delay. Contractor must notify Potential Enrollees, Prospective Enrollees, and Enrollees regarding which Network Providers have conscience-based objections, and the Covered Services each such Network Provider refuses to permit, perform, or participate in because of a conscience-based objection, as follows:

	5.6.4.1 to Potential Enrollees, prior to enrollment; 5.6.4.2 to Prospective Enrollees, during enrollment; and 5.6.4.3 to Enrollees, within ninety (90) days after entering into a Provider agreement with a Network Provider that refuses to permit, perform, or participate in Covered Services because of a conscience-based objection. Such notice shall include information about other Network Providers who may offer such Covered Services as well as information on how an Enrollee can obtain information from the Department explaining how to access those Covered Services subject to this section 5.6. Contractor shall also publish such notice and information in the Provider directory as set forth in subsection 5.10.6."
5.10.6 (pages 82-83)	We suggest adding the following underlined text (and deleting the strikethrough text) to this subsection: "**Provider directory**. Contractor shall meet all Provider directory requirements under 305 ILCS 5/5-30.3 ~~and~~, 42 CFR §438.10, and section 5.6, including: 5.10.6.1 Ensure its Provider directory is available to Enrollees and Providers via Contractor's web portal and in paper form upon request. 5.10.6.2 Request, at least annually, Provider office hours for each Provider type and publish such hours in the Provider directory. 5.10.6.3 Confirm with Providers who have not submitted claims within the six (6) months prior to the start of this Contract that the Provider intends to remain in the network and correct any incorrect Provider directory information. 5.10.6.4 Conspicuously display an e-mail address and a toll-free number to which any individual may report an inaccuracy in the Provider directory. 5.10.6.5 Provider directory information in paper form must be updated at least monthly and electronic Provider directories must be updated no later than thirty (30) days after Contractor receives updated Provider information. 5.10.6.6 Investigate and correct any inaccurate information communicated to any individual Enrollee or from Department notification within three (3) days after notification by the Department. 5.10.6.6 Publish and update any information regarding which Network Providers have conscience-based objections to Covered Services, the Covered Services each such Network Provider refuses to permit, perform, or participate in because of a conscience-based objection, information about other Network Providers who may

STATE OF ILLINOIS
EXCEPTIONS TO CONTRACT TERMS AND CONDITIONS

	offer such Covered Services, and information about how an Enrollee can obtain information from the Department explaining how to access such Covered Services.
5.21.5.6 (page 107)	We suggest adding the following underlined text to this subsection: "the amount, duration, and scope of benefits available, in sufficient detail to ensure that the Enrollee understands the benefits to which the Enrollee is entitled, as well as any benefits that may be excluded pursuant to section 5.6, and information about how an Enrollee can obtain information from the Department explaining how to access benefits excluded pursuant to section 5.6;"
Attachment XXI, 2.1.3 (page 318)	We suggest adding the underlined text (and deleting the strikethrough text) to the first two sentences of this subsection regarding minimum covered services for Family Planning, as follows: "Contractor shall ensure provision of the full spectrum of Family Planning options and reproductive health services within the practitioner's scope of practice and demonstrated competence. Contractor shall follow federal and State laws regarding minor consents and confidentiality. Family Planning and reproductive health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy, terminating pregnancy, or ~~to improve~~ improving maternal health and birth outcomes."
	ADDITIONAL PROVISIONS
New Section or Subsection No.	State the new section or subsection number, the title of the new section or subsection, and the language of the desired term or condition.
5.21.1.16 (pages 103-104)	We suggest creating the following new subsection 5.2.1.16 as part of Subsection 5.2.1, specifying that the following must be provided as part of the required "basic information" for Enrollees: "any Covered Services which the Contractor, and/or any Network Provider, refuses to provide pursuant to section 5.6, and information about how an Enrollee can obtain information from Contractor and/or the Department explaining how to access such Covered Services."
5.32.16 (pages 126-129)	We suggest creating the following new subsection 5.32.16 as part of Section 5.32, specifying that Provider agreements are subject to the following condition: "As set forth in section 5.6, all Provider agreements entered into by Contractor must include a list of any Covered Services that the Network Provider refuses to permit, perform, or participate in because of a conscience-based objection, and document the Network Provider's written access to care and information protocols that are designed to ensure that conscience-based objections

STATE OF ILLINOIS
EXCEPTIONS TO CONTRACT TERMS AND CONDITIONS

	do not cause impairment of Enrollees' health and that explain how conscience-based objections will be addressed in a timely manner to facilitate Enrollees' access to Covered Services."
Attachment XXI, 2.1.3.18 (pages 319-328)	We suggest creating the following new subsection 2.1.3.18 as part of subsection 2.1.3, specifying that as part of the full spectrum of Family Planning options and reproductive health services, Contractor shall ensure the provision of the following: "Contractor shall have procedures in place to enable Enrollees to access abortion (termination of pregnancy) pursuant to subsection 5.5.1."

By: Amy Meek (ACLU of Illinois)

Signed: [redacted]

Amy Meek
Staff Attorney
ACLU of Illinois
150 N. Michigan Ave., Ste. 600, Chicago, IL 60601
312.201.9740 x341
ameek@aclu-il.org

Position: Staff Attorney, Women's and Reproductive Rights Project, Roger Baldwin Foundation of the ACLU of Illinois

Date: Sept. 15, 2017

THE
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INC.

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T: 312-201-9740
F: 312-201-9760
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September 19, 2017

VIA EMAIL

Felicia Norwood, Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield IL 62763
Felicia.Norwood@illinois.gov

Dear Director Norwood:

Thank you for expressing your commitment to addressing the concerns raised by the ACLU of Illinois regarding the State of Illinois Medicaid Managed Care Organization Request for Proposals 2018-24-001 ("the RFP"), including the draft Model Contract between the Department of Healthcare and Family Services ("the Department") and contracting managed care organizations ("MCOs"). We appreciate the efforts made by the Department to address some of these issues in the updated version of the Model Contract posted September 8, 2017. However, additional modifications are necessary in order to ensure that MCO enrollees have adequate access to medically necessary covered services as required by state and federal law.

Accordingly, on Friday, September 15, 2017, we submitted suggested exceptions for incorporation into the final version of the Model Contract. I am enclosing that submission, as well as our March 9, 2017 letter to the Department, which provides additional background on our concerns relating to the RFP.

We look forward to working with the Department to address these and other issues regarding the Department's obligation to ensure adequate access to the full spectrum of reproductive-health services, including abortion care, for all individuals enrolled in Illinois medical assistance programs. Please contact me if you have any questions or would like to discuss further.

Sincerely,

[redacted]

Amy Meek
Staff Attorney, Women's & Reproductive Rights Project
Roger Baldwin Foundation of the ACLU of Illinois

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December 6, 2017

VIA EMAIL AND U.S. MAIL

Felicia Norwood, Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield IL 62763
Felicia.Norwood@illinois.gov

Dear Director Norwood:

We have reviewed the final Illinois Department of Healthcare and Family Services ("HFS") Model Contract language for managed care organizations ("MCOs") to provide state medical assistance services beginning January 1, 2018 ("the Model Contract"). With more than 80% of Medicaid enrollees in Illinois expected to participate in these managed care plans, it is essential that the MCO contracts accurately reflect the scope of covered services. In addition, the MCOs must be prepared to provide coverage for such care in their networks and to ensure that enrollees have clear information about such coverage. To this end, the ACLU has repeatedly urged HFS to provide clear and accurate guidance regarding the scope of abortion coverage under state law. For your convenience, we are attaching our previous comments to HFS regarding the MCO RFP and Model Contract.

We understand that Governor Rauner signed House Bill 40 (now Public Act 100-538) after the Model Contracts were largely drafted, and that this timing may have presented certain challenges for HFS. We also recognize that, after HFS received comments on a previous version of the Model Contract, one section was revised to remove inaccurate language restricting abortion coverage and to state that abortion coverage shall be provided in accordance with state law. Unfortunately, however, this change does not clarify the scope of abortion coverage, as the Model Contract continues to reference sources of earlier confusion, such as outdated and inconsistent regulations, policies, and procedures. It is simply not in the interest of enrollees, MCOs or providers for the MCO contracts to perpetuate the confusion and inconsistencies about abortion coverage that P.A. 100-538 should have put to rest. These concerns are all the more urgent because HFS has not updated these regulations, policies, or procedures, or otherwise communicated to MCOs, providers, or enrollees regarding implementation of the new law. We urge HFS to take the necessary steps to assure compliance with P.A. 100-538 when it takes effect on January 1, 2018.

1. Conflicting Guidance Regarding Scope of Abortion Coverage

P.A. 100-538 is clear about the scope of coverage for abortion care in Illinois. It removes from the Public Aid Code the abortion discriminatory language that – although subject to federal

court injunction – previously led to confusion about the scope of abortion coverage. It also includes an affirmative requirement that state medical assistance programs cover all abortion care that is otherwise legal in Illinois.[1] Nevertheless, the Model Contract perpetuates confusion by failing to set forth clearly the scope of abortion coverage. For example, Section 5.5.1 of the Model Contract states that the "[c]ontractor may provide termination of pregnancy only as allowed by applicable State and federal law."[2] This language suggests that there are limitations on abortion coverage, defined only by reference to "State and federal law." The provision thus leaves any reader to question whether the restrictions of federal law (under the Hyde Amendment) somehow apply to limit abortion coverage, notwithstanding the provisions of our state statute. Even if the MCOs are not misled by this language, it is likely to confuse providers and enrollees because, as we have explained in previous comments to HFS, most MCO handbooks simply reprint this contract provision verbatim, without attempting to explain what abortion services are actually required to be covered.

Other provisions of the Model Contract create similar confusion. For example, Section 5.1 directs MCOs to conform to HFS regulations regarding covered services, which could be read to incorporate the HFS regulation that states that abortion can only be covered in cases in which the life of the pregnant woman is threatened.[3] This regulation has been subject to two federal court injunctions since the early 1990's, but has never been corrected by HFS, and stands in direct conflict to P.A. 100-538. The general reference to regulations in the Model Contract serves only to muddy the waters regarding the requirement that enrollees be covered for abortion care.

Similarly, Section 1.1.127 defines "medically necessary" services as those services that are appropriate "as indicated in State statute and regulations, the State plan, and other State policy and procedures." However, the relevant state statute, state regulations, and state policy and procedures offer conflicting guidance regarding abortion coverage. For example, HFS provider handbooks improperly cite outdated state and federal regulations that purport to limit abortion coverage to situations in which the pregnant woman's life is in danger.[4]

HFS can address the conflicts between the statutory and regulatory language by issuing emergency regulations to implement P.A. 100-538 and then updating its handbooks and other materials to accurately reflect the current state of Illinois law. HFS has the authority to issue emergency regulations here, because its failure to do so creates a threat to the public interest by denying enrollees legally required coverage.[5] Absent emergency rulemaking to bring the relevant regulations into conformity with P.A. 100-538, state statutory and regulatory language will continue to conflict, creating dangerous and unnecessary confusion, until HFS updates the relevant regulation.

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[1] 305 ILCS 5/5-5.
[2] Model Contract, Section 5.5.1.
[3] *See* 89 Ill. Adm. Code 140.413.
[4] *See, e.g.*, HFS Managed Care Manual for Medicaid Providers (Jan. 2016), at 24 (limiting abortion coverage by citation and link to 42 CFR Part 441, Subpart E, which includes an outdated formulation of the Hyde Amendment), *available at* https://www.illinois.gov/hfs/SiteCollectionDocuments/MCOManual.pdf; HFS Handbook for Providers, Chapter 100 – General Policy and Procedures (Sept. 2017), Sections 103.1 and 104 (limiting abortion coverage by citation and link to 89 Ill. Adm. Code 140.413).
[5] 5 ILCS 100/5-45 (permitting an agency to adopt an emergency rule in any situation that it "finds reasonably constitutes a threat to the public interest, safety, or welfare.").

If, however, HFS does not intend to issue emergency rules, we urge HFS to issue clear guidance to MCOs, enrollees, and providers regarding the required scope of abortion coverage beginning January 1, 2018 – including the imminent need for MCOs to establish provider networks that assure adequate access to abortion care for enrollees. At an absolute minimum, we suggest addressing these issues in the required Readiness Reviews for MCOs, issuing a bulletin to providers, and requiring revision of MCO handbooks and other materials to ensure that they adequately reflect the scope of required coverage.

2. HFS Form 2390 Requirement for Abortion Reimbursement

Section 5.5.1 of the Model Contract also requires completion of HFS Form 2390 for all abortions. Form 2390 requires that providers indicate whether the abortion was performed because of rape, incest, life endangerment for the woman, or to protect the woman's health.[6] HFS must immediately inform MCOs and providers as to whether Form 2390 will no longer be required once P.A. 100-538 is in effect, whether it will be required only in cases for which HFS will seek reimbursement from the federal government (life, rape or incest), or whether the form will be altered to reflect the passage of P.A. 100-538 prior to the law taking effect.

3. Abortion Coverage for CHIP Enrollees

Section 5.5.1 of the Model Contract also prohibits contracting MCOs from providing abortion coverage for enrollees in the state's Children's Health Insurance Program ("CHIP").[7] As detailed in our previous comments to HFS, this exclusion violates the injunction entered in *Doe v. Wright*[8] and contravenes the Illinois CHIP State Plan.[9] It is also inconsistent with the clear mandate of P.A. 100-538, which requires the state to cover all abortion care that is otherwise legal in Illinois for those enrolled in the state medical assistance programs.[10]

Because the Model Contract bars MCOs from providing abortion coverage to CHIP enrollees, HFS must take steps to fill this gap in legally required services, either by providing fee-for-service reimbursement or by negotiating separate contracts with MCOs to cover abortion care for CHIP enrollees by January 1, 2018.[11] We urge HFS to promptly inform MCOs, enrollees, and providers about how the state intends to provide abortion coverage to CHIP enrollees pursuant to the requirements of P.A. 100-538 and the CHIP State Plan.[12]

---

[6] HFS Abortion Payment Application Form 2390, *available at* https://www.illinois.gov/hfs/SiteCollectionDocuments/hfs2390.pdf.

[7] Model Contract, Section 5.5.1 states that a contracting MCO "shall not provide termination of pregnancy to Enrollees who are eligible under SCHIP (215 ILCS 106)."

[8] *Doe v. Wright*, No. 91 CH 1958 (Ill. Cir. Ct. Dec. 2, 1994) (requiring that state medical assistance programs cover abortions when necessary to protect a woman's health).

[9] Illinois CHIP State Plan (2002), at 30, *available at* https://www medicaid.gov/CHIP/Downloads/IL/ILCurrentStatePlan.pdf (providing that enrollees who are eligible under SCHIP may enroll under Medicaid in order to obtain coverage for abortion services).

[10] 305 ILCS 5/5-5. *See also* 215 ILCS 106/25 (Illinois CHIP statute requires state to provide eligible children with health care benefits that are identical to those provided to enrollees in the state Medicaid program).

[11] As you are aware, federal regulations require that any state wishing to provide abortion coverage for CHIP enrollees in circumstances beyond those permitted by federal Hyde restrictions must do so through a separate managed care contract using non-Federal funds. 42 CFR 457.475.

[12] In addition, HFS must update the CHIP regulations, 89 Ill. Adm. Code 125.305, to conform to the requirements of P.A. 100-538.

4. Preserving Confidentiality in Recipient Verification of Services Procedures

Finally, we note that the Model Contract requires a contracting MCO to annually submit to HFS, for prior approval, the MCO's plan for verifying with enrollees whether services billed by providers were actually received, as required by federal regulations (42 C.F.R. 455.20).[13] Although neither the Model Contract nor the federal regulations specifically requires that an Explanation of Benefits (EOB) be sent to enrollees to verify that such services were received, such a practice is common among state Medicaid agencies and contracting MCOs.[14]

Information conveyed through an EOB may inadvertently reveal sensitive health care information to parents, a spouse, or other family members about the services a patient has received. In order to protect patient confidentiality, Illinois law restricts Medicaid MCOs from sending EOBs or otherwise divulging information concerning "sensitive health services," except in certain limited circumstances.[15] This statutory provision defines "sensitive health services" to include "reproductive health services [and] family planning services". However, the MCO Model Contract does not include abortion care in its definition of "Family-Planning and reproductive-health services."[16] As a result, MCOs that have procedures in place to comply with the confidentiality requirements for "sensitive health services" may interpret them in a manner that does not cover patients receiving abortion care – which, without question, can put abortion patient safety and confidentiality at risk.

Accordingly, HFS must direct contracting MCOs to take steps, in formulating their plans for verifying with enrollees whether services billed by providers were received, to ensure that information about sensitive health services (including abortion care) is protected in accordance with 305 ILCS 5/5-30(i). HFS must also review any such plan submitted by a contracting MCO to ensure that it has established adequate procedures for protecting confidentiality regarding abortion care.

***

As P.A. 100-538's effective date approaches, we urge HFS to immediately take all necessary steps to ensure that it is properly implemented for all medical assistance programs in Illinois.

Sincerely,

[redacted]

Lorie Chaiten
Director, Women's and Reproductive Rights Project

Amy Meek
Staff Attorney, Women's and Reproductive Rights Project

[13] Model Contract Attachment XIII, page 278.
[14] National Family Planning & Reproductive Health Association, Confidentiality, Third-Party Billing, & the Health Insurance Claims Process: Implications for Title X, at 12, *available at* https://www.confidentialandcovered.com/file/ConfidentialandCovered_WhitePaper.pdf.
[15] 305 ILCS 5/5-30(i).
[16] Model Contract, Section 1.1.79 ("Family-Planning and reproductive-health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy, or to improve maternal health and birth outcomes.").

Lee, Kyong

From: Amy Meek <ameek@ACLU-il.org>
Sent: Wednesday, December 06, 2017 2:51 PM
To: Norwood, Felicia
Cc: Hursey, Teresa; McGady, Shawn; Doran, Mary; Lorie Chaiten
Subject: [External] RE: MCO Model Contract and HB40 implementation
Attachments: 2017-12-06 ACLU Letter to Dir Norwood re finalized model contract.pdf; 2017-03-09 ACLU Letter to HFS re MCO RFP 2018-24-001.pdf; 2017-09-15 ACLU Suggested Exceptions re RFP 201824001ExceptionsForm.pdf; 2017-09-19 ACLU Cover Letter to Felicia Norwood re MCO RFP Contract Exceptions.pdf

Hi – I apologize that I didn't include our previous comments (see attached).
Thanks,
Amy

From: Amy Meek
Sent: Wednesday, December 06, 2017 2:46 PM
To: 'Norwood, Felicia'
Cc: 'Hursey, Teresa' ; 'McGady, Shawn' ; 'Doran, Mary' ; Lorie Chaiten
Subject: MCO Model Contract and HB40 implementation

Good afternoon,
Thank you for sharing the finalized MCO Model Contract with us. Our comments are attached. Please let us know how we can be of assistance with implementation moving forward.

Amy Meek
Staff Attorney, Women's and Reproductive Rights Project
Pronouns: She/Her/Hers
ACLU of Illinois
150 N. Michigan Ave., Ste. 600, Chicago, IL 60601
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Lee, Kyong

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Amy Meek
Staff Attorney, Women's and Reproductive Rights Project
Pronouns: She/Her/Hers
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ameek@aclu-il.org
www.aclu-il.org

Lee, Kyong

From: Doran, Mary
Sent: Friday, November 03, 2017 1:58 PM
To: Barger, Sara
Subject: FW: Abortion coverage under Medicaid
Attachments: All Materials with Index and Bookmarks.pdf

FYI

From: Lorie Chaiten [mailto:lchaiten@ACLU-il.org]
Sent: Friday, November 03, 2017 1:41 PM
To: Dellamorte, Gina; Norwood, Felicia
Cc: Amy Meek; Hursey, Teresa; McGady, Shawn; Doran, Mary
Subject: [External] RE: Abortion coverage under Medicaid

Dear all,
Thank you for making the time to meet yesterday. We look forward to working together as implementation of HB 40 moves forward.

As promised, I am attaching a pdf of the binder we brought to the meeting. In addition, on the question of whether other states that provide coverage beyond Hyde seek reimbursement for abortions from the federal government, I am sending links to two Guttmacher reports. The most recent is "Public Funding for Family Planning and Abortion Services, FY 1980–2015" (https://www.guttmacher.org/sites/default/files/report_pdf/public-funding-family-planning-abortion-services-fy-1980-2015.pdf). The relevant table starts on page 14. Illinois appears to be one of only 4 (out of the 17 states with policies/court orders to provide abortion coverage for Medicaid enrollees using state funding) to obtain reimbursement for abortions from the federal government, and the only one of the 17 states that obtained reimbursement for any significant number. In FY 2015, the federal government reimbursed for 58 abortions performed in Illinois. The only other states among the 17 were Arizona (6 abortions), Minnesota (4 abortions), and Montana (1 abortion). The other 13 states did not obtain federal reimbursement for a single abortion in FY 2015. (As you can see from the table, it's also pretty rare even among the states that do not provide state funding for abortion coverage). There is also an earlier report (that has FY 2010 numbers) at https://www.guttmacher.org/sites/default/files/report_pdf/public-funding-fp-2010.pdf -- this reflects essentially the same patterns.

Thank you again.
Lorie

Lorie Chaiten
Director, Women's and Reproductive Rights Project
Roger Baldwin Foundation of the ACLU of IL
150 N. Michigan Ave. #600
Chicago, IL 60601
312-201-9740 x324
lchaiten@aclu-il.org

From: Dellamorte, Gina [mailto:Gina.Dellamorte@illinois.gov]
Sent: Thursday, October 19, 2017 10:18 AM
To: Lorie Chaiten <lchaiten@ACLU-il.org>
Cc: Amy Meek <ameek@ACLU-il.org>; Hursey, Teresa <Teresa.Hursey@illinois.gov>; McGady, Shawn <Shawn.McGady@illinois.gov>; Doran, Mary <Mary.Doran@Illinois.gov>
Subject: RE: Abortion coverage under Medicaid

Lorie,

Good Morning.

Director Norwood has availability on November 2nd at 10am at the 401 South Clinton address.

Please let me know if this will work for you and I well send out an invite.

Thank you.

From: Norwood, Felicia
Sent: Monday, October 16, 2017 5:10 PM
To: Lorie Chaiten
Cc: Amy Meek; Dellamorte, Gina; Hursey, Teresa; McGady, Shawn; Doran, Mary
Subject: RE: Abortion coverage under Medicaid

Lorie,

It's been incredibly busy as we get ready to roll out the new MCO contracts and also work on other year-end priorities.

I'll have my Chicago assistant, Gina, get back to you with some dates that work with our schedules.

It will likely be near the end of October/first part of November.

Felicia

Felicia F. Norwood
Director
Illinois Department of Healthcare and Family Services
Chicago Office: 312-793-4792
Springfield Office: 217-782-7755

From: Lorie Chaiten [mailto:lchaiten@ACLU-il.org]
Sent: Monday, October 16, 2017 4:57 PM
To: Norwood, Felicia
Cc: Amy Meek
Subject: [External] RE: Abortion coverage under Medicaid

Dear Director Norwood,
I am writing again to see if we can schedule a meeting with you/and or others at HFS to discuss HB 40 implementation. Please let me know if there is a time in the near future when you would be available for a meeting. Thank you.
Lorie

Lorie Chaiten

Director, Women's and Reproductive Rights Project
Roger Baldwin Foundation of the ACLU of IL
150 N. Michigan Ave. #600
Chicago, IL 60601
312-201-9740 x324
lchaiten@aclu-il.org

From: Lorie Chaiten
Sent: Wednesday, October 04, 2017 9:20 AM
To: Norwood, Felicia <Felicia.Norwood@illinois.gov>
Cc: Amy Meek <ameek@ACLU-il.org>
Subject: Abortion coverage under Medicaid

Dear Director Norwood,
As you know, the ACLU has been reviewing DHFS policies, procedures and materials as they relate to abortion coverage. Now that House Bill 40 has been signed, we would love to have the opportunity to meet with you and/or your staff to discuss the changes that will be necessary in order to implement the law. Please let me know if there is a time in the near future that would work for a meeting. Thank you.
Lorie

Lorie Chaiten
Director, Women's and Reproductive Rights Project
Roger Baldwin Foundation of the ACLU of IL
150 N. Michigan Ave. #600
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Lee, Kyong

From: Lorie Chaiten <lchaiten@ACLU-il.org>
Sent: Friday, November 03, 2017 1:41 PM
To: Dellamorte, Gina; Norwood, Felicia
Cc: Amy Meek; Hursey, Teresa; McGady, Shawn; Doran, Mary
Subject: [External] RE: Abortion coverage under Medicaid
Attachments: All Materials with Index and Bookmarks.pdf

Dear all,
Thank you for making the time to meet yesterday. We look forward to working together as implementation of HB 40 moves forward.

As promised, I am attaching a pdf of the binder we brought to the meeting. In addition, on the question of whether other states that provide coverage beyond Hyde seek reimbursement for abortions from the federal government, I am sending links to two Guttmacher reports. The most recent is "Public Funding for Family Planning and Abortion Services, FY 1980–2015" (https://www.guttmacher.org/sites/default/files/report_pdf/public-funding-family-planning-abortion-services-fy-1980-2015.pdf). The relevant table starts on page 14. Illinois appears to be one of only 4 (out of the 17 states with policies/court orders to provide abortion coverage for Medicaid enrollees using state funding) to obtain reimbursement for abortions from the federal government, and the only one of the 17 states that obtained reimbursement for any significant number. In FY 2015, the federal government reimbursed for 58 abortions performed in Illinois. The only other states among the 17 were Arizona (6 abortions), Minnesota (4 abortions), and Montana (1 abortion). The other 13 states did not obtain federal reimbursement for a single abortion in FY 2015. (As you can see from the table, it's also pretty rare even among the states that do not provide state funding for abortion coverage). There is also an earlier report (that has FY 2010 numbers) at https://www.guttmacher.org/sites/default/files/report_pdf/public-funding-fp-2010.pdf -- this reflects essentially the same patterns.

Thank you again.
Lorie

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From: Dellamorte, Gina [mailto:Gina.Dellamorte@illinois.gov]
Sent: Thursday, October 19, 2017 10:18 AM

To: Lorie Chaiten
Cc: Amy Meek ; Hursey, Teresa ; McGady, Shawn ; Doran, Mary
Subject: RE: Abortion coverage under Medicaid

Lorie,

Good Morning.

Director Norwood has availability on November 2nd at 10am at the 401 South Clinton address.

Please let me know if this will work for you and I well send out an invite.

Thank you.

From: Norwood, Felicia
Sent: Monday, October 16, 2017 5:10 PM
To: Lorie Chaiten
Cc: Amy Meek; Dellamorte, Gina; Hursey, Teresa; McGady, Shawn; Doran, Mary
Subject: RE: Abortion coverage under Medicaid

Lorie,

It's been incredibly busy as we get ready to roll out the new MCO contracts and also work on other year-end priorities.

I'll have my Chicago assistant, Gina, get back to you with some dates that work with our schedules.

It will likely be near the end of October/first part of November.

Felicia

Felicia F. Norwood
Director
Illinois Department of Healthcare and Family Services
Chicago Office: 312-793-4792
Springfield Office: 217-782-7755

From: Lorie Chaiten [mailto:lchaiten@ACLU-il.org]
Sent: Monday, October 16, 2017 4:57 PM
To: Norwood, Felicia
Cc: Amy Meek
Subject: [External] RE: Abortion coverage under Medicaid

Dear Director Norwood,
I am writing again to see if we can schedule a meeting with you/and or others at HFS to discuss HB 40 implementation. Please let me know if there is a time in the near future when you would be available for a meeting. Thank you.
Lorie

Lorie Chaiten
Director, Women's and Reproductive Rights Project
Roger Baldwin Foundation of the ACLU of IL
150 N. Michigan Ave. #600
Chicago, IL 60601

312-201-9740 x324
lchaiten@aclu-il.org

From: Lorie Chaiten
Sent: Wednesday, October 04, 2017 9:20 AM
To: Norwood, Felicia <Felicia.Norwood@illinois.gov>
Cc: Amy Meek <ameek@ACLU-il.org>
Subject: Abortion coverage under Medicaid

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As you know, the ACLU has been reviewing DHFS policies, procedures and materials as they relate to abortion coverage. Now that House Bill 40 has been signed, we would love to have the opportunity to meet with you and/or your staff to discuss the changes that will be necessary in order to implement the law. Please let me know if there is a time in the near future that would work for a meeting. Thank you.
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Index of Materials for Nov. 2, 2017 Discussion with HFS about HB40 Implementation

A – HB40 Text

B – HFS Medicaid Rules

1. HFS Rule 140.6
2. HFS Rule 140.413

C - All KIDS/CHIP Materials (including CHIP Rules)

1. Illinois CHIP Act Excerpt (215 ILCS 106/25)
2. HFS Rule 125.300
3. HFS Rule 125.305
4. Georgetown Study on Benefits in CHIP Programs (excerpts)
5. 42 CFR 457.475 (separate managed care contract for CHIP abortion coverage beyond Hyde)

D – Issues for MCO enrollees

1. ACLU-IL letter to HFS regarding MCO RFP (Mar. 9, 2017)
2. ACLU-IL comments to HFS regarding revised MCO contract (Sept. 15, 2017)
3. ACLU-IL table reviewing MCO handbooks and guidance re: abortion coverage (May 17, 2017)

E – HFS Handbook Excerpts

1. HFS Provider Handbook Chapter 100 (excerpt)
2. HFS Hospital Handbook Chapter 200 (excerpt)
3. HFS Practitioner Handbook Chapter A-200 (excerpt)
4. HFS ASTC Handbook Chapter G-200 (excerpt)
5. HFS Managed Care Manual

F - HFS forms billing info and codes

1. HFS Form 2390 - Abortion Payment Application
2. HFS Form 2360 – Practitioner Claim Form
3. HFS Modifier Code Listing for Practitioners (June 7, 2016)
4. HFS Modifier Code Listing for Practitioners (Jan. 1, 2017)
5. HFS Practitioner Handbook Appendices
6. HFS Form UB-04 – Hospital Claim Form
7. HFS Hospital Handbook Appendix h200a (excerpt)
8. HFS New UB-92 Condition Codes for Abortion Procedures (for hospitals)

G – Presumptive Eligibility for Pregnant Women

1. Presumptive eligibility for pregnant women (HFS Rule 120.66)

H – Illinois Medicaid and CHIP State Plans

1. IL Medicaid State Plan amendment including outdated abortion language
2. IL CHIP State Plan amendment with abortion language

AN ACT concerning abortion.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Sections 6 and 6.1 as follows:

(5 ILCS 375/6) (from Ch. 127, par. 526)

Sec. 6. Program of health benefits.

(a) The program of health benefits shall provide for protection against the financial costs of health care expenses incurred in and out of hospital including basic hospital-surgical-medical coverages. The program may include, but shall not be limited to, such supplemental coverages as out-patient diagnostic X-ray and laboratory expenses, prescription drugs, dental services, hearing evaluations, hearing aids, the dispensing and fitting of hearing aids, and similar group benefits as are now or may become available. ~~However, nothing in this Act shall be construed to permit, on or after July 1, 1980, the non-contributory portion of any such program to include the expenses of obtaining an abortion, induced miscarriage or induced premature birth unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live~~

~~viable child and such procedure is necessary for the health of the mother or the unborn child.~~ The program may also include coverage for those who rely on treatment by prayer or spiritual means alone for healing in accordance with the tenets and practice of a recognized religious denomination.

The program of health benefits shall be designed by the Director (1) to provide a reasonable relationship between the benefits to be included and the expected distribution of expenses of each such type to be incurred by the covered members and dependents, (2) to specify, as covered benefits and as optional benefits, the medical services of practitioners in all categories licensed under the Medical Practice Act of 1987, (3) to include reasonable controls, which may include deductible and co-insurance provisions, applicable to some or all of the benefits, or a coordination of benefits provision, to prevent or minimize unnecessary utilization of the various hospital, surgical and medical expenses to be provided and to provide reasonable assurance of stability of the program, and (4) to provide benefits to the extent possible to members throughout the State, wherever located, on an equitable basis. Notwithstanding any other provision of this Section or Act, for all members or dependents who are eligible for benefits under Social Security or the Railroad Retirement system or who had sufficient Medicare-covered government employment, the Department shall reduce benefits which would otherwise be paid by Medicare, by the amount of benefits for which the member or

dependents are eligible under Medicare, except that such reduction in benefits shall apply only to those members or dependents who (1) first become eligible for such medicare coverage on or after the effective date of this amendatory Act of 1992; or (2) are Medicare-eligible members or dependents of a local government unit which began participation in the program on or after July 1, 1992; or (3) remain eligible for but no longer receive Medicare coverage which they had been receiving on or after the effective date of this amendatory Act of 1992.

Notwithstanding any other provisions of this Act, where a covered member or dependents are eligible for benefits under the federal Medicare health insurance program (Title XVIII of the Social Security Act as added by Public Law 89-97, 89th Congress), benefits paid under the State of Illinois program or plan will be reduced by the amount of benefits paid by Medicare. For members or dependents who are eligible for benefits under Social Security or the Railroad Retirement system or who had sufficient Medicare-covered government employment, benefits shall be reduced by the amount for which the member or dependent is eligible under Medicare, except that such reduction in benefits shall apply only to those members or dependents who (1) first become eligible for such Medicare coverage on or after the effective date of this amendatory Act of 1992; or (2) are Medicare-eligible members or dependents of a local government unit which began participation in the

program on or after July 1, 1992; or (3) remain eligible for, but no longer receive Medicare coverage which they had been receiving on or after the effective date of this amendatory Act of 1992. Premiums may be adjusted, where applicable, to an amount deemed by the Director to be reasonably consistent with any reduction of benefits.

(b) A member, not otherwise covered by this Act, who has retired as a participating member under Article 2 of the Illinois Pension Code but is ineligible for the retirement annuity under Section 2-119 of the Illinois Pension Code, shall pay the premiums for coverage, not exceeding the amount paid by the State for the non-contributory coverage for other members, under the group health benefits program under this Act. The Director shall determine the premiums to be paid by a member under this subsection (b).

(Source: P.A. 93-47, eff. 7-1-03.)

(5 ILCS 375/6.1) (from Ch. 127, par. 526.1)

Sec. 6.1. The program of health benefits may offer as an alternative, available on an optional basis, coverage through health maintenance organizations. That part of the premium for such coverage which is in excess of the amount which would otherwise be paid by the State for the program of health benefits shall be paid by the member who elects such alternative coverage and shall be collected as provided for premiums for other optional coverages.

~~However, nothing in this Act shall be construed to permit, after the effective date of this amendatory Act of 1983, the noncontributory portion of any such program to include the expenses of obtaining an abortion, induced miscarriage or induced premature birth unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.~~

(Source: P.A. 85-848.)

Section 10. The Illinois Public Aid Code is amended by changing Sections 5-5, 5-8, 5-9, and 6-1 as follows:

(305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial

care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant women, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services, including to ensure that the individual's need for intervention or treatment of mental disorders or substance use disorders or co-occurring mental health and substance use disorders is determined using a uniform screening, assessment, and evaluation process inclusive of criteria, for children and adults; for purposes of this item (13), a uniform screening, assessment, and evaluation process refers to a process that includes an appropriate evaluation and, as warranted, a referral; "uniform" does not mean the use of a singular instrument, tool, or process that all must utilize; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined

in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State~~, but not including abortions, or induced miscarriages or premature births, unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child. The Illinois Department, by rule, shall prohibit any physician from providing medical assistance to anyone eligible therefor under this Code where such physician has been found guilty of performing an abortion procedure in a wilful and wanton manner upon a woman who was not pregnant at the time such abortion procedure was performed~~. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

Notwithstanding any other provision of this Section, a comprehensive tobacco use cessation program that includes purchasing prescription drugs or prescription medical devices approved by the Food and Drug Administration shall be covered

under the medical assistance program under this Article for persons who are otherwise eligible for assistance under this Article.

Notwithstanding any other provision of this Code, reproductive health care that is otherwise legal in Illinois shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article.

Notwithstanding any other provision of this Code, the Illinois Department may not require, as a condition of payment for any laboratory test authorized under this Article, that a physician's handwritten signature appear on the laboratory test order form. The Illinois Department may, however, impose other appropriate requirements regarding laboratory test order documentation.

Upon receipt of federal approval of an amendment to the Illinois Title XIX State Plan for this purpose, the Department 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. CPS shall ensure that its vendor or vendors are enrolled as providers in the medical assistance program and in any capitated Medicaid managed care entity (MCE) serving individuals enrolled in a school within the CPS system. Under any contract procured under this provision, the vendor or vendors must serve only individuals enrolled in a school within the CPS system. Claims

for services provided by CPS's vendor or vendors to recipients of benefits in the medical assistance program under this Code, the Children's Health Insurance Program, or the Covering ALL KIDS Health Insurance Program shall be submitted to the 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.

On and after July 1, 2012, the Department of Healthcare and Family Services may provide the following services to persons eligible for assistance under this Article who are participating in education, training or employment programs operated by the Department of Human Services as successor to the Department of Public Aid:

(1) dental services provided by or under the supervision of a dentist; and

(2) eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select.

Notwithstanding any other provision of this Code and subject to federal approval, the Department may adopt rules to allow a dentist who is volunteering his or her service at no cost to render dental services through an enrolled not-for-profit health clinic without the dentist personally enrolling as a participating provider in the medical assistance program. A not-for-profit health clinic shall include a public health clinic or Federally Qualified Health Center or other

enrolled provider, as determined by the Department, through which dental services covered under this Section are performed. The Department shall establish a process for payment of claims for reimbursement for covered dental services rendered under this provision.

The Illinois Department, by rule, may distinguish and classify the medical services to be provided only in accordance with the classes of persons designated in Section 5-2.

The Department of Healthcare and Family Services must provide coverage and reimbursement for amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when the prescribing physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

The Illinois Department shall authorize the provision of, and shall authorize payment for, screening by low-dose mammography for the presence of occult breast cancer for women 35 years of age or older who are eligible for medical assistance under this Article, as follows:

(A) A baseline mammogram for women 35 to 39 years of age.

(B) An annual mammogram for women 40 years of age or older.

(C) A mammogram at the age and intervals considered medically necessary by the woman's health care provider for

women under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.

(D) A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a physician licensed to practice medicine in all of its branches.

(E) A screening MRI when medically necessary, as determined by a physician licensed to practice medicine in all of its branches.

All screenings shall include a physical breast exam, instruction on self-examination and information regarding the frequency of self-examination and its value as a preventative tool. For purposes of this Section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with an average radiation exposure delivery of less than one rad per breast for 2 views of an average size breast. The term also includes digital mammography and includes breast tomosynthesis. As used in this Section, the term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast. If, at any time, the Secretary of the United States

Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage for breast tomosynthesis outlined in this paragraph, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for breast tomosynthesis set forth in this paragraph.

On and after January 1, 2016, the Department shall ensure that all networks of care for adult clients of the Department include access to at least one breast imaging Center of Imaging Excellence as certified by the American College of Radiology.

On and after January 1, 2012, providers participating in a quality improvement program approved by the Department shall be reimbursed for screening and diagnostic mammography at the same rate as the Medicare program's rates, including the increased reimbursement for digital mammography.

The Department shall convene an expert panel including representatives of hospitals, free-standing mammography facilities, and doctors, including radiologists, to establish

quality standards for mammography.

On and after January 1, 2017, providers participating in a breast cancer treatment quality improvement program approved by the Department shall be reimbursed for breast cancer treatment at a rate that is no lower than 95% of the Medicare program's rates for the data elements included in the breast cancer treatment quality program.

The Department shall convene an expert panel, including representatives of hospitals, free standing breast cancer treatment centers, breast cancer quality organizations, and doctors, including breast surgeons, reconstructive breast surgeons, oncologists, and primary care providers to establish quality standards for breast cancer treatment.

Subject to federal approval, the Department shall establish a rate methodology for mammography at federally qualified health centers and other encounter-rate clinics. These clinics or centers may also collaborate with other hospital-based mammography facilities. By January 1, 2016, the Department shall report to the General Assembly on the status of the provision set forth in this paragraph.

The Department shall establish a methodology to remind women who are age-appropriate for screening mammography, but who have not received a mammogram within the previous 18 months, of the importance and benefit of screening mammography. The Department shall work with experts in breast cancer outreach and patient navigation to optimize these reminders and

shall establish a methodology for evaluating their effectiveness and modifying the methodology based on the evaluation.

The Department shall establish a performance goal for primary care providers with respect to their female patients over age 40 receiving an annual mammogram. This performance goal shall be used to provide additional reimbursement in the form of a quality performance bonus to primary care providers who meet that goal.

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program in areas of the State with the highest incidence of mortality related to breast cancer. At least one pilot program site shall be in the metropolitan Chicago area and at least one site shall be outside the metropolitan Chicago area. On or after July 1, 2016, the pilot program shall be expanded to include one site in western Illinois, one site in southern Illinois, one site in central Illinois, and 4 sites within metropolitan Chicago. An evaluation of the pilot program shall be carried out measuring health outcomes and cost of care for those served by the pilot program compared to similarly situated patients who are not served by the pilot program.

The Department shall require all networks of care to develop a means either internally or by contract with experts in navigation and community outreach to navigate cancer

patients to comprehensive care in a timely fashion. The Department shall require all networks of care to include access for patients diagnosed with cancer to at least one academic commission on cancer-accredited cancer program as an in-network covered benefit.

Any medical or health care provider shall immediately recommend, to any pregnant woman who is being provided prenatal services and is suspected of drug abuse or is addicted as defined in the Alcoholism and Other Drug Abuse and Dependency Act, referral to a local substance abuse treatment provider licensed by the Department of Human Services or to a licensed hospital which provides substance abuse treatment services. The Department of Healthcare and Family Services shall assure coverage for the cost of treatment of the drug abuse or addiction for pregnant recipients in accordance with the Illinois Medicaid Program in conjunction with the Department of Human Services.

All medical providers providing medical assistance to pregnant women under this Code shall receive information from the Department on the availability of services under the Drug Free Families with a Future or any comparable program providing case management services for addicted women, including information on appropriate referrals for other social services that may be needed by addicted women in addition to treatment for addiction.

The Illinois Department, in cooperation with the

Departments of Human Services (as successor to the Department of Alcoholism and Substance Abuse) and Public Health, through a public awareness campaign, may provide information concerning treatment for alcoholism and drug abuse and addiction, prenatal health care, and other pertinent programs directed at reducing the number of drug-affected infants born to recipients of medical assistance.

Neither the Department of Healthcare and Family Services nor the Department of Human Services shall sanction the recipient solely on the basis of her substance abuse.

The Illinois Department shall establish such regulations governing the dispensing of health services under this Article as it shall deem appropriate. The Department should seek the advice of formal professional advisory committees appointed by the Director of the Illinois Department for the purpose of providing regular advice on policy and administrative matters, information dissemination and educational activities for medical and health care providers, and consistency in procedures to the Illinois Department.

The Illinois Department may develop and contract with Partnerships of medical providers to arrange medical services for persons eligible under Section 5-2 of this Code. Implementation of this Section may be by demonstration projects in certain geographic areas. The Partnership shall be represented by a sponsor organization. The Department, by rule, shall develop qualifications for sponsors of Partnerships.

Nothing in this Section shall be construed to require that the sponsor organization be a medical organization.

The sponsor must negotiate formal written contracts with medical providers for physician services, inpatient and outpatient hospital care, home health services, treatment for alcoholism and substance abuse, and other services determined necessary by the Illinois Department by rule for delivery by Partnerships. Physician services must include prenatal and obstetrical care. The Illinois Department shall reimburse medical services delivered by Partnership providers to clients in target areas according to provisions of this Article and the Illinois Health Finance Reform Act, except that:

(1) Physicians participating in a Partnership and providing certain services, which shall be determined by the Illinois Department, to persons in areas covered by the Partnership may receive an additional surcharge for such services.

(2) The Department may elect to consider and negotiate financial incentives to encourage the development of Partnerships and the efficient delivery of medical care.

(3) Persons receiving medical services through Partnerships may receive medical and case management services above the level usually offered through the medical assistance program.

Medical providers shall be required to meet certain qualifications to participate in Partnerships to ensure the

delivery of high quality medical services. These qualifications shall be determined by rule of the Illinois Department and may be higher than qualifications for participation in the medical assistance program. Partnership sponsors may prescribe reasonable additional qualifications for participation by medical providers, only with the prior written approval of the Illinois Department.

Nothing in this Section shall limit the free choice of practitioners, hospitals, and other providers of medical services by clients. In order to ensure patient freedom of choice, the Illinois Department shall immediately promulgate all rules and take all other necessary actions so that provided services may be accessed from therapeutically certified optometrists to the full extent of the Illinois Optometric Practice Act of 1987 without discriminating between service providers.

The Department shall apply for a waiver from the United States Health Care Financing Administration to allow for the implementation of Partnerships under this Section.

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. Such records must be retained for a period of not less than 6 years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period

then the records must be retained until the audit is completed and every exception is resolved. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The rules and regulations shall require that proof of the receipt of prescription drugs, dentures, prosthetic devices and eyeglasses by eligible persons under this Section accompany each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after September 16, 1984 (the effective date of Public Act 83-1439), the Illinois Department

shall establish a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

~~The rules and regulations of the Illinois Department shall require that a written statement including the required opinion of a physician shall accompany any claim for reimbursement for abortions, or induced miscarriages or premature births. This statement shall indicate what procedures were used in providing such medical services.~~

Notwithstanding any other law to the contrary, the Illinois Department shall, within 365 days after July 22, 2013 (the effective date of Public Act 98-104), establish procedures to permit skilled care facilities licensed under the Nursing Home Care Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall, by July 1, 2016, test the viability of the new system and implement any necessary operational or structural changes to its information technology platforms in order to allow for the direct acceptance and payment of nursing home claims.

Notwithstanding any other law to the contrary, the Illinois Department shall, within 365 days after August 15, 2014 (the

effective date of Public Act 98-963), establish procedures to permit ID/DD facilities licensed under the ID/DD Community Care Act and MC/DD facilities licensed under the MC/DD Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall have an additional 365 days to test the viability of the new system and to ensure that any necessary operational or structural changes to its information technology platforms are implemented.

The Illinois Department shall require all dispensers of medical services, other than an individual practitioner or group of practitioners, desiring to participate in the Medical Assistance program established under this Article to disclose all financial, beneficial, ownership, equity, surety or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services in this State under this Article.

The Illinois Department may require that all dispensers of medical services desiring to participate in the medical assistance program established under this Article disclose, under such terms and conditions as the Illinois Department may by rule establish, all inquiries from clients and attorneys regarding medical bills paid by the Illinois Department, which inquiries could indicate potential existence of claims or liens for the Illinois Department.

Enrollment of a vendor shall be subject to a provisional

period and shall be conditional for one year. During the period of conditional enrollment, the Department may terminate the vendor's eligibility to participate in, or may disenroll the vendor from, the medical assistance program without cause. Unless otherwise specified, such termination of eligibility or disenrollment is not subject to the Department's hearing process. However, a disenrolled vendor may reapply without penalty.

The Department has the discretion to limit the conditional enrollment period for vendors based upon category of risk of the vendor.

Prior to enrollment and during the conditional enrollment period in the medical assistance program, all vendors shall be subject to enhanced oversight, screening, and review based on the risk of fraud, waste, and abuse that is posed by the category of risk of the vendor. The Illinois Department shall establish the procedures for oversight, screening, and review, which may include, but need not be limited to: criminal and financial background checks; fingerprinting; license, certification, and authorization verifications; unscheduled or unannounced site visits; database checks; prepayment audit reviews; audits; payment caps; payment suspensions; and other screening as required by federal or State law.

The Department shall define or specify the following: (i) by provider notice, the "category of risk of the vendor" for each type of vendor, which shall take into account the level of

screening applicable to a particular category of vendor under federal law and regulations; (ii) by rule or provider notice, the maximum length of the conditional enrollment period for each category of risk of the vendor; and (iii) by rule, the hearing rights, if any, afforded to a vendor in each category of risk of the vendor that is terminated or disenrolled during the conditional enrollment period.

To be eligible for payment consideration, a vendor's payment claim or bill, either as an initial claim or as a resubmitted claim following prior rejection, must be received by the Illinois Department, or its fiscal intermediary, no later than 180 days after the latest date on the claim on which medical goods or services were provided, with the following exceptions:

(1) In the case of a provider whose enrollment is in process by the Illinois Department, the 180-day period shall not begin until the date on the written notice from the Illinois Department that the provider enrollment is complete.

(2) In the case of errors attributable to the Illinois Department or any of its claims processing intermediaries which result in an inability to receive, process, or adjudicate a claim, the 180-day period shall not begin until the provider has been notified of the error.

(3) In the case of a provider for whom the Illinois Department initiates the monthly billing process.

(4) In the case of a provider operated by a unit of local government with a population exceeding 3,000,000 when local government funds finance federal participation for claims payments.

For claims for services rendered during a period for which a recipient received retroactive eligibility, claims must be filed within 180 days after the Department determines the applicant is eligible. For claims for which the Illinois Department is not the primary payer, claims must be submitted to the Illinois Department within 180 days after the final adjudication by the primary payer.

In the case of long term care facilities, within 5 days of receipt by the facility of required prescreening information, data for new admissions shall be entered into the Medical Electronic Data Interchange (MEDI) or the Recipient Eligibility Verification (REV) System or successor system, and within 15 days of receipt by the facility of required prescreening information, admission documents shall be submitted through MEDI or REV or shall be submitted directly to the Department of Human Services using required admission forms. Effective September 1, 2014, admission documents, including all prescreening information, must be submitted through MEDI or REV. Confirmation numbers assigned to an accepted transaction shall be retained by a facility to verify timely submittal. Once an admission transaction has been completed, all resubmitted claims following prior rejection

are subject to receipt no later than 180 days after the admission transaction has been completed.

Claims that are not submitted and received in compliance with the foregoing requirements shall not be eligible for payment under the medical assistance program, and the State shall have no liability for payment of those claims.

To the extent consistent with applicable information and privacy, security, and disclosure laws, State and federal agencies and departments shall provide the Illinois Department access to confidential and other information and data necessary to perform eligibility and payment verifications and other Illinois Department functions. This includes, but is not limited to: information pertaining to licensure; certification; earnings; immigration status; citizenship; wage reporting; unearned and earned income; pension income; employment; supplemental security income; social security numbers; National Provider Identifier (NPI) numbers; the National Practitioner Data Bank (NPDB); program and agency exclusions; taxpayer identification numbers; tax delinquency; corporate information; and death records.

The Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary for medical assistance program integrity functions and oversight. The Illinois Department shall develop, in cooperation with

other State departments and agencies, and in compliance with applicable federal laws and regulations, appropriate and effective methods to share such data. At a minimum, and to the extent necessary to provide data sharing, the Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, including but not limited to: the Secretary of State; the Department of Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial and Professional Regulation.

Beginning in fiscal year 2013, the Illinois Department shall set forth a request for information to identify the benefits of a pre-payment, post-adjudication, and post-edit claims system with the goals of streamlining claims processing and provider reimbursement, reducing the number of pending or rejected claims, and helping to ensure a more transparent adjudication process through the utilization of: (i) provider data verification and provider screening technology; and (ii) clinical code editing; and (iii) pre-pay, pre- or post-adjudicated predictive modeling with an integrated case management system with link analysis. Such a request for information shall not be considered as a request for proposal or as an obligation on the part of the Illinois Department to take any action or acquire any products or services.

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition,

repair and replacement of orthotic and prosthetic devices and durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1) immediate repair or replacement of such devices by recipients; and (2) rental, lease, purchase or lease-purchase of durable medical equipment in a cost-effective manner, taking into consideration the recipient's medical prognosis, the extent of the recipient's needs, and the requirements and costs for maintaining such equipment. Subject to prior approval, such rules shall enable a recipient to temporarily acquire and use alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department. Notwithstanding any provision of Section 5-5f to the contrary, the Department may, by rule, exempt certain replacement wheelchair parts from prior approval and, for wheelchairs, wheelchair parts, wheelchair accessories, and related seating and positioning items, determine the wholesale price by methods other than actual acquisition costs.

The Department shall require, by rule, all providers of durable medical equipment to be accredited by an accreditation organization approved by the federal Centers for Medicare and Medicaid Services and recognized by the Department in order to bill the Department for providing durable medical equipment to recipients. No later than 15 months after the effective date of the rule adopted pursuant to this paragraph, all providers must

meet the accreditation requirement.

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department on Aging, to effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (ii) the establishment and development of non-institutional services in areas of the State where they are not currently available or are undeveloped; and (iii) notwithstanding any other provision of law, subject to federal approval, on and after July 1, 2012, an increase in the determination of need (DON) scores from 29 to 37 for applicants for institutional and home and community-based long term care; if and only if federal approval is not granted, the Department may, in conjunction with other affected agencies, implement utilization controls or changes in benefit packages to effectuate a similar savings amount for this population; and (iv) no later than July 1, 2013, minimum level of care eligibility criteria for institutional and home and community-based long term care; and (v) no later than October 1, 2013, establish procedures to permit long term care providers access to eligibility scores for individuals with an admission date who are seeking or receiving services from the long term care provider. In order to select the minimum level of care eligibility criteria, the Governor shall establish a workgroup that includes affected agency representatives and

stakeholders representing the institutional and home and community-based long term care interests. This Section shall not restrict the Department from implementing lower level of care eligibility criteria for community-based services in circumstances where federal approval has been granted.

The Illinois Department shall develop and operate, in cooperation with other State Departments and agencies and in compliance with applicable federal laws and regulations, appropriate and effective systems of health care evaluation and programs for monitoring of utilization of health care services and facilities, as it affects persons eligible for medical assistance under this Code.

The Illinois Department shall report annually to the General Assembly, no later than the second Friday in April of 1979 and each year thereafter, in regard to:

(a) actual statistics and trends in utilization of medical services by public aid recipients;

(b) actual statistics and trends in the provision of the various medical services by medical vendors;

(c) current rate structures and proposed changes in those rate structures for the various medical vendors; and

(d) efforts at utilization review and control by the Illinois Department.

The period covered by each report shall be the 3 years ending on the June 30 prior to the report. The report shall include suggested legislation for consideration by the General

Assembly. The filing of one copy of the report with the Speaker, one copy with the Minority Leader and one copy with the Clerk of the House of Representatives, one copy with the President, one copy with the Minority Leader and one copy with the Secretary of the Senate, one copy with the Legislative Research Unit, and such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act shall be deemed sufficient to comply with this Section.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

Because kidney transplantation can be an appropriate, cost effective alternative to renal dialysis when medically necessary and notwithstanding the provisions of Section 1-11 of this Code, beginning October 1, 2014, the Department shall cover kidney transplantation for noncitizens with end-stage

renal disease who are not eligible for comprehensive medical benefits, who meet the residency requirements of Section 5-3 of this Code, and who would otherwise meet the financial requirements of the appropriate class of eligible persons under Section 5-2 of this Code. To qualify for coverage of kidney transplantation, such person must be receiving emergency renal dialysis services covered by the Department. Providers under this Section shall be prior approved and certified by the Department to perform kidney transplantation and the services under this Section shall be limited to services associated with kidney transplantation.

Notwithstanding any other provision of this Code to the contrary, on or after July 1, 2015, all FDA approved forms of medication assisted treatment prescribed for the treatment of alcohol dependence or treatment of opioid dependence shall be covered under both fee for service and managed care medical assistance programs for persons who are otherwise eligible for medical assistance under this Article and shall not be subject to any (1) utilization control, other than those established under the American Society of Addiction Medicine patient placement criteria, (2) prior authorization mandate, or (3) lifetime restriction limit mandate.

On or after July 1, 2015, opioid antagonists prescribed for the treatment of an opioid overdose, including the medication product, administration devices, and any pharmacy fees related to the dispensing and administration of the opioid antagonist,

shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article. As used in this Section, "opioid antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.

Upon federal approval, the Department shall provide coverage and reimbursement for all drugs that are approved for marketing by the federal Food and Drug Administration and that are recommended by the federal Public Health Service or the United States Centers for Disease Control and Prevention for pre-exposure prophylaxis and related pre-exposure prophylaxis services, including, but not limited to, HIV and sexually transmitted infection screening, treatment for sexually transmitted infections, medical monitoring, assorted labs, and counseling to reduce the likelihood of HIV infection among individuals who are not infected with HIV but who are at high risk of HIV infection.

(Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13; 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff. 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15; 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for the effective date of P.A. 99-407);

99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff. 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; revised 9-20-16.)

(305 ILCS 5/5-8) (from Ch. 23, par. 5-8)

Sec. 5-8. Practitioners. In supplying medical assistance, the Illinois Department may provide for the legally authorized services of (i) persons licensed under the Medical Practice Act of 1987, as amended, except as hereafter in this Section stated, whether under a general or limited license, (ii) persons licensed under the Nurse Practice Act as advanced practice nurses, regardless of whether or not the persons have written collaborative agreements, (iii) persons licensed or registered under other laws of this State to provide dental, medical, pharmaceutical, optometric, podiatric, or nursing services, or other remedial care recognized under State law, and (iv) persons licensed under other laws of this State as a clinical social worker. The Department shall adopt rules, no later than 90 days after the effective date of this amendatory Act of the 99th General Assembly, for the legally authorized services of persons licensed under other laws of this State as a clinical social worker. ~~The Department may not provide for legally authorized services of any physician who has been convicted of having performed an abortion procedure in a wilful and wanton manner on a woman who was not pregnant at the time such abortion procedure was performed.~~ The utilization of the

services of persons engaged in the treatment or care of the sick, which persons are not required to be licensed or registered under the laws of this State, is not prohibited by this Section.

(Source: P.A. 99-173, eff. 7-29-15; 99-621, eff. 1-1-17.)

(305 ILCS 5/5-9) (from Ch. 23, par. 5-9)

Sec. 5-9. Choice of Medical Dispensers. Applicants and recipients shall be entitled to free choice of those qualified practitioners, hospitals, nursing homes, and other dispensers of medical services meeting the requirements and complying with the rules and regulations of the Illinois Department. However, the Director of Healthcare and Family Services may, after providing reasonable notice and opportunity for hearing, deny, suspend or terminate any otherwise qualified person, firm, corporation, association, agency, institution, or other legal entity, from participation as a vendor of goods or services under the medical assistance program authorized by this Article if the Director finds such vendor of medical services in violation of this Act or the policy or rules and regulations issued pursuant to this Act. ~~Any physician who has been convicted of performing an abortion procedure in a wilful and wanton manner upon a woman who was not pregnant at the time such abortion procedure was performed shall be automatically removed from the list of physicians qualified to participate as a vendor of medical services under the medical assistance~~

~~program authorized by this Article.~~

(Source: P.A. 95-331, eff. 8-21-07.)

(305 ILCS 5/6-1) (from Ch. 23, par. 6-1)

Sec. 6-1. Eligibility requirements. Financial aid in meeting basic maintenance requirements shall be given under this Article to or in behalf of persons who meet the eligibility conditions of Sections 6-1.1 through 6-1.10. In addition, each unit of local government subject to this Article shall provide persons receiving financial aid in meeting basic maintenance requirements with financial aid for either (a) necessary treatment, care, and supplies required because of illness or disability, or (b) acute medical treatment, care, and supplies only. If a local governmental unit elects to provide financial aid for acute medical treatment, care, and supplies only, the general types of acute medical treatment, care, and supplies for which financial aid is provided shall be specified in the general assistance rules of the local governmental unit, which rules shall provide that financial aid is provided, at a minimum, for acute medical treatment, care, or supplies necessitated by a medical condition for which prior approval or authorization of medical treatment, care, or supplies is not required by the general assistance rules of the Illinois Department. ~~Nothing in this Article shall be construed to permit the granting of financial aid where the purpose of such aid is to obtain an abortion, induced miscarriage or~~

~~induced premature birth unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.~~

(Source: P.A. 92-111, eff. 1-1-02.)

Section 15. The Problem Pregnancy Health Services and Care Act is amended by changing Section 4-100 as follows:

(410 ILCS 230/4-100) (from Ch. 111 1/2, par. 4604-100)

Sec. 4-100. The Department may make grants to nonprofit agencies and organizations ~~which do not use such grants to refer or counsel for, or perform, abortions and~~ which coordinate and establish linkages among services that will further the purposes of this Act and, where appropriate, will provide, supplement, or improve the quality of such services.

(Source: P.A. 83-51.)

Section 20. The Illinois Abortion Law of 1975 is amended by changing Section 1 as follows:

(720 ILCS 510/1) (from Ch. 38, par. 81-21)

Sec. 1. It is the intention of the General Assembly of the State of Illinois to reasonably regulate abortion in

conformance with the legal standards set forth in the decisions of the United States Supreme Court of January 22, 1973. ~~Without in any way restricting the right of privacy of a woman or the right of a woman to an abortion under those decisions, the General Assembly of the State of Illinois do solemnly declare and find in reaffirmation of the longstanding policy of this State, that the unborn child is a human being from the time of conception and is, therefore, a legal person for purposes of the unborn child's right to life and is entitled to the right to life from conception under the laws and Constitution of this State. Further, the General Assembly finds and declares that longstanding policy of this State to protect the right to life of the unborn child from conception by prohibiting abortion unless necessary to preserve the life of the mother is impermissible only because of the decisions of the United States Supreme Court and that, therefore, if those decisions of the United States Supreme Court are ever reversed or modified or the United States Constitution is amended to allow protection of the unborn then the former policy of this State to prohibit abortions unless necessary for the preservation of the mother's life shall be reinstated.~~

~~It is the further intention of the General Assembly to assure and protect the woman's health and the integrity of the woman's decision whether or not to continue to bear a child, to protect the valid and compelling state interest in the infant and unborn child, to assure the integrity of marital and~~

~~familial relations and the rights and interests of persons who participate in such relations, and to gather data for establishing criteria for medical decisions. The General Assembly finds as fact, upon hearings and public disclosures, that these rights and interests are not secure in the economic and social context in which abortion is presently performed.~~

(Source: P.A. 81-1078.)

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SECTION 140.6 MEDICAL SERVICES NOT COVERED

Section 140.6 Medical Services Not Covered

The following services are not covered under the Department's medical assistance programs:

a) Services available without charge;

b) Services prohibited by State or Federal law;

c) Experimental procedures;

d) Research oriented procedures;

e) Medical examinations required for entrance into educational or vocational programs;

f) Autopsy examinations;

g) Artificial insemination;

h) Abortion, except under the conditions stated in Section 140.413(a)(1);

i) Medical or surgical procedures performed for cosmetic purposes;

j) Medical or surgical transsexual treatment, for dates of service prior to April 1, 2015;

k) Diagnostic and/or therapeutic procedures related to primary infertility/sterility;

l) Acupuncture;

m) Subsequent treatment for venereal disease, when such services are available through State and/or local health agencies;

n) Medical care provided by mail or telephone;

o) Unkept appointments;

p) Non-medically necessary items and services provided for the convenience of recipients and/or their families;

q) Preparation of routine records, forms and reports;

r) Visits with persons other than a recipient, such as family members or group care facility staff.

(Source: Amended at 38 Ill. Reg. 23623, effective December 2, 2014)

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMS
PART 140 MEDICAL PAYMENT
SECTION 140.413 LIMITATION ON PHYSICIAN SERVICES

Section 140.413 Limitation on Physician Services

a) When provided in accordance with the specified limitations and requirements, the Department shall pay for the following services:

1) Termination of pregnancy – only in those cases in which the physician has certified in writing to the Department that the procedure is necessary to preserve the life of the mother. All claims for reimbursement for abortions or induced miscarriages or premature births must be accompanied by the physician's written certification that the procedure is necessary for preservation of the life of the woman, or that the induced premature birth was to produce a live viable child and was necessary for the health of the mother or her unborn child.

2) Sterilization

A) Therapeutic sterilization – only when the procedure is either a necessary part of the treatment of an existing illness, or is medically indicated as an accompaniment of an operation on the female genitourinary tract. Mental incapacity does not constitute an illness or injury that would authorize this procedure.

B) Nontherapeutic sterilization – only for recipients age 21 or older and mentally competent. The physician must obtain the recipient's informed written consent in a language understandable to the recipient before performing the sterilization and must advise the recipient of the right to withdraw consent at any time prior to the operation. The operation shall be performed no sooner than 30 days and no later than 180 days following the date of the recipient's written informed consent, except in cases of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since informed consent was given.

3) Effective October 1, 2012, surgery for morbid obesity is covered only with prior approval by the Department. The Department shall approve payment for this service only in those cases in which the physician determines that obesity is exogenous in nature, the recipient has had the benefit of other

therapy with no success, endocrine disorders have been ruled out, and the body mass index (BMI) is 40 or higher, or 35 to 39.9 with serious medical complications. The medical record must contain the following documentation of medical necessity:

A) Documentation of review of systems (history and physical);

B) Client height, weight and BMI;

C) Listing of co-morbidities;

D) Patient participation in a six month consecutive medically supervised weight loss program working in conjunction with a registered dietician and or physician within two years prior to the surgery, with at least four documented visits within the consecutive six months;

E) Current and complete psychiatric evaluation indicating the patient is an appropriate candidate for weight loss surgery; and

F) Documentation of nutritional counseling.

4) Psychiatric services

A) Treatment – when the services are provided by a physician who has been enrolled as an approved provider with the Department.

B) Consultation – only when necessary to determine the need for psychiatric care. Services provided subsequent to the initial consultation must comply with the requirements for treatment.

C) Group Psychotherapy – payment may be made for up to two group sessions per week, with a maximum of one session per day. The following conditions must be met for group psychotherapy:

i) documentation maintained in the patient's medical record must indicate the person participating in the group session has been diagnosed with a mental illness as defined in the International Classification of Diseases (ICD-9-CM) or, upon implementation, International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), or the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). The allowable diagnosis code ranges will be specified in the Handbook for Practitioners Rendering Medical Services; and

ii) beginning 1/1/10, the entire group psychotherapy service is directly performed by a physician licensed to practice medicine in all its branches who has completed an approved general psychiatry residency program or is providing the service as a resident or attending physician at an approved or accredited residency program; and

iii) the group size does not exceed 12 patients, regardless of payment source; and

iv) the minimum duration of a group session is 45 minutes; and

v) the group session is documented in the patient's medical record by the rendering physician, including the session's primary focus, level of patient participation, and begin and end times of each session; and

vi) the group treatment model, methods, and subject content have been selected on evidence-based criteria for the target population of the group and follows recognized practice guidelines for psychiatric services; and

vii) the group session is provided in accordance with a clear written description of goals, methods and referral criteria; and

viii) Effective July 1, 2012, group psychotherapy is not covered for recipients who are residents in a facility licensed under the Nursing Home Care Act [210 ILCS 45] or the Specialized Mental Health Rehabilitation Act [210 ILCS 48].

5) Services provided to a recipient in his or her home – only when the recipient is physically unable to go to the physician's office.

6) Services provided to recipients in group care facilities by a physician other than the attending physician – only for emergency services provided when the attending physician of record is not available or when the attending physician has made referral with the recipient's knowledge and permission.

7) Services provided to recipients in a group care facility by a physician who derives a direct or indirect profit from total or partial ownership (or from other types of financial investment for profit in the facility) – only when occasioned by an emergency due to acute illness or unavailability of essential treatment facilities in the vicinity for short-term care pending transfer, or when there is no comparable facility in the area.

8) Maternity care – Payment shall be made for pre-natal and post-natal care only when the following conditions are met:

A) the physician, whether based in a hospital, clinic or individual practice, retains hospital delivery privileges, maintains a written referral arrangement with another physician who retains such privileges, or has been included in the Maternal and Child Health Program as a result of having entered into an appropriate Healthy Moms/Healthy Kids Program provider agreement;

B) the written referral agreement is kept on file and is available for inspection at the physician's place of business, and details procedures for timely transfer of medical records; and

C) maternal services are delivered in a manner consistent with the quality of care guidelines published by the American College of

Obstetricians and Gynecologists in the current edition of the "Standards for Obstetric-Gynecologic Services" (1989 Edition), 409 12th Street, S.W., Washington, D.C. 20024-2188.

9) Physician services to children under age 21

A) Payment shall be made only when the physician meets one or more of the following conditions. The physician:

i) has admitting privileges at a hospital; or

ii) is certified or is eligible for certification in pediatrics or family practice by the medical specialty board recognized by the American Board of Medical Specialties; or

iii) is employed by or affiliated with a Federally Qualified Health Center; or

iv) is a member of the National Health Service Corps; or

v) has been certified by the Secretary of the Department of Health and Human Services as qualified to provide physician services to a child under 21 years of age; or

vi) has current, formal consultation and referral arrangements with a pediatrician or family practitioner for the purposes of specialized treatment and admission to a hospital. The written referral agreement is kept on file and is available for inspection at the physician's place of business, and details procedures for timely transfer of medical records; or

vii) has entered into a Maternal and Child Health provider agreement or has otherwise been transferred in from the Healthy Moms/Healthy Kids Program;

B) The physician shall certify to the Department the way in which he or she meets the above criteria; and

C) Services to children shall be delivered in a manner consistent with the standards of the American Academy of Pediatrics and rules published by the Illinois Department of Public Health (77 Ill. Adm. Code 630, Maternal and Child Health Services; 77 Ill. Adm. Code 665, Child Health Examination Code; 77 Ill. Adm. Code 675, Hearing Screening; 77 Ill. Adm. Code 685, Vision Screening).

10) Hysterectomy – only if the individual has been informed, orally and in writing, that the hysterectomy will render her permanently incapable of reproducing and the individual has signed a written acknowledgment of receipt of the information. The Department will not pay for a hysterectomy that would not have been performed except for the purpose of rendering an individual permanently incapable of reproducing.

11) Selected surgical procedures, including:

A) Tonsillectomies or Adenoidectomies

B) Hemorrhoidectomies

C) Cholecystectomies

D) Disc Surgery/Spinal Fusion

E) Joint Cartilage Surgery/Meniscectomies

F) Excision of Varicose Veins

G) Submucous Resection/Rhinoplasty/Repair of Nasal System

H) Mastectomies for Non-Malignancies

I) Surgical procedures that generally may be performed in an outpatient setting (see Section 140.117) only if the Department authorizes payment. The Department will in some instances require that a second physician agree that the surgical procedure is medically necessary prior to approving payment for one of these procedures. The Department will require a second opinion when the attending physician has been notified by the Department that he or she will be required to obtain prior approval for payment for the surgeries listed. (See Sections 140.40 through 140.42 for prior approval requirements.) The Department will select physicians for this requirement based on the recommendation of a peer review committee that has reviewed the utilization pattern of the physician.

12) Mammography screening

A) Covered only when ordered by a physician for screening by low-dose mammography for the presence of occult breast cancer under the following guidelines:

i) a baseline mammogram for women 35 through 39 years of age; and

ii) a mammogram once per year for women 40 years of age or older.

B) As used in this subsection (a)(12), "low-dose mammography" means the x-ray examination of the breast using equipment specifically designated for mammography that will meet appropriate radiological standards.

13) Pap tests and prostate-specific antigen tests – coverage is provided for the following:

A) An annual cervical smear or Pap smear test for women.

B) An annual digital rectal examination and a prostate-specific antigen test, upon the recommendation of a physician licensed to practice medicine in all its branches, for:

i) asymptomatic men age 50 and over;

ii) African-American men age 40 and over; and

iii) men age 40 and over with a family history of prostate cancer.

14) Effective July 1, 2012, coronary artery by-pass grafts are covered only with prior approval by the Department.

15) Face-to-face tobacco cessation counseling only for pregnant and up to 60-day postpartum women age 21 and over. The tobacco cessation counseling services:

A) Must be provided by or under supervision of a physician, or by any other health care professional who is legally authorized to furnish those services under State law, and who is authorized to provide Medicaid covered services other than tobacco cessation services.

B) Are limited to a maximum of three quit attempts, with four individual face-to-face counseling sessions per quit attempt, per calendar year.

C) Must be properly documented in the patient's medical record and include the total time spent and what was discussed during the counseling session, including cessation techniques, resources available and follow-up. Distinct documentation to support this service is required if reported in conjunction with another evaluation and management service.

D) Rendered to participants under age 21 are not subject to the limitations in this subsection (a)(15).

b) In cases in which a physical examination by a second physician is needed, the Department will notify the recipient and designate a physician to perform the examination. Physicians will be subject to this requirement for six months, after which a request can be submitted to the peer review committee to consider removal of the prior approval requirement.

(Source: Amended at 39 Ill. Reg. 4394, effective March 11, 2015)

(215 ILCS 106/25)

Sec. 25. Health benefits for children.

(a) The Department shall, subject to appropriation, provide health benefits coverage to eligible children by:

(1) Until December 31, 2013 and providing that no application for such coverage shall be accepted after September 30, 2013, subsidizing the cost of privately sponsored health insurance, including employer based health insurance, to assist families to take advantage of available privately sponsored health insurance for their eligible children; and

(2) Purchasing, until December 31, 2013, or providing health care benefits for eligible children. The health benefits provided under this subdivision (a)(2) shall, subject to appropriation and without regard to any applicable cost sharing under Section 30, be identical to the benefits provided for children under the State's approved plan under Title XIX of the Social Security Act. Providers under this subdivision (a)(2) shall be subject to approval by the Department to provide health care under the Illinois Public Aid Code and shall be reimbursed at the same rate as providers under the State's approved plan under Title XIX of the Social Security Act. In addition, providers may retain co-payments when determined appropriate by the Department.

(b) The subsidization provided pursuant to subdivision (a)(1) shall be credited to the family of the eligible child.

(c) The Department is prohibited from denying coverage to a child who is enrolled in a privately sponsored health insurance plan pursuant to subdivision (a)(1) because the plan does not meet federal benchmarking standards or cost sharing and contribution requirements. To be eligible for inclusion in the Program, the plan shall contain comprehensive major medical coverage which shall consist of physician and hospital inpatient services. The Department is prohibited from denying coverage to a child who is enrolled in a privately sponsored health insurance plan pursuant to subdivision (a)(1) because the plan offers benefits in addition to physician and hospital inpatient services.

(d) The total dollar amount of subsidizing coverage per child per month pursuant to subdivision (a)(1) shall be equal to the average dollar payments, less premiums incurred, per child per month pursuant to subdivision (a)(2). The Department shall set this amount prospectively based upon the prior fiscal year's experience adjusted for incurred but not reported claims and estimated increases or decreases in the cost of medical care. Payments obligated before July 1, 1999, will be computed using State Fiscal Year 1996 payments for children eligible for Medical Assistance and income assistance under the Aid to Families with Dependent Children Program, with appropriate adjustments for cost and utilization changes through January 1, 1999. The Department is prohibited from providing a subsidy pursuant to subdivision (a)(1) that is more than the individual's monthly portion of the premium.

(e) An eligible child may obtain immediate coverage under this Program only once during a medical visit. If coverage lapses, re-enrollment shall be completed in advance of the next covered medical visit and the first month's required premium shall be paid in advance of any covered medical visit.

(f) In order to accelerate and facilitate the development of networks to deliver services to children in areas outside counties with populations in excess of 3,000,000, in the event less than 25% of the eligible children in a county or contiguous counties has enrolled with a Health Maintenance Organization

pursuant to Section 5-11 of the Illinois Public Aid Code, the Department may develop and implement demonstration projects to create alternative networks designed to enhance enrollment and participation in the program. The Department shall prescribe by rule the criteria, standards, and procedures for effecting demonstration projects under this Section.

(g) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Act or the Illinois Public Aid Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e of the Illinois Public Aid Code.

(Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13.)

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS
PART 125 CHILDREN'S HEALTH INSURANCE PROGRAM
SECTION 125.300 COVERED SERVICES

Section 125.300 Covered Services

For children covered under the All Kids Health Plan, covered health care services shall be the same covered services for children as described at 89 Ill. Adm. Code 140, 77 Ill. Adm. Code 2090, and 59 Ill. Adm. Code 132, except as provided in Section 125.305, and subject to appropriation and any applicable cost sharing requirements defined in Section 125.310 and Section 125.320.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS
PART 125 CHILDREN'S HEALTH INSURANCE PROGRAM
SECTION 125.305 SERVICE EXCLUSIONS

Section 125.305 Service Exclusions

The following health care services will not be covered under the All Kids Health Plan:

a) Services provided only through a waiver approved under section 1915(c) of the Social Security Act (42 USC 1396n(c)).

b) Abortion services.

(Source: Amended at 37 Ill. Reg. 10253, effective June 27, 2013)

NATIONAL ACADEMY for STATE HEALTH POLICY®

Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

Benefits and Cost Sharing in Separate CHIP Programs

Anita Cardwell, Joanne Jee, and Catherine Hess
National Academy for State Health Policy
and
Joe Touschner, Martha Heberlein, and Joan Alker
Georgetown University Center for Children and Families

May 2014

Table H: Coverage of Vision Services, Hearing, Podiatry, and Chiropractic Services, continued

State	Vision Services		Hearing Services		Podiatry	Chiropractic
	Exams	Corrective Lenses	Exams	Hearing Aids		
Mississippi	C	C	C	LQ	C	L$
Missouri	C	LQ	C	LQ	C	U
Montana	C	C,E	C	LQ	U	C
Nevada	C	C	C	C	C	C
New Jersey	C | C	C | C	C | LA	C | LA	C,E | C,E	C | U
New York	C	C	C	C	C, E	U
North Carolina	C	C	C	LA	C, E	U
North Dakota	C	L$, LQ	C	L$, LQ	LC	LC
Oregon	C | C	C | L$	C | C	LQ | C	LC | LC	C | C
Pennsylvania	C	L$	C	LQ, L$	LC	U
South Dakota	C	C	C	C	C, E	C
Tennessee	C	L$, LQ	C	LQ	LC	LC
Texas	C	C	C	C	LC	LQ
Utah	C	C	C	C, E	C	U
Vermont	C	LQ, LA	C	LQ	C	LQ
Virginia	LQ	L$	C	LQ	U	L$
Washington	C	C	C	C	C	C
West Virginia	C	L$	C	C	C, E	C
Wisconsin	C | C	C | C	C | LA	C | U	C | C	C | C
Wyoming	C	L$	C	U	U	U

Key for coverage codes: C=Covered; C, E=Covered and exclusions apply; U=Uncovered; LQ=Limited by quantity, such as number of visits or days; L$=Limited by dollar amount; LA=Limited by age; LL=Limited to a list of approved drugs or specified services; LC=Limited by condition or diagnosis

Note: Programs with multiple limits are listed with a "," between coverage codes. States with multiple CHIP programs are indicated with a "|" between coverage codes. Summary counts include both programs. For details, see state-specific benefit summary tables in Appendix 2.

Benefit Group 7: Prenatal Care and Pre-Pregnancy Family Services and Supplies, Abortion, Premiums for Private Health Insurance Coverage, Medical Transportation, and Enabling Services

This group includes the remaining categories of benefits examined in the analysis.

Prenatal Care and Pre-Pregnancy Family Services and Supplies

Almost all separate CHIP programs provided prenatal and pre-pregnancy services without significant limitations, with just two (NC and WV) excluding pregnancy care. (As reported previously, Pennsylvania's program had a 50-visit limit on a range of clinic services, including this type.) A small number of programs reported that they did not cover maternity care. Depending on her family's income, a CHIP beneficiary could become categorically eligible for Medicaid as a pregnant woman and would be eligible to receive her maternity and delivery care under that program.

Abortion

As mentioned above, federal CHIP funds may not be used to provide abortion services except when necessary to save the life of the mother or in cases of rape or incest.[40] A majority of separate CHIP programs did provide federally-permissible abortion services, but five programs (AL, FL's lower-age program, IL, LA, TX) did not provide them even under these limited circumstances.

Premiums for Private Health Insurance Coverage

Premium assistance is the use of public funds through CHIP to purchase private coverage. Most commonly, states offer to subsidize the purchase of employer-sponsored insurance (ESI) and eligible families can choose whether to access CHIP benefits directly or to use premium assistance to enroll their children in private plans.[41] States must also provide "wraparound" coverage for any benefits covered in the state's CHIP program but not offered in the private plan, and pay cost sharing that exceeds CHIP requirements unless they obtain a federal Section 1115 waiver.[42] Eleven programs indicated the availability of coverage for private health insurance premiums.

Medical Transportation

All separate CHIP programs covered emergency transportation without reported limits; however, coverage of non-emergency medical transportation (NEMT) varied considerably. Fifteen programs reported coverage of NEMT without limits, while eight offered limited coverage, and 19 indicated no coverage.[43] The most common limits programs imposed on the coverage of NEMT are those based on an enrollee's condition. States also put different restrictions on NEMT, for example, by limiting it to transportation between medical facilities or on the basis of a physician's order.

Enabling Services

While 14 separate CHIP programs indicated that they provided coverage of enabling services, as with some other benefit categories it is not apparent that states defined the set of services consistently. For example, under the state plan template, transportation, translation, and outreach services are listed as "enabling services;" however, both transportation and outreach efforts are described elsewhere in the state plan.[44] Whether states also indicated that they provide "enabling services" when these benefits were discussed in another section is unclear. Therefore, cross-state comparisons should be made cautiously. Most of the programs reporting such coverage merely indicated that they covered enabling services, with just a few listing specific services, such as translation and transportation, under the category.

Table I: Prenatal Care and Pre-Pregnancy Family Services and Supplies, Abortion, Premium Assistance, Medical Transportation, and Enabling Services

State	Prenatal Care and Pre-Pregnancy Services	Abortion, to save the life of a mother or if pregnancy is the result of rape/incest	Premiums for Private Coverage	Medical Transportation		Enabling Services
				Emergency Transportation	Non-Emergency Transportation	
Total Programs with Full Coverage	39	37	11	42	15	14
Total Limited Coverage	3	0	0	0	8	0
Total Uncovered	0	5	31	0	19	28
Alabama	C	U	U	C	LC	C
Arizona	C	C	U	C	C	C
Arkansas	C	C	U	C	U	U
Colorado	C	C	U	C	U	U
Connecticut	C	C	U	C	LC	C
Delaware	C	C	U	C	U	U
Florida	C | C	U | C	U | U	C | C	C | U	U | U
Georgia	C	C	U	C	U	U
Idaho	C	C	C	C	C	C
Illinois	C	U	U	C	C, E	C
Indiana	C	C	U	C	LC	U
Iowa	C	C	U	C	LC	U
Kansas	C	C	U	C	C	C
Kentucky	C	C	U	C	U	C
Louisiana	C	U	U	C	C	U
Maine	C	C	U	C	C	C
Massachusetts	C	C	C	C	U	U
Michigan	C	C	U	C	LC	U
Mississippi	C	C	U	C	U	U
Missouri	C	C	C	C	U	U
Montana	C	C	U	C	C	U
Nevada	C	C	U	C	U	C
New Jersey	C | C	C | C	C | C	C | C	C | U	U | U
New York	C	C	U	C	U	U
North Carolina	C, E	C	U	C	U	U
North Dakota	C	C	U	C	C	U
Oregon	C | C	C | C	C | C	C | C	C | U	C | U
Pennsylvania	LQ	C	U	C	U	U
South Dakota	C	C	U	C	C	U

Table I: Prenatal Care and Pre-Pregnancy Family Services and Supplies, Abortion, Premium Assistance, Medical Transportation, and Enabling Services, continued

State	Prenatal Care and Pre-Pregnancy Services	Abortion, to save the life of a mother or if pregnancy is the result of rape/incest	Premiums for Private Coverage	Medical Transportation		Enabling Services
				Emergency Transportation	Non-Emergency Transportation	
Tennessee	C	C	U	C	U	U
Texas	C	U	U	C	U	U
Utah	C	C	C	C	U	U
Vermont	C	C	U	C	C	C
Virginia	C	C	C	C	LC	U
Washington	C	C	U	C	C	C
West Virginia	C, E	C	U	C	LC	U
Wisconsin	C | C	C | C	C | C	C | C	C | C	C | C
Wyoming	C	C	U	C	U	U

Key for coverage codes: C=Covered; C, E=Covered and exclusions apply; U=Uncovered; LQ=Limited by quantity, such as number of visits or days; L$=Limited by dollar amount; LA=Limited by age; LL=Limited to a list of approved drugs or specified services; LC=Limited by condition or diagnosis

Note: Programs with multiple limits are listed with a "," between coverage codes. States with multiple CHIP programs are indicated with a "|" between coverage codes. Summary counts include both programs. For details, see state-specific benefit summary tables in Appendix 2.

Detailed Findings on Premiums and Cost Sharing

Within federal limits, states have considerable flexibility in setting premiums and cost sharing for enrollees in separate CHIP programs. In general, federal regulations allow states to adopt such policies as long as their combined amount does not exceed five percent of family income and does not favor higher-income families over lower-income families.[45] Only two programs (OR's lower-income program and SD) do not charge any premiums or cost sharing, with the remainder requiring premiums, enrollment fees, and/or per-service cost sharing.

Premiums and Enrollment Fees

Thirty separate CHIP programs require families to pay premiums, either monthly (24), quarterly (two), or annually (four). Nine programs (AL, AZ, DE, both programs in FL, GA, ID, NV, and UT) require premiums from families with income below 150 percent of the FPL. States more often charge premiums at higher income levels, with 20 programs charging families premiums at 151 percent of the FPL and 27 doing so at 201 percent of the FPL. In addition, premium amounts frequently increase as income rises. In programs charging premiums, the median monthly premium per child is $10 for those with income less than 150 percent of the FPL; $15 at 151 percent of the FPL; $20 at 201 percent of the FPL; $32 at 251 percent of the FPL; and $33 at 301 percent of the FPL.[46]

Cost Sharing

Separate CHIP programs also charge cost sharing when enrollees use services, predominately copayments, although a few require coinsurance or deductibles.[47] As with premiums, federal rules limit the amount that

Title 42: Public Health
PART 457—ALLOTMENTS AND GRANTS TO STATES
Subpart D—State Plan Requirements: Coverage and Benefits

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§457.475 Limitations on coverage: Abortions.

(a) *General rule.* FFP under title XXI is not available in expenditures for an abortion, or in expenditures for the purchase of health benefits coverage that includes coverage of abortion services unless the abortion services meet the conditions specified in paragraph (b) of this section.

(b) *Exceptions*—(1) *Life of mother.* FFP is available in expenditures for abortion services when a physician has found that the abortion is necessary to save the life of the mother.

(2) *Rape or incest.* FFP is available in expenditures for abortion services performed to terminate a pregnancy resulting from an act of rape or incest.

(c) *Partial Federal funding prohibited.* (1) FFP is not available to a State for any amount expended under the title XXI plan to assist in the purchase, in whole or in part, of health benefits coverage that includes coverage of abortions other than those specified in paragraph (b) of this section.

(2) If a State wishes to have managed care entities provide abortions in addition to those specified in paragraph (b) of this section, those abortions must be provided under a separate contract using non-Federal funds. A State may not set aside a portion of the capitated rate paid to a managed care entity to be paid with State-only funds, or append riders, attachments or addenda to existing contracts with managed care entities to separate the additional abortion services from the other services covered by the contract.

(3) Nothing in this section affects the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than those expended under the State plan) for any abortion services or for health benefits coverage that includes coverage of abortion services.

THE
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DELIVERED VIA EMAIL AND U.S. MAIL March 9, 2017

Lynette Schafer
Illinois Department of Healthcare and Family Services
Division of Medical Programs
Bureau of Managed Care
201 South Grand Avenue
East Springfield, IL 62794
HFS.Procurement@illinois.gov

Re: State of Illinois Medicaid Managed Care Organization Request for Proposals 2018-24-001

Dear Ms. Schafer:

I am a staff attorney in the Women's and Reproductive Rights Project of the Roger Baldwin Foundation of ACLU, Inc. ("ACLU" or "ACLU of Illinois"). I write to raise questions and concerns regarding the State of Illinois Medicaid Managed Care Organization Request for Proposals 2018-24-001 ("the RFP"), including the draft Model Contract between HFS and contracting managed care organizations ("MCO" or "Contractor") set forth in Appendix I of the RFP ("the draft Model Contract").

The ACLU of Illinois is a nonprofit organization dedicated to securing freedom, liberty, equality and justice. The ACLU's Women's and Reproductive Rights Project seeks, through litigation, public education, and administrative and legislative advocacy, to ensure that all in our society have access to the full range of reproductive health care options. The ACLU has a long and proud history of defending religious liberty and believes that the right to practice one's religion, or no religion, is a core component of our civil liberties. For this reason, the ACLU routinely brings cases designed to protect the rights of individuals to worship and express their religious beliefs. At the same time, the ACLU vigorously protects women's rights and reproductive freedom. To that end, we have been conducting an investigation of Medicaid coverage of reproductive health care services, including abortion care, in Illinois. We have, among other things, gathered documents through Freedom of Information Act ("FOIA") requests to the Illinois Department of Healthcare and Family Services ("HFS") and information about the experiences of patients in the Medicaid system who face barriers to access to essential reproductive health care.

As set forth below, the RFP and draft Model Contract raise critical issues about coverage for such care, including creating harmful barriers for patients who participate in the Medicaid program. We urge HFS to address these issues to ensure that all enrollees in MCOs selected for contracts under this RFP have adequate access to medically necessary covered services as required by state and federal law.

1. **The Draft Model Contract Language Regarding "Right of Conscience" Creates Refusal Rights Beyond Those Contemplated by the Health Care Right of Conscience Act.**

Section 5.6 of the draft Model Contract purports to incorporate rights under 745 ILCS 70/1 et seq., the Illinois Health Care Right of Conscience Act ("HCRCA"), by permitting any contracting MCO to "choose to exercise a right of conscience by refusing to pay or arrange for the payment of certain Covered Services."[1] The draft Model Contract allows a contracting MCO to do so simply by notifying HFS in writing of the "services that the Contractor refuses to pay, or to arrange for the payment of."[2] This contractual provision expands the right to refuse to participate in payment for services beyond that which is provided for in the HCRCA.

Contrary to the draft Model Contract, the HCRCA only permits a health care payer to refuse "to pay for or arrange for the payment of any particular form of health care services that violate the health care payer's conscience" if the health care payer's objection is "*documented in its ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents*" (emphasis added).[3] The draft Model Contract must therefore be revised to properly incorporate the terms of the HCRCA by requiring an objecting Contractor to submit to HFS formal corporate documents that demonstrate that the health care services at issue violate the health care payer's conscience.

2. **HFS Must Create Procedures to Ensure That Enrollees Can Access Covered Services When Their MCO Objects Under the HCRCA.**

HFS must take steps to ensure that Medicaid enrollees have adequate and timely access to covered services, as required by law, even when their MCO refuses to cover such services because of an objection covered by the HCRCA. As the Illinois General Assembly recently affirmed in an amendment to the HCRCA that went into effect on January 1, 2017, it is "the public policy of the State of Illinois to ensure that patients receive timely access to information and medically appropriate care," even in the face of conscience objections to such services.[4]

We appreciate that the draft Model Contract requires that, when a contracting MCO refuses to be involved in payment for health care services under the HCRCA, it must notify potential, prospective and existing enrollees at certain times specified in Subsection 5.6.2., and that such notice must include information about how an enrollee can obtain information from HFS regarding those covered services. However, we do not believe that this is adequate notice. Patients often do not know that they will need a particular service in advance and thus could not choose an MCO based on the notice that is currently required. We urge HFS to specify in the contract that the MCO must follow specific procedures that will enable an enrollee to access services when their MCO will not pay for, or arrange for payment of, such services. We also urge HFS to ensure that such information is available to enrollees at all times by requiring that the contracting MCO include this information in its enrollee handbook.

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[1] Subsection 5.6.1 of the draft Model Contract.
[2] *Id*.
[3] 745 ILCS 70/11.2 to 70/11.4.
[4] 745 ILCS 70/2.

3. The Draft Model Contract Misstates the State's Obligation to Cover Abortion Care for Patients Enrolled in State Medical Assistance Programs.

Since 1994, Illinois has been under a court order (*Doe v. Wright*) requiring the state's medical assistance programs to provide coverage for abortion services necessary to protect a woman's health.[5] This requirement addresses the gap in Medicaid coverage created by the Hyde Amendment, which bans the use of federal Medicaid funding to cover abortion services except in cases of rape, incest, or life endangerment. Such bans on insurance coverage for abortion are heavy-handed intrusions into a decision that is best left to a woman and her family.

Even though the 1994 court order, among other things, enjoined HFS regulations to the extent that they failed to cover abortions necessary to protect a woman's health, HFS has never updated its regulations to reflect this decision. Outdated regulations, combined with confusing instructions, conflicting paperwork requirements, and other needless obstacles to coverage, have made it so difficult for providers to obtain Medicaid reimbursement for medically necessary abortion services that the Guttmacher Institute recently concluded that Illinois may be in violation of this longstanding court order.[6]

As Illinois has increasingly sought to shift Medicaid enrollees into MCOs, it is particularly important that MCOs have an accurate understanding of what services are covered under Illinois Medicaid. The RFP emphasizes that a contracting MCO must ensure that "providers understand billing requirements" and must "provide billing education to providers," which includes offering clear and accurate guidance to providers regarding the scope of covered services.[7]

Nonetheless, the draft Model Contract misleadingly describes the scope of covered services for abortion by repeatedly citing outdated state and federal regulations that provide that abortion services are only covered when necessary to save a woman's life.

First, Section 5.1 of the draft Model Contract states that "Covered Services shall be provided in the amount, duration, and scope as set forth in 89 Ill. Adm. Code, Part 140, and in this Contract" but fails to acknowledge that these regulations include a subsection (89 Ill. Adm. Code 140.413) which has been enjoined because it unlawfully provides that abortion services shall be covered "only in those cases in which the physician has certified in writing to the Department that the procedure is necessary to preserve the life of the mother."

Second, Subsection 5.5.1 of the draft Model Contract, which purports to explain the limitations on covered services for abortion care, is misleading and inaccurate. This subsection states:

> Contractor may provide termination of pregnancy only as allowed by applicable State and federal law (42 CFR §441, Subpart E). In any such case, Contractor shall fully comply with the requirements of such laws, complete HFS Form 2390, and file the completed form in the Enrollee's medical record. Contractor shall not

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[5] *Doe v. Wright*, No. 91 CH 1958 (Ill. Cir. Ct. Dec. 2, 1994).
[6] Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, Guttmacher Pol. Rev., Vol. 19 (2016), *available at* https://www.guttmacher.org/sites/default/files/article_files/gpr1904616_0.pdf.
[7] Subsection 5.2.8.2 of the RFP.

provide termination of pregnancy to Enrollees who are eligible under SCHIP (215 ILCS 106).

This subsection fails to explain that abortion services are covered by Illinois Medicaid where necessary to protect the health or life of the pregnant woman, or in cases of rape or incest. Moreover, the outdated federal regulation (42 CFR §441, Subpart E) this subsection cites as "applicable . . . law" would limit coverage for abortion services solely to situations in which a woman's life is in danger.[8] Finally, the guidance offered in this subsection regarding abortion service coverage for enrollees eligible under the State Children's Health Insurance Program ("SCHIP" or "CHIP") raises a number of concerns, including that it conflicts with the Illinois CHIP State Plan. The Illinois CHIP State Plan specifically provides that enrollees who are eligible under SCHIP may enroll under Medicaid in order to obtain coverage for abortion services.[9]

HFS has included this misleading and inaccurate language in its contracts with MCOs, as well as in its Managed Care Manual for Medicaid Providers, in the past. As a result, most MCOs provide their enrollees and providers with similarly misleading and inaccurate guidance about the scope of abortion service coverage under Illinois medical assistance programs. The ACLU of Illinois reviewed enrollee handbooks and provider handbooks provided by MCOs for Integrated Care Programs ("ICPs") and Family Health Plans ("FHPs") in Illinois, and found that only a few accurately set forth the scope of Illinois Medicaid coverage for abortion services. Most MCO handbooks simply reprint the language of Subsection 5.5.1 verbatim, without attempting to explain to enrollees or providers what services are actually required to be covered. Indeed, several MCO handbooks imported the restrictions of the federal Hyde Amendment without acknowledging that Illinois medical assistance programs must cover abortion services when necessary to protect a woman's health.[10] These issues put Illinois patients enrolled in Medicaid at risk and deny them their legal rights to access medically necessary health care.

We urge HFS to correct this misleading contract language and provide full and accurate guidance to MCOs and providers regarding the extent of required coverage for abortion services under Illinois medical assistance programs.

4. HFS Must Ensure that Contracting MCOs Meet Network Adequacy Requirements and Quality Assurance Standards for Abortion Services as part of Comprehensive Reproductive Health Care.

Finally, we urge HFS to take affirmative steps to ensure that contracting MCOs have adequate provider networks and quality assurance standards to offer access to all covered services, including abortion services. The RFP and the draft Model Contract recognize that, as required by state and federal laws and regulations, a contracting MCO must build a provider

[8] In 1993, federal restrictions on abortion coverage were amended to include coverage in cases of rape and incest as well as to preserve the life of the pregnant woman. A 1994 federal court decision ensures that Illinois follows this federal law. *Planned Parenthood v. Wright*, No. 94 C 6886, 1994 WL 750638 (N.D.Ill. Dec. 6, 1994).
[9] Illinois CHIP State Plan (2002), at 30, available at https://www.medicaid.gov/CHIP/Downloads/IL/ILCurrentStatePlan.pdf.
[10] Some MCOs have instituted reporting or documentation requirements in cases of rape or incest that even deny or impede coverage for abortion services covered under federal Hyde Amendment restrictions. Such requirements conflict with the Illinois Medicaid State Plan and violate federal law. *See Elizabeth Blackwell Health Ctr. for Women v. Knoll*, 61 F.3d 170, 181 (3d Cir. 1995).

network and meet quality assurance standards to ensure adequate access to covered services for all enrollees. The RFP requires that MCOs submit information about their provider networks, including proposals for how they plan to recruit providers, build their networks, and monitor compliance with network adequacy standards.[11] The draft Model Contract provides detailed requirements for network adequacy and quality assurance standards to ensure access to care for family planning and reproductive health services,[12] as well as to care provided to pregnant women,[13] but does not address the need for an adequate provider network or other measures to ensure access to abortion services when necessary to protect the health or life of a pregnant woman, or in cases of rape or incest. Access to these covered services is critical to ensure that pregnant enrollees facing a health-endangering or life-threatening condition, or who are the victims of rape or incest, can access the care they need.

We note that the RFP asks MCOs to explain how they would address the needs of a potential Medicaid enrollee in an example vignette featuring a pregnant woman who has two children under the age of 5; she has schizophrenia and her "medications will need to be reduced during her pregnancy, potentially reducing their effectiveness."[14] The vignette does not specify whether the hypothetical enrollee has decided to carry her pregnancy to term, raising the possibility that she could decide to preserve her health by terminating her pregnancy, in the face of the real and substantial risks to her health posed by reducing her medications during pregnancy. In evaluating each RFP submission, HFS should evaluate whether the responding MCO identifies and addresses the possibility that a pregnant enrollee might decide to terminate her pregnancy in order to preserve her health, and whether the responding MCO offers adequate provider networks and coverage to provide such an enrollee with adequate and timely access to covered abortion services. Unfortunately, in the course of our investigation, we have become aware of women who have needed hospital-based abortion care to address a serious health condition but whose MCO did not contract with a single hospital that provided abortion care. We urge HFS to ensure that that does not continue to happen by requiring true network adequacy.

Thank you for the opportunity to raise questions and concerns regarding the RFP and the draft Model Contract. Please do not hesitate to contact me if you would like to discuss these issues further.

Sincerely,

[redacted]

Amy Meek
Staff Attorney, Women's & Reproductive Rights Project
Roger Baldwin Foundation of the ACLU of Illinois

cc: Representative Greg Harris

[11] Subsections 4.2.6 and 5.2.8 of the RFP.
[12] Section 5.8, Attachment XI ("Quality Assurance"), and Attachment XXI ("Required minimum standards of care") of the draft Model Contract.
[13] *Id.*
[14] Subsection 5.2.2.1 of the RFP.

STATE OF ILLINOIS
EXCEPTIONS TO CONTRACT TERMS AND CONDITIONS

The Roger Baldwin Foundation of ACLU, Inc. ("ACLU of Illinois") submits the following suggested exceptions for incorporation into the final version of the Model Contract issued pursuant to the State of Illinois Request for Proposal ("RFP") (Reference Number: 2018-24-001). These suggestions relate to concerns detailed in our March 9, 2017 letter to the Department of Healthcare and Family Services ("the Department"), about ensuring that enrollees have adequate access to medically necessary covered services as required by state and federal law. For additional background on these concerns, please refer to the March 9, 2017 letter (enclosed).

	CHANGES TO STANDARD TERMS AND CONDITIONS
Section or Subsection No.	State the exception, specifying the section or subsection number and the desired language, using terms such as "add," "replace," "delete," etc.
1.1.79 (page 17)	The full spectrum of reproductive-health services includes abortion care, yet there is considerable confusion about the extent of abortion coverage under Illinois Medicaid. Other states (such as New York) clearly state in Medicaid handbooks and contracts that abortion is part of the range of covered family planning and reproductive health services. Therefore, we suggest adding the underlined text (and deleting the strikethrough text) in the definition of Family Planning as follows: "**Family Planning** means a full spectrum of family-planning options (all FDA-approved birth control methods) and reproductive-health services, appropriately provided within the Provider's scope of practice and competence. Family-Planning and reproductive-health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy, terminating pregnancy, or ~~to improve~~ improving maternal health and birth outcomes."
5.5.1 (page 68)	This subsection offers a description of abortion coverage under Illinois Medicaid that is incomplete and potentially misleading, as the Model Contract does not explain when abortion is covered and directs Contractors to Illinois regulations (89 Ill. Adm. Code 140.413) regarding abortion coverage which have been enjoined by court order (*Doe v. Wright*). This subsection's guidance is also inaccurate with respect to SCHIP enrollees, as the *Doe v. Wright* order applies generally to state medical assistance programs and is not limited to Medicaid; furthermore, it conflicts with the Illinois CHIP State Plan, which permits individuals eligible under SCHIP to enroll under Medicaid to obtain coverage for abortion services. We therefore suggest replacing the text of Subsection 5.5.1 with the following underlined text: "Abortion (termination of pregnancy) is a covered service when the abortion is, in the medical judgment of the attending health care provider, necessary to preserve the woman's health or her life, or when the pregnancy is the result of rape or incest. A medical judgment that an abortion is necessary to preserve a woman's health may consider all factors — such as physical, emotional, psychological, and familial health and the woman's age — which are relevant to the patient's health

	and wellbeing. In any such case, Contractor shall complete HFS Form 2390, and file the completed form in the Enrollee's medical record. Enrollees who are eligible for assistance under SCHIP (215 ILCS 106) may enroll under Medicaid in order to obtain coverage for abortion services."
5.6.3 (page 69)	We suggest adding the following underlined text (and deleting the strikethrough text) in this subsection to ensure that Enrollees receive timely access to medically necessary Covered Services, in accordance with the Health Care Right of Conscience Act, 745 ILCS 70/1 *et seq.*: "Such notice shall include information on how ~~an Enrollee~~ Potential Enrollees, Prospective Enrollees and Enrollees can obtain information from the Department explaining how to access ~~regarding~~ those Covered Services subject to this section 5.6."
5.6.4 (page 69)	We suggest adding the following underlined text (and deleting the strikethrough text) in this subsection (and additional subsections set forth below) to ensure that Enrollees receive timely access to medically necessary Covered Services, in accordance with the Health Care Right of Conscience Act: "As set forth in section 5.32, all Provider agreements entered into by Contractor must include a list of any Covered Services that the Network Provider refuses to permit, perform, or participate in because of a conscience-based objection, and document the Network Provider's written access to care and information protocols that are designed to ensure that conscience-based objections do not cause impairment of Enrollees' health and that explain how conscience-based objections will be addressed in a timely manner to facilitate Enrollees' access to Covered Services. Contractor must require Network Providers to inform Enrollees of their condition, prognosis, legal treatment options, and risks and benefits of the treatment options in a timely manner, consistent with current standards of medical practice or care. If any Network Provider is unable, because of a conscience-based objection, to permit, perform, or participate in a Covered Service that is a diagnostic or treatment option requested by the Enrollee, ~~exercises the right of conscience,~~ Contractor must require such Network Provider to notify the Enrollee that the Covered Service will not be provided and, upon request by an Enrollee, refer or transfer the Enrollee to, or provide written information to the Enrollee about, other Providers who Contractor reasonably believes may offer the Covered Service the Network Provider refuses to permit, perform, or participate in because of a conscience-based objection. Contractor also shall require Network Providers in such an event, and if requested by the Enrollee, to provide copies of medical records to the Enrollee or to the Provider designated by the Enrollee in accordance with Illinois law, without undue delay. Contractor must notify Potential Enrollees, Prospective Enrollees, and Enrollees regarding which Network Providers have conscience-based objections, and the Covered Services each such Network Provider refuses to permit, perform, or participate in because of a conscience-based objection, as follows:

	5.6.4.1 to Potential Enrollees, prior to enrollment; 5.6.4.2 to Prospective Enrollees, during enrollment; and 5.6.4.3 to Enrollees, within ninety (90) days after entering into a Provider agreement with a Network Provider that refuses to permit, perform, or participate in Covered Services because of a conscience-based objection. Such notice shall include information about other Network Providers who may offer such Covered Services as well as information on how an Enrollee can obtain information from the Department explaining how to access those Covered Services subject to this section 5.6. Contractor shall also publish such notice and information in the Provider directory as set forth in subsection 5.10.6."
5.10.6 (pages 82-83)	We suggest adding the following underlined text (and deleting the strikethrough text) to this subsection: "**Provider directory**. Contractor shall meet all Provider directory requirements under 305 ILCS 5/5-30.3 ~~and~~, 42 CFR §438.10, and section 5.6, including: 5.10.6.1 Ensure its Provider directory is available to Enrollees and Providers via Contractor's web portal and in paper form upon request. 5.10.6.2 Request, at least annually, Provider office hours for each Provider type and publish such hours in the Provider directory. 5.10.6.3 Confirm with Providers who have not submitted claims within the six (6) months prior to the start of this Contract that the Provider intends to remain in the network and correct any incorrect Provider directory information. 5.10.6.4 Conspicuously display an e-mail address and a toll-free number to which any individual may report an inaccuracy in the Provider directory. 5.10.6.5 Provider directory information in paper form must be updated at least monthly and electronic Provider directories must be updated no later than thirty (30) days after Contractor receives updated Provider information. 5.10.6.6 Investigate and correct any inaccurate information communicated to any individual Enrollee or from Department notification within three (3) days after notification by the Department. 5.10.6.6 Publish and update any information regarding which Network Providers have conscience-based objections to Covered Services, the Covered Services each such Network Provider refuses to permit, perform, or participate in because of a conscience-based objection, information about other Network Providers who may

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	offer such Covered Services, and information about how an Enrollee can obtain information from the Department explaining how to access such Covered Services.
5.21.5.6 (page 107)	We suggest adding the following underlined text to this subsection: "the amount, duration, and scope of benefits available, in sufficient detail to ensure that the Enrollee understands the benefits to which the Enrollee is entitled, as well as any benefits that may be excluded pursuant to section 5.6, and information about how an Enrollee can obtain information from the Department explaining how to access benefits excluded pursuant to section 5.6;"
Attachment XXI, 2.1.3 (page 318)	We suggest adding the underlined text (and deleting the strikethrough text) to the first two sentences of this subsection regarding minimum covered services for Family Planning, as follows: "Contractor shall ensure provision of the full spectrum of Family Planning options and reproductive health services within the practitioner's scope of practice and demonstrated competence. Contractor shall follow federal and State laws regarding minor consents and confidentiality. Family Planning and reproductive health services are defined as those services offered, arranged, or furnished for the purpose of preventing an unintended pregnancy, terminating pregnancy, or ~~to improve~~ improving maternal health and birth outcomes."
	ADDITIONAL PROVISIONS
New Section or Subsection No.	State the new section or subsection number, the title of the new section or subsection, and the language of the desired term or condition.
5.21.1.16 (pages 103-104)	We suggest creating the following new subsection 5.2.1.16 as part of Subsection 5.2.1, specifying that the following must be provided as part of the required "basic information" for Enrollees: "any Covered Services which the Contractor, and/or any Network Provider, refuses to provide pursuant to section 5.6, and information about how an Enrollee can obtain information from Contractor and/or the Department explaining how to access such Covered Services."
5.32.16 (pages 126-129)	We suggest creating the following new subsection 5.32.16 as part of Section 5.32, specifying that Provider agreements are subject to the following condition: "As set forth in section 5.6, all Provider agreements entered into by Contractor must include a list of any Covered Services that the Network Provider refuses to permit, perform, or participate in because of a conscience-based objection, and document the Network Provider's written access to care and information protocols that are designed to ensure that conscience-based objections

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	do not cause impairment of Enrollees' health and that explain how conscience-based objections will be addressed in a timely manner to facilitate Enrollees' access to Covered Services."
Attachment XXI, 2.1.3.18 (pages 319-328)	We suggest creating the following new subsection 2.1.3.18 as part of subsection 2.1.3, specifying that as part of the full spectrum of Family Planning options and reproductive health services, Contractor shall ensure the provision of the following: "Contractor shall have procedures in place to enable Enrollees to access abortion (termination of pregnancy) pursuant to subsection 5.5.1."

By: Amy Meek (ACLU of Illinois)

Signed: [redacted]

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Date: Sept. 15, 2017

ACLU of Illinois Review of MCO Handbooks & Other Guidance Available on the Internet Regarding Scope of Abortion Coverage (Updated May 17, 2017)

Care coordination entity	Handbook or material	Adequacy of guidance re: abortion coverage	Notes on language
Aetna Better Health	ICP Member Handbook	Adequate	States that abortion is covered when necessary to preserve the woman's life or health or when the pregnancy is the result of rape or incest.
	FHP/ACA Member Handbook	Inadequate	No information provided in this document regarding abortion coverage.
	Provider Manual	Inadequate	Includes part of the misleading HFS contract clause on abortion.
Blue Cross Community	FHP/ACA Member Handbook	Inadequate	Lists situations in which an abortion is covered without including situations in which abortion is necessary to preserve a woman's health. States that "Elective abortion" is not a covered service.
	ICP Member Handbook	Inadequate	Lists situations in which an abortion is covered without including situations in which abortion is necessary to preserve a woman's health.
	ICP Summary of Benefits	Inadequate	Lists situations in which an abortion is covered without including situations in which abortion is necessary to preserve a woman's health.
	Provider Manual	Inadequate	States that preauthorization is required for termination of pregnancy, and directs providers to the (inaccurate) Member Handbook.
Cigna-HealthSpring	ICP Member Handbook	Inadequate	No information provided in this document regarding abortion coverage.
	ICP Description of Coverage	Inadequate	No information provided in this document regarding abortion coverage.
	Provider Manual	Adequate	Under "Abortion" states "Health care professional must submit required HFS Form 2390 with the claim submission."
Community Care Alliance	ICP Member Handbook	Inadequate	No information provided in this document regarding abortion coverage.
	ICP Certificate of Coverage	Inadequate	Includes the misleading HFS contract clause on abortion.
	Provider Manual	Inadequate	States that abortion coverage has "limitations and specific forms that must be filled out prior to rendering these services." Does not state what the coverage limitations are.
CountyCare	Enrollee Handbook	Inadequate	"Covered Services" include "Pregnancy termination if medically necessary as defined by Illinois law." Under "Services Not Covered" is "Elective abortions."
	Certificate of Coverage	Inadequate	Lists situations in which an abortion is covered without including situations in which abortion is necessary to preserve a woman's health.
	Provider Manual	Adequate	Under "Termination of Pregnancy" the manual states only that "HFS requires form 2390 with claim."
Family Health Network	FHP/ACA Member Handbook	Inadequate	No information provided in this document regarding abortion coverage.
	FHP/ACA Certificate of Coverage	Inadequate	Includes the misleading HFS contract clause on abortion.
	Provider Manual	Inadequate	States that abortion coverage has "limitations and specific forms that must be filled out prior to rendering these services." Does not state what the coverage limitations are.

ACLU of Illinois Findings on MCO Handbooks & Other Guidance Regarding Scope of Abortion Coverage, Continued (Updated May 17, 2017)

Care coordination entity	Handbook or material	Adequacy of guidance re: abortion coverage	Notes on language
Harmony Health Plan	FHP/ACA Member Handbook	Inadequate	"Not Covered: Elective abortions." No information suggesting that any abortion services are covered.
	FHP/ACA Certificate of Coverage	Inadequate	Includes the misleading HFS contract clause on abortion.
	Provider Manual	Inadequate	Lists situations in which an abortion is covered without including situations in which abortion is necessary to preserve a woman's health. Excludes enrollees eligible under SCHIP.
Humana Health Plan	ICP Member Handbook	Adequate	States that abortion is covered when necessary to preserve the woman's life or health or when the pregnancy is the result of rape or incest.
	ICP Certificate of Coverage	Inadequate	Includes the misleading HFS contract clause on abortion.
	Provider Manual	Inadequate	Includes the misleading HFS contract clause on abortion.
Illinicare Health	ICP Member Handbook	Inadequate	Lists situations in which an abortion is covered without including situations in which abortion is necessary to preserve a woman's health.
	FHP/ACA Member Handbook	Inadequate	Lists situations in which an abortion is covered without including situations in which abortion is necessary to preserve a woman's health.
	Provider Manual	Inadequate	Regarding abortion, states that the provider must "Inlcude HFS Form 2399 [*sic*]." (This is the wrong form number.)
Meridian Health Plan	FHP/ACA Member Handbook	Adequate	Accurately states that abortion is covered "if medically necessary as defined by Illinois state law."
	ICP Member Handbook	Adequate	Accurately states that abortion is covered "if medically necessary as defined by Illinois state law."
	Provider Manual	Inadequate	"Non-covered services" includes "Elective abortions" but no information is provided about when abortions are covered.
Molina Healthcare	ICP Member Handbook	Inadequate	Lists situations in which an abortion is covered without including situations in which abortion is necessary to preserve a woman's health. Falsely states that abortions in cases of rape are covered only if it is a "reported" rape.
	ICP Certificate of Coverage	Inadequate	Same as above.
	FHP/ACA Member Handbook	Inadequate	Same as above.
	FHP/ACA Certificate of Coverage	Inadequate	Same as above.
	Provider Manual	Inadequate	"Services Not Covered" includes "Elective abortions" but no information is provided about when abortions are covered.
NextLevel Health	Member Handbook	Inadequate	No information provided in this document regarding abortion coverage.
	Certificate of Coverage	Inadequate	Includes the misleading HFS contract clause on abortion.
	Provider Manual	Inadequate	No information provided in this document regarding abortion coverage.

Handbook for Providers of Medical Services Chapter 100

General Policy and Procedures

Illinois Department of Healthcare and Family Services

Issued September 2017

Foreword

Provider handbooks, along with recent provider notices, will act as an effective guide to participation in the Department's Medical Programs. Use of this handbook is intended for all Medicaid providers and contains general policies and procedures to which all enrolled providers must adhere.

It is important that both the provider of services, and the provider's billing personnel, read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions and supplements to the handbook are released as necessary based on operational need and State or federal laws requiring policy and procedural changes. Updates are posted to the Department's website.

Providers are held responsible for compliance with all policy and procedures contained herein. Providers should register to receive e-mail notification, when new provider information has been posted by the Department. The e-mail notification process is not restricted and providers should share this feature with billing services, pay to providers (payees) or any other interested entities.

Provider handbooks are available on the Department's website. A complete handbook consists of three chapters:

- Chapter 100 contains general policy, procedures and appendices applicable to all participating providers.
- Chapter 200 handbook series contains policy, procedures and appendices applicable to a specific provider type or to the provision of a specific medical service.
- Chapter 300 contains companion guides for all providers who submit the X12 (5010A1) or NCPDP (5.1 or 1.1 batch). It is a supplement to the Electronic Data Interchange transaction standards outlined within the current HIPAA Implementation Guides.

In addition to the handbooks listed above, the Department has prepared a manual containing helpful information on the Medicaid managed care program. The Managed Care Manual for Medicaid Providers is available on the Department's Care Coordination webpage.

Each Chapter 200 handbook is designated by an alphabetical character. Depending on the range of services, a provider may need more than one handbook from the Chapter 200 series. The organization and alphabetical numbering system of the Chapter 200 handbooks are as follows:

Type of Provider or Service	Handbook Number
Advanced Practice Nurse	A-200
Ambulatory Surgical Treatment Center	G-200
Audiology	E-200
Birth Centers	BC-200
Chiropractor	B-200
Dentist *	NA
Durable Medical Equipment	M-200
Encounter Rate Clinics	D-200
Healthy Kids	HK-200
Home Health Agencies	R-200
Hospice	K-200
Hospital	H-200
Laboratory Services	L-200
Local Education Agencies	U-200
Long Term Care **	N/A
Optometrist, Optician, Optical Company	O-200
Pharmacy	P-200
Podiatrist	F-200
Practitioners/Physicians	A-200
Imaging Services	A-200
Independent Diagnostic Testing Facilities	A-200
School Based/Linked Health Center Services	S-200
Screening, Assessment and Support Services	CMH-200
Supportive Living Facility	C-200
Therapy (Physical, Occupational and Speech)	J-200
Transportation	T-200

*The handbook for dental providers is maintained by the Department's dental contractor. The Dental Office Reference Manual is available on-line or can be requested by phone at 888-281-2076, by fax at 262-241-7379, or by email.

**The Handbook for Providers of Long Term Care (LTC) Services is being updated. An electronic version of this handbook is not available at this time. Questions relating to policy and billing requirements for LTC providers should be directed to the Bureau of Long Term Care at 217-782-0545.

Providers must register for e-mail notification. When registering, providers may select multiple provider/service categories listed. To ensure notification of all applicable information, providers are encouraged to check the category of "All Medical Assistance Providers," in addition to any other categories selected. The e-mail notification process is not restricted and providers should share this feature with billing services, pay to providers (payees) or any other interested entities.

102 HFS Medical Programs Overview

Payment can be made by the Department only for covered medical care and services provided to individuals who are eligible on the date of service. It is the responsibility of the provider to verify a patient's eligibility prior to providing services, except where prohibited by law (e.g., emergency ambulance services or hospital emergency room services). Information on how to verify patient eligibility can be found in Topic 108 of this handbook.

102.1 Applying for Coverage

Under an interagency agreement with HFS, the Department of Human Services' (DHS) Family Community Resource Centers (FCRCs) accept applications and determine the eligibility of individuals and families for Illinois' Medical Programs. DHS' FCRCs are organized and supervised by regions. When providers need to make contact with DHS regarding a participant, the FCRC that serves the county in which the participant lives should be contacted. In Cook County, providers should contact the appropriate neighborhood FCRC. To locate a FCRC use the DHS on-line Office Locator.

HFS' Bureau of All Kids can determine eligibility for children, pregnant women, parents and caretaker relatives who apply by mail or web application, as well as applications that are transferred from the Health Insurance Marketplace.

The Department of Children and Family Services (DCFS) is responsible for children who are youth in care of the State and covered by Medicaid or whose care is subsidized by DCFS. DCFS has responsibility for administering its own cases. Eligibility for DCFS cases is determined by DHS staff located within the DCFS office. When providers need to make contact with DCFS regarding a participant, the DCFS Regional Medical Liaison that serves the county in which the child is living should be contacted.

102.1.1 Application for Benefits Eligibility — ABE

ABE is Illinois' web-based application portal for all Medical Programs administered by HFS and the Supplemental Nutrition Assistance Program (SNAP) and Cash Assistance Program benefits, both administered by the Department of Human Services (DHS). Providers who are enrolled with the Department and certified under the Medicaid Presumptive Eligibility Program are encouraged to use ABE.

Through ABE, applicants, medical providers and community-based organizations certified under the Illinois Assister Program, can only apply online for the following HFS Medical Programs; All Kids, Family Care, Moms & Babies, Medical Assistance for Seniors and Persons with Disabilities (SPD), ACA Adults, and, former foster care clients. Assister Programs were created under the Affordable Care Act (ACA) so

community-based organizations could help support enrollment, outreach and education in both the Health Insurance Marketplace and Medicaid. Assisters are Certified Application Counselors (CACs). For information on what it means, and how to apply, to be a CAC go to the Certified Application Counselor organization website.

102.1.2 Prior and Retroactive Coverage

When an applicant initially applies for coverage they may request that their coverage is backdated to cover service they may have received for up to three months prior to the month of their application. The first time children are approved for the Family Health Plans of All Kids Share or All Kids Premium, the children may be eligible for payment of medical services received from two weeks before the date of application until the date their coverage under All Kids begins.

If the participant requests that the provider bill the Department for medical services rendered during the retroactive or prior coverage period, the provider should verify eligibility first. Refer to Topic 108 HFS Medical Card – Eligibility Verification.

Unless otherwise noted in the program descriptions that follow, participants in HFS' Medical Programs receive a Form HFS 469, HFS Medical Card, or, a DCFS youth in care, a CFS 930-C, Notice of Medicaid Coverage for DCFS Clients.

102.2 Medical Assistance Program

The Illinois Medical Assistance Program is the program which implements Title XIX of the Social Security Act or Medicaid. It is administered by HFS under the Illinois Public Aid Code. The Department has statutory responsibility and authority for the formulation of medical policy in conformance with federal and state requirements.

102.3 The Family Health Plan Program

The Family Health Plan Program is a joint federal and state funded program operating under Title XIX and Title XXI of the Social Security Act, the Illinois Public Aid Code [305ILCS 5/1-1et seq.1] and the Children's Health Insurance Program Act [215ILCS 106] that authorizes the Department to administer an insurance program to assist families in providing medical coverage for their children. The Family Health Plan Program is comprised of four plans:

- All Kids Assist/FamilyCare Plan – All Kids Assist pays for a child's health care with no copayments or premiums from the participant. FamilyCare pays for a parent or caregiver relative's health care with copayments for some services. Refer to Topic 114, Patient Cost-Sharing.
- All Kids Share Plan – this plan pays for a child's health care with a low copayment due from the participant on certain services. Refer to Topic 114, Patient Cost-Sharing.

- All Kids Premium Plan – this plan requires participants to pay a low premium each month and a low copayment on certain services. Refer to Topic 114, Patient Cost-Sharing.
- Moms and Babies – this plan covers pregnant women throughout pregnancy, 60 days postpartum and babies for the first year of the baby's life with no copayments or premiums from the participant.

  Refer to Topic 103 for a description of covered services. Please note, the medical services that are covered for participants in the Family Health Plans of All Kids Share and All Kids Premium are the same as those listed in Topic 103, with the exception of services provided through a waiver approved under Section 1915(c) of the Social Security Act and abortion services. Non-emergency transportation services are not covered for participants enrolled in All Kids Premium Level 2 program.

More information on these plans can be found on the All Kids webpage and the FamilyCare webpage.

102.4 Senior and Persons with Disabilities (SPD) Program – Formerly AABD

The Senior and Persons with Disabilities (SPD) Program provides medical coverage under Medicaid to seniors, persons who are blind and persons with disabilities with income up to 100 percent of the federal poverty level (FPL) and no more than $2,000 of non-exempt resources. Refer to Topic 103 for a description of covered services.

102.5 The Affordable Care Act (ACA) Adult Group

Effective January 1, 2014, the Affordable Care Act (ACA) established a new federal eligibility group for medical coverage for adults age 19-64 without children and with incomes up to 138% FPL. These low-income adults may be eligible for health coverage through Medicaid. In addition, they are also eligible to receive, if qualified, Long Term Care Supports and Services (LTSS), including nursing home care; services in an Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/IDD); or services provided through Home and Community-Based Services (HCBS) waivers under subsection 1915(c) of the Social Security Act. For more information on the ACA Adult Group visit HFS' Affordable Care Act webpage. Refer to Topic 103 for a description of covered services.

102.6 Medicare Savings Program (MSP)

The Department's Medicare Savings Program (MSP) offers assistance to qualified Medicare beneficiaries in paying Medicare premiums, deductibles and coinsurance. The MSP consists of three programs:

- Qualified Medicare Beneficiary (QMB) - for eligible QMB participants, the Department pays the monthly Medicare premiums, deductibles and coinsurance.
- Specified Low-Income Medicare Beneficiary (SLIB/SLMB) - for eligible SLIB/SLMB participants, the Department pays the monthly Medicare Part B Supplemental Medical Insurance premiums.
- Qualified Individual (QI) 1 – for eligible QI-1 participants, the Department pays the monthly Medicare Part B Supplemental Medical Insurance premiums.

For a brochure on the Medicare Savings for Qualified Beneficiaries visit the Department's Medical Programs Brochures webpage.

102.7 State Chronic Renal Disease Program

The State Chronic Renal Disease Program is operated by the Department under the authority of the Renal Disease Treatment Act [410 ILCS 430]. This is a state only funded program that covers the cost of renal dialysis services for eligible Illinois residents diagnosed with chronic renal failure. The only medical service covered for participants is the dialysis itself.

If a patient has Medicare as their primary insurance, the State Chronic Renal Disease Program will still remain the secondary payer. If a patient does not have health insurance or their primary insurance does not cover the costs currently being covered through the State Chronic Renal Disease Program, the patient may be required to apply for coverage through HFS' ACA Adult Group or through Illinois' official healthcare marketplace: Get Covered Illinois.

The application package for the State Chronic Renal Disease Program is supplied by the Department to social workers in renal dialysis centers. Social workers assist the patient in completing the application and submit it to the Department. Department staff performs a financial and eligibility evaluation and determine what the patient's participation fee will be, if any.

Participants of the State Chronic Renal Disease Program do not receive a medical card. Questions regarding applications or the eligibility of participants should be directed to the Bureau of Hospital and Provider Services at 1-877-782-5565. For more detailed information, please refer to the State Chronic Renal Disease Program webpage.

102.8 State Hemophilia Program

The State Hemophilia Program is operated by the Department under the authority of the Hemophilia Care Act [410 ILCS 420]. This is a state only funded program that covers certain services when directly related to the participant's hemophilia.

Medical services covered for participants in the State Hemophilia Program vary according to the age of the participant.

For eligible children under the age of 21, the Department assists in coverage only for blood clotting factor. Other medical expenses are reimbursed by the University of Illinois at Chicago, Division of Specialized Care for Children (DSCC).

For eligible adults, the Department assists with expenses incurred for blood clotting factor and other medical expenses related to the disease, including: two comprehensive exams per year which includes physician and laboratory services; outpatient services.

If a patient has Medicare as their primary insurance, the State Hemophilia Program will still remain the secondary payer. If a patient does not have health insurance or their primary insurance does not cover the costs currently being covered through the State Hemophilia Program, the patient may be required to apply for coverage through HFS' ACA Adult Group or through Illinois' official healthcare marketplace, Get Covered Illinois. Eligibility for this program is determined by the Department. Once approved, participants are sent an application every fiscal year to reapply. Applications are returned to:

Illinois Department of Healthcare and Family Services
Attn: State Hemophilia Program
P.O. Box 19129
Springfield, IL 62794-9129

Participants of the State Hemophilia Program do not receive an HFS Medical card. Questions regarding applications or the eligibility of participants should be directed to the Bureau of Hospital and Provider Services at 877-782-5565.

102.9 State Sexual Assault Survivors Emergency Treatment Program

The Illinois Sexual Assault Survivors Emergency Treatment Program is administered under the authority of the Sexual Assault Survivors Emergency Treatment Act [410 ILCS 70]. This program covers medical expenses for sexual assault survivors who seek emergency services from a certified hospital and who are not eligible for medical coverage through the Department and who are not covered for these services by a health insurance policy.

The medical services listed below are covered for participants in the State Sexual Assault Survivors Emergency Treatment Program when they are directly related to an alleged sexual assault. The Department may request medical records to verify that the services are eligible for reimbursement.

- Emergency Department/Room Physician Services
- Hospital Emergency Department/Room Visits
- Transportation to the hospital emergency department/room
- Follow-up services, such as practitioner services, laboratory services and pharmacy services for a period of 90 days with a hospital issued "Authorization for Payment Voucher"

Participants of the State Sexual Assault Survivors Emergency Treatment Program do not receive an HFS Medical Card. Inquiries on this program should be directed to the Bureau of Hospital and Provider Services at 877-782-5565 or to:

Office of the Attorney General of Illinois
Crime Victims Compensation Program
100 W. Randolph Street, 13th Floor
Chicago, IL 60601 Telephone: 800-228-3368

102.10 Health Benefits for Persons with Breast or Cervical Cancer Program

The Health Benefits for Persons with Breast or Cervical Cancer Program assists uninsured persons who have been diagnosed with breast or cervical cancer or a precancerous condition. The Illinois Department of Public Health administers the screening portion of the program. HFS administers the treatment portion of the program.

Eligibility for the program is determined by the Department's Breast and Cervical Cancer (BCC) Eligibility Unit. Participants in the Health Benefits for Persons with Breast or Cervical Cancer Program receive the same medical benefits as participants in the Medical Assistance Family Health and ACA Adult Programs. Refer to Topic 103 for a description of covered services. Questions regarding the Health Benefits for Persons with Breast or Cervical Cancer program should be directed to the Department of Public Health Women's Health line at 888-522-1282, TTY at 800-547-0466. Additional information on the program can be found on the Illinois Breast and Cervical Cancer Program website.

102.11 Health Benefits for Workers with Disabilities (HBWD) Program

The Health Benefits for Workers with Disabilities (HBWD) Program assists persons with disabilities who wish to go to work, or increase their earnings without the fear of losing Medicaid benefits. Eligibility for this program is determined by the Department's Bureau of Medical Eligibility Policy and Special Programs. Applications are submitted to:

Health Benefits for Workers with Disabilities Program
P.O. Box 19145
Springfield, IL 62794-9145

Participants in the HBWD Program receive the same medical benefits as participants in the Medical Assistance Family Health and ACA Adult Programs. Refer to Topic 103 for a description of covered services. Questions regarding the HBWD Program should be directed to 800-226-0768. Additional information on the program can be found on the Health Benefits for Workers with Disabilities Program webpage.

102.12 Emergency Services for Noncitizens Not Meeting Immigration Status

Persons age 19 or older, who are not eligible for medical benefits because they do not meet citizen/immigration requirements, may qualify for medical coverage for emergencies only. Persons applying for Emergency Services for Noncitizens Not Meeting Immigration Status must need, or have received emergency medical services in the month of their application, or during the three months before the month of the application. These individuals must meet all the program requirements for FamilyCare Assist, ACA Adult, or SPD medical coverage, except for a Social Security Number and verification of immigration status. People who meet these requirements are classified as noncitizens not meeting immigration status and are only eligible for short-term medical coverage for emergency care. Noncitizens not meeting immigration status are ineligible for cash and regular medical benefits, including organ transplants. Refer to Topic 103 for a description of covered services.

An ineligible noncitizen who comes to Illinois solely to receive medical care does not qualify. Medical coverage is given only to the person with the emergency medical condition; other non-citizen family members are not eligible.

103 Covered Services

The range of services for which the Department will pay varies depending on the program or plan under which a participant is covered. Topic 108 describes how to determine which persons are eligible for each of the following lists of services.

103.1 Medical Assistance, Family Health Plan and ACA Adult Programs

The medical services that are covered for participants in Medical Assistance (Medicaid), the Family Health Plans and ACA Adults include the following:

- Abortion services in limited situations (89 Ill. Adm. Code 140.413)
- Advanced Practice Nurse Services (89 Ill. Adm. Code 140.435, 140.436)
- Ambulatory Surgical Treatment Center Services (89 Ill. Adm. Code Part 146, Subpart A)
- Audiology Services (89 Ill. Adm. Code 140.497)
- Chiropractic Services (89 Ill. Adm. Code 140.428)
- Clinic Services (89 Ill. Adm. Code 140.460, 140.461, 140.462, 140.463, 140.464 and 140.467)
- Dental Services (89 Ill. Adm. Code 140.420, 140.421)
- EPSDT Services (89 Ill. Adm. Code 140.485)
- Family Planning Services and Supplies (89 Ill. Adm. Code 140.482, 140.483 and 140.484)
- Home Health Agency Visits (89 Ill. Adm. Code 140.470, 140.471, 140.472,140.473 and 140.474)
- Hospice Services (89 Ill. Adm. Code 140.469)
- Hospital Ambulatory (Outpatient) Services (89 Ill. Adm. Code 148.140).
- Hospital Inpatient Services (89 Ill. Adm. Code, Part 148,Part 149 and Part 152)
- Hospital Emergency Department Services (89 Ill. Adm. Code148.140)
- Imaging Services (89 Ill. Adm. Code 140.438)
- Laboratory (89 Ill. Adm. Code 140.430, 140.431, 140.432, 140.433, 140.434).
- Long Term Care Services (89 Ill. Adm. Code Part 147 and Part 153)
- Medical Supplies, Equipment, Prostheses and Orthoses (89 Ill. Adm. Code 140.475, 140.476, 140.477, 140.478, 140.479, 140.480 and 140.481)
- Mental Health Services (89 Ill. Adm. Code 140.452, 140.453, 140.454, 140.455)
- Optical Services/Supplies (89 Ill. Adm. Code 140.416, 140.417 and 140.418).
- Pharmacy Services (89 Ill. Adm. Code 140.440, 140.441, 140.442, 140.443, 140.444, 140.445, 140.446, 140.447, 140.448, 140.449,140.450 and 140.451)
- Physician Services (89 Ill. Adm. Code 140.410, 140.411, 140.412, 140.413 and 140.414)
- Podiatric Services (89 Ill. Adm. Code 140.425, 140.426)
- Renal Dialysis Services (89 Ill. Adm. Code 148.140)

- Sub-acute Alcohol-Substance Abuse Services (89 Ill. Adm. Code 148.340 and 148.370)
- Telehealth Services (89 Ill. Adm. Code 140.403)
- Therapy Services (89 Ill. Adm. Code 140.457, 140.458 and 140.459)
- Transportation to secure covered medical services (89 Ill. Adm. Code 140.490, 140.491, 140.492, 140.493 and 140.494)

In addition to the services listed above, certain medical services that are funded through other state agencies are covered for participants in Medical Assistance (Medicaid), the Family Health Plan and ACA Adults. These include:

- Services provided through a waiver approved under Section 1915(c) of the Social Security Act and funded through the Department on Aging and the Department of Human Services.
- Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option and funded through the Department of Human Services and the Department of Children and Family Services; and sub-acute alcohol and substance abuse treatment services funded through the Department of Human Services.

103.2 Emergency Services Defined

Throughout all the programs administered by the Department, the following definition of “emergency” is used, unless otherwise specified. Emergency is defined as “An emergency medical condition that occurs suddenly and unexpectedly, is caused by injury or illness, and requires immediate medical attention to prevent serious jeopardy to the patient’s health, or serious impairment to bodily functions or parts.”

104 Services Not Covered

Services for which medical necessity is not clearly established are not covered in the Department's Medical Programs, in accordance with 89 Ill. Adm. Code 140.6. Services and supplies for which payment will not be made under any of the Department's medical programs include, but are not limited to, the following:

- Abortion services, except as allowed pursuant to 89 Ill. Admin. Code 140.413(a)(1)
- Acupuncture
- Artificial insemination
- Autopsy examinations
- Diagnostic or therapeutic procedures related to primary infertility or sterility
- Experimental procedures
- Items or services for which medical necessity is not clearly established
- Medical care provided by mail or telephone, except for approved telemedicine services described in Chapter 200 handbooks for practitioners and providers of encounter clinic services. This does not prohibit the mailing of medically necessary covered items, for example, prescription drugs sent to a patient by a mail-order pharmacy
- Medical examinations required for entrance in to adult educational or vocational programs
- Medical or surgical procedures performed for cosmetic purposes
- Preparation of routine records, forms and reports
- Research oriented procedures
- Services available without charge
- Services prohibited by state or federal law
- Services provided by terminated or barred providers
- Services provided only, or primarily, for the convenience of the patient/family
- Services or supplies not personally rendered by the provider, unless specifically allowed in this handbook or in the Chapter 200 handbook or otherwise specifically authorized in writing by the Department
- Subsequent treatment for venereal disease when such services are available free of charge through state and/or local health agencies
- Unkept appointments
- Visits with persons other than a patient, such as family members or long term care facility staff

Payments for services rendered after the death of a participant will be recovered by the Department. Other action may also be taken as appropriate, including possible civil or criminal fraud prosecution where warranted. The Chapter 200 handbook series may contain other exclusions which are specific to a provider type (specialty/subspecialty) or service.

Handbook for Providers of Hospital Services

Chapter H-200 Policy and Procedures For Hospital Services

Illinois Department of Healthcare and Family Services

Issued September 2014

g. The patient was advised that the sterilization will not be performed for at least 30 days, except in cases of premature deliveries or emergency abdominal surgery as indicated above.

2. Suitable arrangements were made to ensure that the information specified in (1) (a) through (g) was effectively communicated to any patient who is blind, deaf, or otherwise handicapped;

3. An interpreter was provided if the patient to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent;

4. The patient to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;

5. The consent form requirements specified below were met; and

6. Any additional requirements of state or local law for obtaining consent, except a requirement for spousal consent, were followed.

Informed consent may not be obtained while the individual to be sterilized is:

1. In labor or childbirth,
2. Seeking to obtain or obtaining an abortion; or
3. Under the influence of alcohol or other substances that affect the individual's state of awareness.

The patient's written consent for sterilization must be obtained on Form 2189 Sterilization Consent Form. All appropriate sections of the form are to be completed. **The HFS 2189 must be attached to the UB-04 billing form when charges are submitted.**

H-254.6 Abortion Services

Charges for an abortion and associated hospital services are covered services in the Illinois Medical Assistance Program only when the mother's life is endangered, to end pregnancies resulting from rape or incest, or if necessary to protect a woman's health.

Form 2189 Abortion Payment Application must be completed by a licensed physician certifying that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term; or certifying that the patient reported that the pregnancy was the result of rape or incest; or certifying that the abortion is necessary to protect a woman's health.

A copy of the completed HFS 2390 must be attached to the UB-04 claim form when charges are submitted. The claim must contain the appropriate Condition Code to reflect the reason the abortion was performed. Refer to the UB-04 Data Specifications Manual for the appropriate Condition Codes relating to the limited abortion circumstances above.

H-254.7 Claims for Illinois Department of Corrections (IDOC) and Illinois Department of Juvenile Justice (IDJJ) Inmates

All current and future inmates will be assigned a case number. Inmates who qualify for Medicaid will be assigned the applicable Category of Assistance. Inmates who do not qualify for Medicaid will be given a special eligibility segment designating them as having "Department of Corrections Eligibility." **Responsible Office Number 195 within the case identification number will designate the patient as an IDOC or IDJJ inmate.** The responsible Office Number appears as the second set of numeric digits in the case identification number.

When an inmate presents at a hospital for services, an IDOC/IDJJ representative must accompany the inmate. The representative may give the hospital the recipient identification number for the inmate, if one has already been assigned, for the hospital to use when billing HFS. IDOC/IDJJ inmates are not issued regular medical cards and providers **should not** complete an application for medical assistance for IDOC/IDJJ inmates.

The message, "Eligible for Limited IDOC Hospital Benefit Package," now appears in the Medicaid Recipient Eligibility Verification (REV) System; the Medical Electronic Data Interchange, Internet Electronic Claims (MEDI/IEC) System; and the Automated Voice Response System (AVRS). After checking eligibility through one of the verification systems listed above, hospitals may submit their bills.

In the event that the above message does not appear for an inmate, **please call HFS at 217-782-3541 for assistance.**

The "Eligible for Limited IDOC Hospital Benefit Package" message only extends medical coverage to inmates who are in custody of IDOC/IDJJ at the time services are rendered. **The IDOC/IDJJ special eligibility segment is considered valid only if an IDOC/IDJJ representative accompanies the person to the hospital.**

In the event that an IDOC/IDJJ representative does not accompany an inmate but the above message appears in the eligibility verification system, hospital providers are to consider the person as private-pay or self-pay and can complete an application for assistance on their behalf. Paroled or discharged inmates whose eligibility has not been updated are not the responsibility of HFS.

All services provided by an enrolled hospital provider, those reimbursed as institutional services and those reimbursed as fee-for-service, must be billed directly to HFS.

Handbook for Practitioners Rendering Medical Services

Chapter A-200 Policy and Procedures For Medical Services

Illinois Department of Healthcare and Family Services
Issued October 2016

A-203 Covered Services

Covered services are those reasonably necessary medical and remedial services, which are recognized as standard medical care, required for immediate health and well-being because of illness, disability, infirmity or impairment. Refer to Chapter 100 for a general list of covered services.

While various procedure codes may be used to designate services provided or procedures performed, such usage does not necessarily assure payment. Any question a practitioner may have about coverage of a particular service is to be directed to the Department prior to provision of the service.

A-203.1 Referral Requirements

A practitioner should only refer a participant to a participating source of medical care if the care and service for which the referral is made are medically necessary, covered under the Department's Medical Programs, and are not available locally.

If the necessary services are available locally, and referral is made to a non-local provider for the preference or convenience of the practitioner or the participant, the Department will not assume responsibility for related expenses involved, such as transportation costs, etc.

A-203.1.1 PCP to PCP and PCP to Specialist Referrals

Recipient Restriction Program (RRP)

When a participant is in the RRP, all non-emergency services require written prior authorization from the Primary Care Physician (PCP) designated on the restricted participant's eligibility file. The rendering provider is responsible for obtaining a completed form HFS 1662 Primary Care Provider Referral Authorization (pdf) from the PCP and attaching the form to the claim form submitted to HFS for the service.

Illinois Health Connect PCP Referrals

Illinois Health Connect requires a participant to be seen by his/her own PCP or by a practitioner or clinic affiliated with the PCP. PCPs seeing participants enrolled in Illinois Health Connect who are not enrolled on their panel (or on an affiliated PCP's panel) must obtain a referral from the participant's PCP. If a claim requires a referral from the participant's PCP, but no referral is on file, the claim will be rejected. For information regarding direct access services that do not require a PCP referral, please refer to the Illinois Health Connect Primary Care Provider Handbook.

Specialist Referrals

A specialist may choose to enroll with HFS as a PCP for certain participants. If the specialist is enrolled as a PCP with HFS, a referral will be required when rendering services to any participant not on his primary care roster.

Providers who are not enrolled as PCPs, including specialists or PCPs who provide direct access services as listed in the IHC Handbook do not need a referral from a participant's PCP at this time. Providers will be informed via an informational notice when these services will require a referral.

A-204 Non-Covered Services

Services for which medical necessity is not clearly established are not covered in the Department's Medical Programs, in accordance with 89 Ill. Adm. Code 140.6. See Chapter 100 Handbook for general services and supplies for which payment will not be made. In addition, the following services are excluded from coverage in the Department's Medical Programs.

- Examination required for the determination of disability or incapacity. (Local Department of Human Services offices may request that such examinations be provided with payment authorized from non-medical funds. Practitioners are to follow specific billing instructions given when such a request is made).
- Services provided in Federal or State institutions.
- Sterilization of a mentally incompetent or institutionalized individual or an individual who is less than 21 years of age.
- Diagnostic and/or therapeutic procedures related to fertility, e.g., tubal or vasectomy reversal or pharmaceuticals.
- Those prosthetic devices inserted or implanted which do not increase physical capacity, overcome a handicap, restore a physiological function or eliminate a functional disability. (**Note**: Does not apply to breast prosthetic devices provided following cancer surgery.)
- Autopsy examination.
- Artificial insemination, in-vitro fertilization, or any other form of infertility treatment.
- Abortion, except in accordance with 89 Ill. Adm. Code 140.413(a)(1).
- Medical or surgical transsexual treatment services for service provided prior to April 1, 2015.
- Subsequent treatment for venereal diseases when such services are available free of charge through State and/or local health agencies.
- Dietitian counseling.

Refer to 89 Ill. Adm. Code 140.6 for a complete list of services that are not covered under the Department's medical assistance programs.

Handbook for Ambulatory Surgical Treatment Centers

Chapter G-200 Policy and Procedures For Ambulatory Surgical Treatment Centers

Illinois Department of Healthcare and Family Services

Issued December 2014

4. The patient to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;

5. The consent form requirements specified below were met; and

6. Any additional requirements of State or local law for obtaining consent, except a requirement for spousal consent, were followed.

Informed consent may not be obtained while the individual to be sterilized is:

1. In labor or childbirth,
2. Seeking to obtain or obtaining an abortion; or
3. Under the influence of alcohol or other substances that affect the individual's state of awareness.

The patient's written consent for sterilization must be obtained on Form HFS 2189 Sterilization Consent. All appropriate sections of the form are to be completed. **The HFS 2189 must be attached to the UB-04 billing form when charges are submitted.**

G-254.3 Abortion Services

Charges for an abortion and associated ASTC services are covered under the department's medical programs only when the mother's life is endangered, to end pregnancies resulting from rape or incest or if necessary, to protect a woman's health.

Form 2390 Abortion Payment Application, must be completed by a licensed physician certifying that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term; or certifying that the patient reported that the pregnancy was the result of rape or incest; or certifying that the abortion is necessary to protect a woman's health.

A copy of the completed HFS 2390 must be attached to the UB-04 claim form when charges are submitted. The claim must contain the appropriate Condition Code to reflect the reason the abortion was performed. Refer to the UB-04 Data Specifications Manual for the appropriate Condition Codes relating to the limited abortion circumstances above.

Illinois Department of Healthcare and Family Services

Managed Care Manual for Medicaid Providers

January 2016

TABLE OF CONTENTS

Intent of this Manual:

This manual contains helpful information regarding the Medicaid managed care program for Providers enrolled in Medicaid. Please be advised that this manual is not intended to supersede, modify, or replace any policies, guidelines, or other Provider handbooks applicable to Providers in the Medical Assistance Program under the Fee-For-Service payment system. Further, this handbook does not alter or supersede any managed care contractual obligations, duties, or requirements between Providers and Health Plans or between the Illinois Department of Healthcare and Family Services and Health Plans. Further guidance regarding the Medicaid Fee-For-Service program can be found in the HFS Provider Handbooks.

Chapter 1 Managed Care Overview

1.10 Introduction

In order to carry out the mission of the Department of Healthcare and Family Services to improve the health of Medicaid Participants by providing access to, and coordination of, quality health care, HFS is reforming the systems that deliver medical care to participants. This mission includes providing a Primary Care Provider (PCP) for every participant; maintaining continuity of care with that PCP; creating comprehensive networks of care around participants including primary care, specialists, hospitals and behavioral care; and offering care coordination to help participants with complex needs navigate the healthcare system pursuant to the Medicaid reform law (*Public Acts 096-1501* and *97-689)* and the federal Affordable Care Act *(Public Law 111-148).* Risk and performance is tied to reimbursement in order to transform the Medicaid healthcare delivery system to one with a focus on improved health outcomes.

HFS has completed the roll-out of mandatory care coordination programs for most Medicaid-only participants in five mandatory managed care counties, and for the Dual Eligible population in two demonstration areas for the MMAI program. Through these programs HFS surpassed the 50% goal required by law, with an enrollment of over 2 million participants in care coordination programs. The five mandatory managed care regions include Rockford, Central Illinois, Metro East, Quad Cities, and Greater Chicago (Cook and Collar Counties).

1.20 Managed Care Map

Providers are able to view the current expansion map (pdf) on the HFS website. This map shows the programs and Health Plans participating in each county.

1.30 Populations and Programs

Illinois Medicaid Managed Care consists of four programs and within those programs are several Health Plans. Program definitions, populations and participating Health Plans are listed below:

Integrated Care Program (ICP): The Integrated Care Program (ICP) was implemented in May of 2011. ICP is a program for Seniors and Persons with Disabilities who are eligible for the Medicaid program, but not eligible for Medicare. This care delivery system brings together an Enrollee's Providers as an integrated care team to provide a more coordinated medical approach and keep the Enrollee healthier. Integrated care focuses on all of the factors that can affect a person's health and well-being and puts a plan in place to manage all the Enrollee's health needs, whether those needs are physical, behavioral or social.

The ICP program operates in the following regions:

- Greater Chicago (Cook, DuPage, Kane, Kankakee, Lake and Will counties)
- Rockford (Winnebago, Boone and McHenry counties)
- Central Illinois (Knox, Stark, Peoria, Tazewell, McLean, Ford, Menard, Logan, Sangamon, Christian, Mason, Piatt, DeWitt, Champaign and Vermilion counties)
- Metro East (St. Clair, Clinton and Madison counties)
- Quad Cities (Rock Island, Henry and Mercer counties)

To achieve improvements in health, ICP coordinates care between local primary care Physicians, specialists, hospitals, nursing homes, behavioral health Providers and other Providers so that all care is organized around the needs of the enrollee. ICP was phased in as two (2) service packages. It began with the initial rollout of Service Package I for acute health services, such as Physician, hospital and pharmacy services. Service Package II covers Long-Term Services and Supports, including Home and Community Based waiver and Nursing Facility services, and became effective February 1, 2013.

Medicare Medicaid Alignment Initiative (MMAI): The Medicare-Medicaid Alignment Initiative (MMAI) was implemented in March 2014. The MMAI demonstration integrates services covered in Medicare and Medicaid under one managed care program and combines financing streams to eliminate conflicting incentives between the two (2) programs. The overarching goal of MMAI is to integrate benefits to create a unified delivery system that is easier for beneficiaries eligible for both Medicare and Medicaid (Dual Eligibles) to navigate. HFS and federal Centers for Medicare and Medicaid Services (CMS) contracted with eight (8) Health Plans to assume financial risk for the care delivered to Dual Eligible participants with responsibilities for robust care coordination efforts where performance will be measured and tied to quality measurement goals. MMAI is a voluntary program with passive enrollment.

The MMAI program operates in the following regions:

- Greater Chicago (Cook, DuPage, Kane, Kankakee, Lake and Will counties)
- Central Illinois (Knox, Stark, Peoria, Tazewell, McLean, Ford, Menard, Logan, Sangamon, Christian, Mason, Piatt, DeWitt, Champaign and Vermilion counties)

Family Health Plans/ACA Adults (FHP): Family Health Plan (FHP)/Affordable Care Act (ACA) program is a mandatory managed care program for the Family Health population and the newly eligible ACA adults. HFS began mandatory enrollment in the summer of 2014. Under this expansion effort, individuals enrolled in the Illinois Health Connect program or with a Voluntary Health Plan, and newly eligible ACA adults, started the process of enrolling with a Health Plan for their health care delivery. HFS has nine (9) contracted Health Plans in the FHP/ACA program.

The FHP program operates in the following regions:

- Greater Chicago (Cook, DuPage, Kane, Kankakee, Lake and Will counties)

- Rockford (Winnebago, Boone and McHenry counties)
- Central Illinois (Knox, Stark, Peoria, Tazewell, McLean, Ford, Menard, Logan, Sangamon, Christian, Mason, Piatt, DeWitt, Champaign and Vermilion counties)
- Metro East (St. Clair, Clinton and Madison counties)
- Quad Cities (Rock Island, Henry and Mercer counties)

Illinois Health Connect (IHC): The Illinois Health Connect (IHC) program was the Department's first step toward implementing managed care throughout the State. During 2014 and 2015, the majority of participants previously enrolled in IHC joined managed care Health Plans for their care coordination services. IHC remains a choice for participants in the non-mandatory managed care regions; however, it is not a choice for participants statewide. To obtain more information regarding IHC, Providers are directed to the IHC website.

Health Plans and the Programs in Which They Participate:

MCOs	ICP	MMAI	FHP/ACA
Aetna Better Health	X	X	X
Blue Cross Blue Shield of Illinois	X	X	X
Community Care Alliance of Illinois (CCAI)	X		
CountyCare	X		X
Family Health Network (FHN)			X
Harmony Health Plan			X
Health Alliance Connect	X	X	X
HealthSpring	X	X	
Humana	X	X	
IlliniCare	X	X	X
Meridian Health Plan of Illinois	X	X	X
Molina Healthcare	X	X	X
NextLevel Health	X		X

1.40 Participant Enrollment

The majority of Medicaid participants are required to enroll in a managed care program. The Illinois Participant Enrollment Services (ICES), Maximus, conducts all enrollment activities for the Department. Based on the eligibility data provided to the ICES by the Department, the ICES will determine which managed care program is appropriate for the participant and mail an initial enrollment packet to the participant's address on file with the Department. The enrollment packet details the Health Plan choices available to the participant and the date by which the participant must respond with a voluntary choice. The initial enrollment packet is followed by a second enrollment packet approximately 30 days later. The second enrollment packet details the Health Plan and a Primary Care Provider (PCP) to whom the participant will be assigned if a voluntary choice is not made by the given response date. The Department encourages participants, their families, or their authorized representatives to make an active choice of a Health Plan since those individuals know the participant's health care needs best.

If a voluntary enrollment is not received by the response date, the ICES will utilize an advanced algorithm to assign the participant to a Health Plan and a PCP. The algorithm considers past Provider relationships and claims history to assign participants to a "best fit" Health Plan and PCP. As a last resort, geo-mapping is used to assign a participant to a Health Plan and PCP within certain specified travel/distance parameters.

For programs that utilize a lock-in period (Family Health and Integrated Care), the ICES will conduct similar enrollment activities for participants during their annual Open Enrollment period. Participants who are required to enroll in a managed care program can do so in one of two ways. Participants (other than those enrolling in the Medicare-Medicaid Alignment Initiative) can enroll via the Internet at the ICES website. All participants may enroll by contacting the ICES at this toll-free number: 1-877-912-8880 (TTY: 1-866-565-8576).

1.50 Provider and Health Plan Participant Education at Provider Locations

If a Provider chooses to educate their patient at their Provider location(s), Providers and their staff must ensure that the patient is aware of all plan choices and use materials approved by the Department for this education. A flyer/letter template is available to Providers to use in their offices which will require the Provider to include all Health Plans with whom they are contracted. The flyer/letter template (pdf) is available on the HFS website.

If a Provider chooses to prefer a Health Plan in the flyer/letter (the preference must be a benefit to the participant, not only to the Provider), Providers may add a paragraph to the flyer/letter indicating their preference. The paragraph must make no false or disparaging statements about other Health Plans and must be presented in a positive way. Any flyer/letter that has a preferred Provider paragraph must be submitted through the preferred Plan for HFS approval.

The Provider template flyer/letter, including those with a preferred Health Plan paragraph must have a statement at the bottom that states, "To learn more about your Health Plan choices please contact Illinois Participant Enrollment Services (ICES) at 1-877-912-8880 or visit the ICES website".

Provider offices may provide a phone for their patients to contact the ICES directly to enroll. Online enrollment is prohibited within any Provider settings, health fairs, etc. This includes all Health Plan Primary Care Provider offices.

Chapter 2 Provider Relations

2.10 Provider Enrollment

Provider enrollment in Medicaid Managed Care consists of a two part process. The first is to enroll with the Illinois Medical Assistance Program (Medicaid) and subsequently receive approval from the State to be a participating Provider in the program. The second is to contract with each Health Plan in which you want to participate. Contracting with a Health Plan does not automatically guarantee enrollment into Medicaid, as Medicaid enrollment is a separate process.

2.20 Enrollment into Medicaid

To comply with the Federal Regulations at 42 CFR Part 455 Subpart E - Provider Screening and Enrollment, Illinois has implemented an electronic Provider enrollment system. The web-based system is known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT).

To obtain more information and/or to enroll in IMPACT, Providers are directed to the IMPACT website.

The effective date of enrollment for the eligible Provider will be established upon final approval of the application by the Department. Payment will not be made for services rendered prior to the effective date of enrollment. Change in ownership or corporate structure necessitating a new federal tax identification number terminates the participation of the enrolled Provider. Participation approval is not transferable. Claims submitted by the new owner using the prior owner's assigned Provider number may result in recoupment of payments and other sanctions.

In preparation for the enrollment process Providers should:

- **Obtain a National Provider Identifier (NPI) number**. The federal government requires that Providers who administer "medical and other health services" should obtain an NPI number – a unique 10-digit identification number for covered health care Providers. For more information visit the federal CMS HIPAA webpage.
- **Renew any professional certifications or licensures.** Current certification or licensure is a condition of participation in the Medicaid Program. If your profession requires a certification or licensure in the State of Illinois, these qualifications must be active at the time of enrollment or revalidation. This includes the Clinical Lab Improvement Amendments Certification, administered by the Illinois Department of Public Health Office of Health Care Regulation.
- **Submit a current W9 to the Illinois State Comptroller for certification**. Be sure it is current, as the comptroller does not accept copies of older versions. This W9 should have the tax number that you intend to be paid under.
- **Decide on an email address**. Your email address is used for communication with the state as this will be the primary mode of communication and will be required in order to complete the enrollment process.

2.30 Enrollment into a Health Plan

Enrollment into a Health Plan is a three step process: contracting, credentialing and Provider load.

1. Contracting. Contact any Health Plan you are interested in contracting with by reaching out to the Provider Network representative on the Health Plan contact list (pdf).
2. Credentialing. In addition to contracting with the Health Plan, Providers must be credentialed by the Health Plan. Credentialing takes approximately thirty (30) to ninety (90) days. It is imperative for Providers to submit clean documents with all applicable information when submitting their credentialing applications.
3. Provider Load. Once a Provider is credentialed, it takes thirty (30) to sixty (60) days to load Provider information into the Health Plan's system.

2.40 Provider Contracting

Medicaid Providers located in or near the mandatory regions are encouraged to contract with one or more of the Health Plans (pdf) to become part of their network(s). The contract negotiated between the Medicaid Provider and the Medicaid Health Plan dictates the relationship between the two parties, including payment provisions, prior authorization requirements, utilization review requirements, Provider Complaint and resolution procedures and panel limitations. Once a Provider has contracted successfully with a Health Plan, the Provider is considered an Affiliated Provider.

2.50 Provider Training

Health Plans are required to meet with the Affiliated Provider and/or the Provider's staff to explain their policies and procedures. Provider orientation or training will include information on the Health Plan's utilization policies and procedures, cultural competency requirements, and billing or claims submittal information in order to be reimbursed for a service rendered. A contact person at the Health Plan will serve as the Provider's representative. These sessions are held via phone call, webinar or in the Providers' offices. The Health Plans and the Department developed a Provider Training Attestation form (pdf), which allows Providers to document that they have already been trained in a particular area from a specific Health Plan, so they aren't taking the same course repeatedly for each Health Plan. The Health Plans have the Provider complete the attestation form and the Health Plan must keep the form on file for auditing purposes.

In most instances Health Plans establish their own utilization and prior authorization requirements which may or may not coincide with the requirements the Department has in place under Fee-For-Service. Health Plans may also establish, via Provider subcontracts, different timely filing requirements than the Department. These are examples of processes that will be explained during a Provider's orientation.

Provider manuals are available online to all Affiliated Providers. Each Health Plan has a Provider portal where the Provider can go to learn administrative and referral requirements and to make a request for prior authorization. The Provider directory (pdf) is also available to Providers online.

If a Provider has a dispute over a claim, the Health Plan will address that dispute through their Complaint and resolution system.

The Department has issued several Provider notices regarding managed care and working with and coordinating care with these organizations. The Health Plans are encouraged to sign up for all Provider notices in order to remain informed of information the Department is providing to all enrolled Medicaid Providers. The Health Plans are also made aware of policy changes and rate changes through Provider notices as well.

2.60 Provider Billing

Providers are responsible to bill the Health Plan directly for Health Plan Enrollees. Every Health Plan's Enrollee ID card contains the Enrollee's HFS RIN. Providers MUST verify coverage and Health Plan enrollment through one of the HFS automated systems using the participant's Social Security Number or the participant's RIN found on either the HFS Medical Card or Health Plan's Enrollee ID card.

It is critical that Providers check the Department's electronic eligibility systems regularly to determine a participant's enrollment in a Health Plan. The three options are: 1) Recipient Eligibility Verification Program (REV); 2) the Medical Electronic Data Interchange (MEDI) system; or 3) the Automated Voice Response System (AVRS) at 1-800-842-1461.

Using REV and MEDI to Determine a Participant's Health Plan

Recipient Eligibility Verification (REV) programs and MEDI identify the name of the Health Plan for Medicaid participants enrolled in a Health Plan. Providers must bill the Health Plan for Health Plan Enrollees.

Using the AVRS to Determine a Participant's Health Plan

Providers can get Participant eligibility information by calling 1-800-842-1461, the Automated Voice Response System (AVRS). To check eligibility on AVRS, Providers will need the:

- 9-, 10- or 12-digit Medicaid Provider number;
- 9-digit Recipient Identification Number (RIN); and
- Date for which eligibility information is being sought.

The AVRS will provide all information relating to a Participant's eligibility, including Health Plan enrollment, and will permit up to 6 eligibility inquiries during each telephone call.

The Department pays the Health Plans on a full-risk capitated basis to cover the cost of Medicaid services and care coordination. Providers must provide services in accordance with each Health Plan's utilization policies and procedures, including procedures for prior

authorization and billing. All questions, including billing questions, should be directed to the Health Plans.

2.70 Encounter Data

If a Provider is paid on a capitated basis, it is imperative that the Provider submits Encounter Data to the Health Plan. If no claim is received, and submitted to the Department by the Health Plan, there is no record of services. Records of services help the Department monitor quality and continue to develop accurate rates for the Health Plans.

2.80 Timely Payment

Health Plans are responsible for making payments to Providers for covered services on a timely basis consistent with the Claims Payment Procedure described at 42 U.S.C. § 1396a(a)(37)(A) and 215 ILCS 5/368a.

- Health Plans must pay 90 percent (90%) of all clean claims from Providers for covered services within thirty (30) days following receipt.
- Health Plan must pay 99 percent (99%) of all clean claims from Providers for covered services within ninety (90) days following receipt.

Note: A “clean claim” is a claim from a Provider for covered services that can be processed without obtaining additional information from the provider of the service or from a Third Party, except a claim submitted by or on behalf of a Provider who is under investigation for Fraud or Abuse, or a claim that is under review for determining whether it was Medically Necessary. For purposes of an Enrollee’s admission to a Nursing Facility, a “clean claim” means that the admission is reflected on the patient credit file that Health Plan receives from the Department.

2.90 Reimbursement

Health Plans are responsible for making payments as required under their contract with the Provider. Exclusions to this rule are listed below:

- **Emergency Services.** Health Plans must pay at least the Department’s rate for appropriate Emergency Services provided by a Non-Affiliated Provider.
- **Post Stabilization Services.** Health Plan must pay a least the Department’s rate for all Post-Stabilization Services as a covered service in any the following situations:
  - Health Plan authorized such services;
  - Such services were administered to maintain the Enrollee’s Stabilized condition within one (1) hour after a request to the Health Plan for authorization of further Post-Stabilization Services; or
  - Health Plan did not respond to a request to authorize such services within one (1) hour, Health Plan could not be contacted, or, if the treating Provider is a Non-Affiliated Provider, Health Plan and the treating Provider could not reach an agreement concerning the Enrollee’s care and an Affiliated Provider was unavailable for a consultation. In such case, the Health Plan must pay for services rendered by

the treating Non-Affiliated Provider until an Affiliated Provider was reached and either concurred with the treating Non-Affiliated Provider's plan of care or assumed responsibility for the Enrollee's care. Such payment shall be made at the same rate the Department would pay for such services according to the level of services provided and exclusive of disproportionate share payments and Medicaid percentage adjustments.

- **Family Planning Services.** Health Plan must pay for family planning services rendered by a Non-Affiliated Provider, for which the Health Plan would pay if rendered by an Affiliated Provider, at the same rate Department would pay for such services exclusive of disproportionate share payments and Medicaid percentage adjustments, unless a different rate was agreed upon by Health Plan and the Non-Affiliated Provider.

If a Provider is having billing problems they should follow up with the managed care representative that was assigned to them for contracting. Provider Complaints must be filed with the Health Plan.

2.100 Provider Complaint Resolution

Health Plans must maintain a complaint and resolution process for providers. If a provider disagrees with a policy, decision, or procedure, the provider should follow the Health Plan provider complaint process. Health Plans are required to make every effort to resolve any Provider Complaints. All disputes are handled between the Health Plan and the provider, unless the Health Plan has not fulfilled its duties under the applicable State Contract.

2.110 Non-Affiliated Providers

Providers who are not contracted with a Health Plan should not provide non-emergency services to Health Plan Enrollees unless they receive a prior authorization from the Health Plan. There are some services that do not require a Non-Affiliated Provider to receive prior authorization, including:

- **Emergency Services.** Health Plan members may access affiliated or Non-Affiliated Providers for appropriate Emergency Services.
- **Post-Stabilization Services.** Post-Stabilization Services are provided under certain situations, including:
  - The Health Plan authorizes such services;
  - Such services are administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to the Health Plan for authorization of further Post-Stabilization Services; or
  - The Health Plan does not respond to a request to authorize further Post-Stabilization Services within one (1) hour; the Health Plan cannot be contacted, or the Health Plan and the treating Non-Affiliated Provider cannot reach an agreement concerning the Enrollee's care and an Affiliated Provider is unavailable for a consultation. In such case, the treating Non-Affiliated Provider must be permitted to continue the

care of the Enrollee until an Affiliated Provider is reached and either concurs with the treating Provider's plan of care or assumes responsibility for the Enrollee's care.

- **Family Planning Services.** Family Planning is a direct access service. Health Plans provide coverage of family planning services for all Enrollees whether the family planning services are covered by an affiliated or Non-Affiliated Provider.
- **School-Based Health Centers.** Under the Family Health Plan Program, Health Plans will accept claims from Non-Affiliated Providers of school health center services outside of the Health Plan's contracting area. Payments of such services will be according to the HFS applicable Medicaid Fee-For-Service reimbursement schedule. Health Plans may require the Non-Affiliated Providers of school health centers to follow its protocols for communication regarding services rendered in order to further care coordination.
- **School Dental Program.** Under the Family Health Plan Program, Health Plans will accept claims from Non-Affiliated Providers of dental services provided in a school for Enrollees under the age of 21 outside of the Health Plans contracting area. Payments of such services will be according to the HFS applicable Medicaid Fee-For-Service reimbursement schedule. Health Plans may require the program to follow its protocols for communication regarding services rendered in order to further care coordination.
- **SASS Services.** Screening, Assessment and Support Services (SASS) program is a statewide program resulting from the Children's Mental Health Act of 2003, which requires the Department to ensure that all eligible children and adolescents receive a screening and assessment prior to any admission to a hospital for inpatient psychiatric care. With the passage of this Act, the Department joined forces with two other Illinois State departments that have been funding screening and assessment services for children and adolescents since 1992 - the Department of Human Services (DHS) and Department of Children and Family Services (DCFS) - to create a coordinated single-point of entry for children and adolescents in need of mental health services. This system is designed to be a family-friendly unified system that will reduce fragmentation in service delivery. Under the Family Health Plan Program, Health Plans will accept claims from a Non-Affiliated Provider of SASS services in the event that an Enrollee is screened, due to necessity, by such Non-Affiliated Provider. The Health Plan will pay for such screening at the Medicaid rate.

Health Plans will accept claims from Non-Affiliated Providers for at least six (6) months after the date the services are provided. Non-Affiliated Providers must be enrolled in the HFS Medical Program prior to receiving payment for services rendered to Illinois Medicaid participants including those enrolled in a Health Plan.

Chapter 3 Care Coordination

3.10 Care Coordination

Health Plans are responsible for offering Care Management through a Care Coordinator who participates in an Interdisciplinary Care Team (ICT) for all medical, behavioral health, functional, and psychosocial needs, as appropriate, to address the needs and preferences of the Enrollee. The higher the risk of the Enrollee, the higher the level of care coordination provided by the MCO.

3.20 Interdisciplinary Care Team

Health Plan's Care Coordinator's may be in touch with Providers to invite them to participate in an Enrollee's Interdisciplinary Care Team (ICT). The Care Coordinator forms an ICT with the help of the Enrollee. The ICT is person centered and is to build on each Enrollee's specific preferences and needs. Each ICT consist of clinical and non-clinical staff whose skills and professional experience will complement and support each other in the oversight of each Enrollee's needs. The Enrollee's PCP is an important part of the health team involved in the coordination and direction of services for the Enrollee. The Care Coordinator provides the PCP with reports, updates, and information regarding the Enrollee's progress through the Care Management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of members.

ICT meetings are not necessarily formal and face to face. Providers can participate by phone, through emails, faxes, etc. Anyway the Provider can participate in the Enrollees overall health care goals is a benefit for the Enrollee.

3.30 Care Plans

The ICT led by the Care Coordinator is responsible for developing a comprehensive person-centered Enrollee Care Plan. The Enrollee Care Plan incorporates an Enrollee's medical, behavioral health, social, and functional needs. Providers, as part of the ICT, are welcome to participate in the development of the care plans.

3.40 Service Plans as Part of the Care Plan

Enrollees receiving Home and Community Based Waiver services have Service Plans, which include information on areas of assistance Enrollees need to keep them safe and residing in their homes. Service Plans are a component of the Care Plan. For example, a Service Plan might contain information on grooming, bathing, housework, and/or meal preparation, and the Service Plan will include how much time a service agency or assistant might need to help Enrollees complete these tasks.

There are three distinct time frames for Health Plans to have a Service Plan, new or existing, in place:

- Service Plans are developed within 15 days of the Health Plan being informed from a State agency that an Enrollee is eligible for Home and Community Based Waiver services.
- Service Plans remain in place for 180 days for an Enrollee who has an existing Service Plan but is new to the Health Plan (Enrollee came from Fee-for-Service).
- Service Plans remain in place for 90 days for an Enrollee who is transferring from one Health Plan to another Health Plan.

The Health Plans will update the Service Plan as an Enrollee's need changes.

3.50 Transition of Care

Health Plans are responsible for any covered services necessary to treat medical conditions that existed before the participant enrolled with the Health Plan. As long as an Enrollee is in an existing course of treatment, the service is a covered service, and the service is Medically Necessary, the Health Plan will support the continuation of that service.

Health Plans are responsible for the on-going course of treatment, also called continuity of care, when a new Enrollee joins the Health Plan while in the middle of actively receiving treatment from a Provider.

- In the Integrated Care Program and the Family Health Plan Program, a Non-Affiliated Provider can continue to treat the Enrollee for an initial 90-day transition period or through the postpartum period. To do so, the Non-Affiliated Provider must agree to accept reimbursement from the Health Plan at the Health Plan's established rates, follow the Health Plan's Quality Assurance requirements, and agree to follow the Health Plan's policies and procedures. This includes the Health Plan's referral and authorization requirements.

- In the Medicare Medicaid Alignment Initiative (MMAI), a Non-Affiliated Provider can continue to treat the Enrollee for an initial 180-day transition period. When the MMAI Enrollee switches from one Health Plan to another, the new Health Plan will offer a 90-day transition period. To do so, the Non-Affiliated Provider must agree to accept reimbursement from the Health Plan at the Health Plan's established rates, follow the Health Plan's Quality Assurance requirements, and agree to follow the Health Plan's policies and procedures. This includes the Health Plan's referral and authorization requirements.

Health Plans also have special transition of care requirements for their LTSS population. LTSS Enrollees are Enrollees residing in a nursing home or receiving Home and Community Based Service waivers (HCBS).

All individuals receiving HCBS have a Service Plan that addresses all identified needs for services received at home. If an Enrollee was receiving HCBS services before becoming enrolled in the Health Plan, that existing Service Plan must remain in effect for at least 180

days. The Health Plan can only change the Service Plan within the 180 days if the Enrollee provides input and agrees to the change.

Chapter 4 Covered Services

The Health Plans are required to cover almost all services offered under Illinois Medicaid. They can also provide services beyond those covered under Medicaid, but Health Plans do so at their own expense. These additional services are approved by the Department before being offered to their members. The monthly Capitation payment the Health Plans receive from the Department for each of their members is based on Medicaid services, not the additional services they choose to offer.

4.10 Service Package I Covered Services

A list of Medicaid services can be found in 89 Ill. Adm. Code, Part 140. The list of covered services, often referred to as Service Package 1, include:

- Advanced Practice Nurse services;
- Ambulatory Surgical Treatment Center services;
- Assistive/Augmentative communication devices;
- Audiology services;
- Blood, blood components and the administration thereof;
- Chiropractic services for Enrollees under age twenty-one (21);
- Dental services, including oral surgeons;
- EPSDT services for Enrollees under age twenty-one (21) pursuant to 89 Ill. Admin. Code Section 140.485, excluding shift nursing for Enrollees in the MFTD HCBS Waiver for individuals who are Medically Fragile and Technology Dependent (MFTD);
- Family planning services and supplies;
- FQHCs, RHCs and other Encounter rate clinic visits;
- Home health agency visits;
- Hospital emergency room visits;
- Hospital inpatient services; Hospital ambulatory services;
- Laboratory and x-ray services (Health Plan shall receive and transmit electronic lab values to support clinical management and for HEDIS® reporting);
- Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;
- Mental health services provided under the Medicaid Clinic Option, Medicaid Rehabilitation Option, and Targeted Case Management Option;
- Nursing care for Enrollees under age twenty-one (21) not in the HCBS Waiver for individuals who are MFTD, pursuant to 89 Ill. Admin. Code Section 140.472;

- Nursing care for the purpose of transitioning children from a hospital to home placement or other appropriate setting for Enrollees under age twenty-one (21), pursuant to 89 Ill. Admin. Code 146, Subpart D;
- Nursing Facility services for the first ninety (90) days (NF services 91+ days included in Service Package II);
- Optical services and supplies;
- Optometrist services;
- Palliative and Hospice services;
- Pharmacy Services (drugs used in the treatment of Hepatitis C are covered only if dispensed in accordance with Health Plan's coverage criteria approved by the Department);
- Physical, Occupational and Speech Therapy services;
- Physician services;
- Podiatric services for Enrollees under age 21;
- Podiatric services for diabetic Enrollees age 21 and over, and, effective October 1, 2014, podiatric services for all Enrollees age 21 and over;
- Post-Stabilization Services;
- Renal Dialysis services;
- Respiratory Equipment and Supplies;
- Services to prevent illness and promote health in accordance with Attachment XXI
- 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);
- Transplants, pursuant to 89 Ill. Admin. Code Section 148.82 (using transplant Providers certified by the Department); and
- Transportation to secure Covered Services.

4.20 Pharmacy Services

Health Plans are required to cover drugs. They must cover all drugs covered by Medicaid, but it does not have to be the exact same set of drugs. The Health Plan's formulary cannot be any more restrictive than the Department's list of covered drugs. The Department reviews and prior approves the Health Plan's formularies.

4.30 Hospice Services

Health Plans are required to cover Hospice Services. Hospice Providers are required to complete a Medicaid Hospice Benefit Election Form (HFS 1592) (pdf) for hospice members.

Hospice Providers must submit this form to both HFS and also send a copy of the form to the Health Plan of the Enrollee.

4.40 Dental Services

Dental services are provided through the Health Plans and the dental Provider must bill the appropriate Health Plan's dental administrator to receive payment. Some Health Plans offer additional dental benefits to their members above the basic Medicaid program benefit.

4.50 Emergency and Non-Emergency Transportation

All non-emergency transportation services for Health Plan Enrollee's must be prior approved by the Health Plan when transport is needed for medical services covered by the Health Plan. To obtain prior approval for non-emergency transportation for Health Plan Enrollees, the Health Plan must be contacted. The phone number for the Health Plan is printed on the Participant's Health Plan ID card. All Health Plans have medical personnel available 24 hours a day to provide prior approval.

The prior approval/post approval (pdf) form the Health Plans utilize can be found on the First Transit website.

Prior approval from the Health Plan is not required in the following circumstances:

- Emergency services do not require prior approval.
- Participants are not limited to Affiliated Providers for family planning services.

Non-emergency transportation Providers may contest any decision by the Health Plan for which no denial was received prior to the time of transport that either denies a request for approval for payment of non-emergency transportation or grants a request for approval of non-emergency transportation at a level of service that entitles the ground ambulance services Provider to a lower level of compensation than requested by the ground ambulance services Provider.

Health Plans require that Long Term Care Facilities and hospitals utilize a uniform certification of medical necessity for non-emergency ambulance transportation except where it is reasonable to believe a delay in transportation can be expected to negatively affect the efficient transportation.

4.60 Behavioral Health

Behavioral health services include both mental health and substance abuse. Health Plans are required to cover both services, including services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option.

Some Health Plans have a subcontractor specializing in providing Behavioral Health services. Health Plans can create their own prior authorization and utilization requirements surrounding behavioral health.

Health Plans require each Affiliated Provider that provides services under a DHS HCBS Waiver, under the Medicaid Clinic Option, or under the Medicaid Rehabilitation Option, or members receiving alcoholism and substance abuse treatment services to continue entering data about that Enrollee into DHS' system. This includes the DHS Automated Reporting and Tracking System (DARTS). This is a requirement under State rules.

4.70 Service Package 2 Covered Services

Health Plans are also responsible for all Service Package 2 services, which includes Nursing Home services and Home and some Community Based Waiver Services (HCBS). These are also called Long Term Supports and Services (LTSS).

4.80 HCBS Services

Illinois has nine (9) HCBS waivers. Different State agencies operate the waivers, with HFS overseeing the operation of each waiver. Each waiver is designed for individuals with similar needs and offers a different set of services. Waiver programs are approved by Federal CMS and allow Illinois to cover a broad range of services to allow individuals to receive non-traditional services in the community or in their own homes, rather than being placed in an institutional setting.

While Illinois offers nine HCBS waivers, only five of the nine are considered part of Service Package 2 and therefore the Health Plans are responsible to arrange and pay for the services under these five waivers. Waivers designed for individuals with Developmental Disabilities are excluded from managed care.

Please note that for the Integrated Care Program and the Family Health Plan Program, individuals enrolled in the Developmental Disabilities waivers are enrolled in managed care for their medical coverage; it is their HCBS waiver services that are excluded and remain under Fee-For-Service.

Under the Medicare Medicaid Alignment Initiative, individuals enrolled in the Developmental Disabilities waivers are excluded from managed care. Children in the Medically Fragile Technology Dependent waiver are excluded from all managed care programs.

Health Plans are only allowed to use HCBS Providers that have been approved and authorized by the State agency in charge of that particular waiver. If a Provider, for example, is only approved by the Illinois Department on Aging to provide HCBS services to those on the Elderly waiver, that Provider is not allowed to provide the same services to members of the Persons with Disabilities waiver. The Provider must first be approved and authorized to provide services under the other waiver(s). The Health Plans do not credential HCBS waivers.

Health Plans are required to pay HCBS Providers at least the Medicaid rate for providing HCBS services. They cannot pay less than what Medicaid offers for these services.

Providers who think managed care members might benefit from HCBS services can refer those members at any time. They can contact the Enrollee's Care Coordinator and suggest an assessment be completed to determine if the Enrollee is eligible for HCBS services. Providers can also refer their members through these websites:

- Rehabilitation Services (to refer members for the Persons with Disabilities, Brain Injury, or HIV/AIDS waiver)
- Senior HelpLine (To refer members for the Elderly waiver)
- Supportive Living Facilities (to refer members for the Supportive Living Program)

All individuals residing in a Nursing Facility or receiving HCBS waiver services receives care coordination from their Health Plan. Care Coordinators who work with the HCBS population must meet certain educational and training criteria. Care Coordinators must also maintain frequent contact with their HCBS and Nursing Facility Enrollees. Those contact requirements are included below in the description of each waiver.

Below is a brief description of the five (5) waivers that are covered by Health Plans under Service Package 2:

1. **HCBS Waiver for Persons who are Elderly.** The Department on Aging (DoA) is the operating agency for the HCBS waiver for persons who are elderly, which is part of the Community Care Program (CCP). The CCP offers services to persons age 60 and over who meet functional and financial eligibility criteria. Examples of services received under the Elderly waiver include Adult Day Care, Homemaker services, and/or the Personal Emergency Response System. Health Plan Care Coordinators for members enrolled in this waiver must meet with the Enrollee face-to-face at least once every 90 days.
2. **HCBS Waiver for Assisted Living, Supportive Living Program.** HFS is the operating agency for the Supportive Living Program. The Supportive Living Program serves persons age 65 and older or persons age 22 to 64 who have physical disabilities. A Supportive Living Facility (SLF) is a Department-approved residential setting in Illinois. Health Plan Care Coordinators for members enrolled in this waiver must meet with the Enrollee face-to-face at least once every year.
3. **Persons with Disabilities Waiver.** The DHS Division of Rehabilitation Services (DHS-DRS) is the operating agency for this waiver, which serves individuals between the ages of birth through 59 years, unless the individual was receiving services prior to the 60th birthday and chose to remain in the waiver. The person must have a medical determination of a diagnosed, severe disability, which is expected to last for at least 12 months or for the duration of life. Examples of services received under the Persons with Disabilities waiver includes Personal Assistants, Adult Day Care, Environmental Accessibility Adaptations, additional therapy services, Home Delivered Meals, Homemaker services, and/or Personal Emergency Response System. Health Plan Care Coordinators for members enrolled in this waiver must meet with the Enrollee face-to-face at least once every 90 days.
4. **Persons with HIV/AIDS Waiver.** DHS-DRS is the operating agency for this waiver, which serves persons with HIV/AIDS of any age who have a medical determination of HIV or AIDS with severe functional limitations, which are expected to last at least 12 months or for the duration of life. Examples of services received under the Persons with

Disabilities waiver includes Personal Assistants, Adult Day Care, Environmental Accessibility Adaptations, additional therapy services, Home Delivered Meals, Homemaker services, and/or Personal Emergency Response System. Health Plan Care Coordinators for Enrollees in this waiver must meet with the Enrollee face-to-face at least once every two months.

5. **Persons with Brain Injury Waiver.** DHS-DRS is the operating agency for this waiver, which serves persons with brain injury of any age who have an acquired brain injury. Examples of services received under the Persons with Disabilities waiver includes Personal Assistants, Adult Day Care, Environmental Accessibility Adaptations, additional therapy services, Home Delivered Meals, Homemaker services, and/or Personal Emergency Response System. Health Plan Care Coordinators for Enrollees in this waiver must meet with the Enrollee face-to-face at least once every month.

Participant direction of services is an important component of HCBS services. The Department expects that the Enrollee will continue to have the authority to exercise decision-making authority over some or all services and accepts the responsibility for taking a direct role in managing them. Participant direction promotes personal choice and control over the delivery of services, including who provides services and how they are delivered. For example, the Enrollee may be afforded the opportunity and be supported to recruit, hire, and supervise individuals who provide daily supports to them.

4.90 Nursing Facilities Services

Health Plans are also responsible for Long Term Care facility services, including room and board and supervision, equipment and supplies including oxygen, laundry services, food, medications, over-the-counter drugs or items ordered by a Physician. Health Plan Care Coordinators for Enrollee residing in a Nursing Facility must meet with the Enrollee face-to-face at least once every 90 days.

4.100 Non-Covered Services

There are several services that Health Plans are **not** responsible for covering. These services remain Fee-For-Service and should be billed to the Department, not to the Health Plans. These services include:

- Services in a State Facility operated as a psychiatric hospital as a result of forensic commitment
- Services provided through a Local Education Agency (LEA)
- Services funded through the Juvenile Rehabilitation Services Medicaid Matching Fund
- Any service considered cosmetic or experimental
- Early Intervention (EI) services

There are also some limitations on covered services including:

- **Termination of pregnancy.** This service can be provided if it meets State and federal law requirements (42 CFR Part 441, Subpart E) and the Provider completes HFS Form 2390 (pdf) after the service is completed. Termination of pregnancy is not a covered service, however, for those eligible under the State Children's Health Insurance Program Act (215 ILCS 106).
- **Sterilization services.** These services can be provided if they meet State and federal law requirements (42 CFR Part 441, Subpart F) with HFS Form 2189 (pdf)completed.
- **Hysterectomy services.** HFS Form 1977 (pdf) must be completed for this service.

Chapter 5 Enrollee Grievance and Appeals

Each Health Plan is required to have an Enrollee Grievance and Appeals policy and procedures established to ensure that actions taken against participants are supported by policy, administrative code and law. The Department serves as a check and balance for managed care companies to make sure participants are receiving covered service to which they are entitled. Medicaid Health Plans are required to establish internal Grievance and Appeals procedures under which Medicaid Enrollees, or an authorized representative acting on their behalf, may make a Complaint, challenge the denial of coverage of, or payment for, covered services. Health Plan Enrollees receive these policies and procedures when they first enroll with the Health Plan in their Enrollee Handbook. The Grievance and Appeals procedures are also listed on each Health Plan's website.

Chapter 6 Quality Assurance Program

Providers must incorporate the delivery of quality care with the primary goal of improving the health status of Enrollees and, where the Enrollee's condition is not amenable to improvement, maintain the Enrollee's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. Providers must actively improve the quality of care provided to Enrollees, consistent with its Quality Program, its quality improvement goals, the Department's quality strategy.

6.10 Quality Assurance, Utilization Review and Peer Review

HFS requires that Health Plans, through contacts with the Affiliated Providers, ensure participation in the Health Plans' Quality Assurance Plan (QAP). Health Plan's utilize their Provider services Department representatives to work closely with the Affiliated Providers to ensure they understand the expectations and requirements of participating in the Health Plan QAP.

6.20 Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are utilized to reduce inter-practitioner/Provider variation in diagnosis and treatment. Provider CPG adherence is measured at least annually by the Health Plans. The CPGs are distributed to appropriate practitioners, Providers and Provider groups. The Health Plan determines how the CPGs are disseminated to Providers and this can be through different means including the Provider portal, web or Provider newsletters. The CPGs are available to Providers upon request.

6.30 Preventive Health Guidelines

Preventive Health Guidelines are utilized to provide coverage of diagnostic preventive procedures based on recommendations published by the US Preventive Services Task Force (USPSTF) and in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Guidelines are updated as necessary and distributed to practitioners/Providers via the on-line Provider directory and or the Provider newsletter.

6.40 Cultural and Linguistic Services

HFS serves a diverse Medicaid population with specific cultural needs and preferences. Providers are responsible to ensure that interpreter services are made available at no cost for Medicaid participants with sensory impairment and/or who are Limited English Proficient (LEP).

Providers may request interpreters for members whose primary language is other than English by calling the Health Plan Enrollee services department. If Enrollee services representatives are unable to provide the interpretation services internally, the Enrollee and Provider are immediately connected to language line telephonic interpreter service. For Health Plan's Enrollee Service phone numbers visit the Program Information Guide website.

6.50 Access to Care Standards

HFS requires that Health Plans provide timely access to care for their Enrollees. Providers are required to offer hours of operation no less than hours of operation offered to commercial patients. Access standards are developed to ensure that all health care services are provided in a timely manner. The PCP or designee must be available 24 hours-a-day, seven-days-a-week to members. This access may be by telephone. Appointment and waiting-time standards are communicated to the Providers through their contract and they are also listed in the on-line Provider directory.

Appointment Access

No more than six scheduled appointments shall be made for each PCP per hour. Notwithstanding this limit, it is recognized that Physicians supervising other licensed healthcare Providers may routinely account for more than six appointments per hour.

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 60 minutes from appointment time, until the time seen by the PCP. All PCPs are required to monitor waiting times and to adhere to this standard.

After Hours

All practitioners must have back-up (on call) coverage after hours or during the practitioner's absence or unavailability. Practitioners are required to maintain a 24-hour phone service, seven days a week. This access can be through an answering service. The service should instruct members with an emergency to hang-up and call 911 or go immediately to the nearest emergency room. After hours phone calls or pages must be returned within 30 minutes.

At least annually, Health Plans are required to conduct an access audit of randomly selected contracted practitioner/Provider offices to determine if appointment access standards are met. One or all of the following appointment scenarios may be addressed: routine care; acute care; preventive care; and after-hours information. Results of the audit are distributed to the practitioners after its completion. A corrective action plan may be required if standards are not met.

6.60 Site and Medical Record-Keeping Practice Reviews

Providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices. Health Plans assess the quality, safety and accessibility of office sites where care is delivered. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting- and examining-room space
- Availability of appointments

- Adequacy of medical/treatment record keeping

During the Provider site-visit, Health Plans review office documentation practices with the practitioner or practitioner's staff. This discussion includes a review of the forms and methods used to keep the medical record information in a consistent manner and include how the practice ensures confidentiality of records.

6.70 Improvement Plans

Providers are required to comply with the Health Plans Quality Improvement Plan (QIP). When compliance is not achieved, the Provider is required to submit a written improvement plan to the Health Plan. This improvement plan must include the expected time frame for completion of activities.

6.80 Measurement of Clinical and Service Quality

HFS requires the Health Plans to monitor and evaluate the quality of care and services provided to Enrollees through the following mechanisms:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

Health Plans are required to collect data to monitor performance with established standards and provide interpretation of these data to its affiliated Practitioners/Providers. Affiliated Providers must allow Health Plans to use its performance data collected in accordance with the Provider's contract. The use of Provider performance data may include, but is not limited to, the following: (1) development of quality improvement activities; (2) public reporting to consumers. To see Health Plan's quality measures, visit the Care Coordination website.

Chapter 7 Definitions

Abuse: (i) A manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs; (ii) the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 CFR Section 488.301).

Action: (i) The denial or limitation of authorization of a requested service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure to respond to an Appeal in a timely manner, or (vi) solely with respect to an Health Plan that is the only Health Plan serving a rural area, the denial of an Enrollee's request to obtain services outside of the contracting Area.

Administrative Rules: The sections of the Illinois Administrative Code that govern the Medicaid Program.

Adults with Disabilities: An individual who is 19 years of age or older, who meets the definition of blind or disabled under Section 1614(a) of the Social Security Act (42 U.S.C.1382), and who is eligible for Medicaid.

Advanced Practice Nurse (APN): A Provider of medical and preventive services, including Certified Nurse Midwives, Certified Family Nurse Practitioners and Certified Pediatric Nurse Practitioners, who is licensed as an APN, holds a valid license in Illinois, is legally authorized under statute or rule to provide services, and is enrolled with the Department and contracted with the Health Plan.

Affiliated Provider: A Provider associated as an employee or by other legally recognizable means with a Health Plan for the purpose of providing services under the Department's contract with the Health Plan.

Anniversary Date: the annual anniversary of an Enrollee's initial enrollment in the Health Plan. For example, if an Enrollee became effective in an Health Plan on October 1, 2010, their Anniversary Date with that Health Plan would be each October 1st thereafter.

Appeal: A request for review of a decision made by the Health Plan with respect to an Action.

CAHPS: Consumer Assessment of Health Plans Survey is a public-private initiative to develop standardized surveys of patient's experience with ambulatory and facility level care.

Capitation: The reimbursement arrangement in which a fixed rate of payment per Enrollee per month is made to the Health Plan for the performance of all of the Health Plan's duties and responsibilities.

Care Coordinator: An employee of the Health Plan, together with an Enrollee and Providers, establishes an Enrollee Care Plan for the Enrollee and, through interaction with Affiliated Providers, ensures the Enrollee receives necessary services.

Care Management: Services that assist Enrollees in gaining access to needed services, including medical, social, educational and other services, regardless of the funding source for the services.

Centers for Medicare & Medicaid Services (Federal CMS): The agency within DHHS that is responsible for the administration of the Medicare program and, in partnership with the states, administers Medicaid, the State Children's Health Insurance Program (CHIP), and the Health Insurance Portability and Accountability Act (HIPAA).

Complaint: A phone call, letter or personal contact from a Participant, Enrollee, family member, Enrollee representative or any other interested person expressing a concern related to the health, safety or well-being of an Enrollee.

Department or HFS: The Illinois Department of Healthcare and Family Services and any successor agency.

DHS: The Illinois Department of Human Services, and any successor agency.

DHS-DRS: The Division of Rehabilitation Services, and any successor agency, within DHS that operates the home services programs for persons with physical disabilities, brain injury and HIV/AIDS.

DoA: The Illinois Department on Aging, and any successor agency.

Dual Eligible: A Participant who is eligible to receive services through both the Medicare and the Medicaid Program.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Emergency Services: Those inpatient and outpatient health care services that are covered services, including transportation, needed to evaluate or stabilize an Emergency Medical Condition, which are furnished by a Provider qualified to furnish Emergency Services.

Encounter: An individual service or procedure provided to an Enrollee that would result in a claim if the service or procedure were to be reimbursed Fee-For-Service under the Medicaid Program.

Encounter Data: The compilation of data elements, as specified by the Department in written notice, identifying an Encounter that includes information similar to that required in a claim for Fee-For-Service payment under the Department's Medical Program.

Enrollee: A Participant who is enrolled in a Health Plan. "Enrollee" shall include the caretaker relative or guardian where the Enrollee is an adult for whom a guardian has been named; provided, however, that the Health Plan is not obligated to cover services for any individual who is not enrolled as an Enrollee with the Health Plan.

Enrollee Care Plan: An Enrollee-centered, goal-oriented, culturally relevant, and logical, written plan of care that assures that the Enrollee receives medical and medically-related necessary services in a supportive, effective, efficient, timely and cost-effective manner that emphasizes prevention and continuity of care.

Fee-For-Service: The method of charging which bills for each service or encounter rendered.

Fraud: Knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

Grievance: An expression of dissatisfaction by an Enrollee, including Complaints, about any matter other than a matter that is properly the subject of an Appeal.

Health Plan: A Health Maintenance Organization or a Managed Care Community Network that provides or arranges to provide covered primary, secondary, and tertiary managed health care services for Medicaid Participants under contract with the Illinois Department of Healthcare and Family Services.

Health Insurance Portability and Accountability Act (HIPAA): Also known as the Kennedy-Kassebaum Bill, the Kennedy-Kassebaum Bill, K2, or Public Law 104-191 (pdf), the federal law that makes a number of changes that have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA provides DHHS with the authority to mandate the use of standards for electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, Providers, payers (or plans), and employers (or sponsors); and to specify the typesof measures required to protect the security and privacy of personally identifiable health care information.

Home and Community-Based Services (HCBS) Waivers: Waivers under Section 1915(c) of the Social Security Act that allow Illinois to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.

ILCS: Illinois Compiled Statutes.

Illinois Participant Enrollment Services (ICES): The entity contracted by the Department to conduct enrollment activities for Potential Enrollees, including providing impartial education on health care delivery choices, providing enrollment materials, assisting with the selection of an Health Plan and PCP, and processing requests to change Health Plans.

Integrated Care Program: The program under which the Department will contract with Health Plans to provide the full spectrum of Medicaid covered services through an integrated care delivery system to Older Adults and Adults with Disabilities who are eligible for Medicaid but are not eligible for Medicare.

Long-Term Care (LTC) Facility or Nursing Facility (NF): A facility that provides Skilled Nursing or intermediate long-term care services, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the counties code; and a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided.

Marketing: Any written or oral communication from a healthcare delivery system or its representative that can reasonably be interpreted as intended to influence a Participant to enroll, not enroll, or to dis-enroll from a health care delivery system.

Medicaid Program: The program under Title XIX of the Social Security Act that provides medical benefits to groups of low-income people.

Medically Necessary: A service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with the Health Plan's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the Enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

National Committee for Quality Assurance (NCQA): A private 501(c) (3) not for profit organization dedicated to improving health care quality and has a process for providing accreditation, certification and recognition, e.g., Health Plan accreditation.

Neglect: A failure to notify the appropriate health care professional, to provide or arrange necessary services to avoid physical or psychological harm to a resident or to terminate the residency of a Participant whose needs can no longer by met, causing an avoidable decline in function. Neglect may be either passive (non-malicious) or willful.

Non-Affiliated Provider: A Provider who is not associated with a Health Plan for the purpose of providing health care services under a Medicaid managed care program pursuant to a written contract or agreement. Limited service agreements or contracts (e.g. single case agreements) do not constitute network participation.

Nursing Facility (NF): See Long-Term Care Facility.

Older Adult: An individual who is 65 years of age or older and who is eligible for the Medicaid program.

Open Enrollment: The specific period of time each year in which Enrollees shall have the opportunity to change from one Health Plan to another Health Plan.

Participant: Any individual determined to be eligible for the Medicaid Program.

Performance Measure: A quantifiable measure to assess how well an organization carries out a specific function or process.

Person: Any individual, corporation, proprietorship, firm, partnership, trust, association, governmental authority, contractor, or other legal entity whatsoever, whether acting in an individual, fiduciary, or other capacity.

Personal Assistant: Individuals who provide Personal Care to a Participant when it has been determined by the Care Coordinator that the Participant has the ability to supervise the Personal Care Provider.

Personal Care: Assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of a Participant.

Personal Emergency Response System (PERS): An electronic device that enables a Participant at high risk of institutionalization to secure help in an emergency.

Physician: means an individual licensed to practice medicine in all its branches in Illinois under the Medical Practice Act of 1987 or any such similar statute of the state in which the individual practices medicine.

Post-Stabilization Services: Medically necessary non-emergency services furnished to an Enrollee after the enrollee is stabilized following an Emergency Medical Condition, in order to maintain such stabilization.

Potential Enrollee: A Participant who is subject to mandatory enrollment in a managed care program, but is not yet an Enrollee of a Health Plan.

Primary Care Provider (PCP): A Provider, including a WHCP, who within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to assigned Enrollees in the Health Plan.

Provider: A Person enrolled with the Department to provide Covered Services to a Participant.

Quality Assurance (QA): A formal set of activities to review, monitor and improve the quality of services by a Provider or Health Plan, including quality assessment, ongoing quality improvement and corrective actions to remedy any deficiencies identified in the quality of direct Enrollee, administrative and support services.

Quality Assurance Plan (QAP): A written document developed by the Health Plan in consultation with its QAP committee and Medical Director that details the annual program goals and measurable objectives, utilization review activities, access and other Performance Measures that are to be monitored with ongoing Physician profiling and focus on quality improvement.

Quality Program: The Health Plan’s overarching mission, vision and values, which through its goals, objectives and processes committed in writing in the QAP, are demonstrated through continuous improvement and monitoring of medical care, Enrollee safety, behavioral health services, and the delivery of services to Enrollees, including ongoing assessment of program standards to determine the quality and appropriateness of care, Case Management and coordination. It is system-wide and implemented through the integration, coordination of services, and resource allocation throughout the organization, its partners, Providers, other entities delegated to provide services to Enrollees, and extended community involved with Enrollees.

Recipient Identification Number (RIN): The nine-digit identification number unique to the individual receiving coverage under one of the Department’s Medical Programs. It is vital that this number be correctly entered on billings for services rendered.

Service Plan: A plan that addresses all identified needs for services received at home.

Significant Change: A decline or improvement in a Participant’s status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical

interventions, where the decline or improvement impacts more than one area of the Participant's health status and requires revision of the Enrollee Care Plan.

Skilled Nursing: Nursing services provided within the scope of the State's Nurse Practice Act by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the State.

Skilled Nursing Facility (SNF): A group care facility that provides Skilled Nursing care, continuous Skilled Nursing observations, restorative nursing and other services under professional direction with frequent medical supervision, during the post-acute phase of illness or during reoccurrences of symptoms in long-term illness.

Speech Therapy: A medically prescribed speech or language based service that is provided by a licensed speech therapist and identified in the Enrollee Care Plan that is used to evaluate or improve an Enrollee's ability to communicate.

Stabilization or Stabilized: A determination with respect to an Emergency Medical Condition made by an attending emergency room Physician or other treating Provider that, within reasonable medical probability, no material deterioration of the condition is likely to result upon discharge or transfer to another facility.

State: The State of Illinois, as represented through any agency, department, board, or commission.

Supportive Living Facility (SLF): A residential apartment-style (assisted living) setting in Illinois that is certified by the Department that provides or coordinates flexible Personal Care services, twenty-four (24) hour supervision and assistance (scheduled and unscheduled), activities, and health related services with a service program and physical environment designed to minimize the need for residents to move within or from the setting to accommodate changing needs and references; has an organizational mission, service programs and physical environment designed to maximize residents' dignity, autonomy, privacy and independence; and encourages family and community involvement.

Third Party: Any person other than the Department, Health Plan, or any of Health Plan's affiliates.

Long Term Supports and Services (LTSS): Nursing home services or Home and Community Based Service waivers (HCBS) services.

Chapter 8 Links

Internet Site
Illinois Department of Healthcare and Family Services
Administrative Rules
All Kids Program
Care Coordination
Claims Processing System Issues
Child Support Enforcement
FamilyCare
Family Community Resource Centers
Health Benefits for Workers with Disabilities
Health Information Exchange
Home and Community Based Waiver Services
Illinois Health Connect
Illinois Veterans Care
Illinois Warrior Assistance Program
Maternal and Child Health Promotion
Medical Electronic Data Interchange (MEDI)
State Chronic Renal Disease Program
Medical Forms Requests
Medical Programs Forms
Non-Institutional Provider Resources
Pharmacy Information
Provider Enrollment Information
Provider Fee Schedules
Provider Handbooks
Provider Notices
Registration for E-mail Notification
Place of Service Codes
Centers for Medicare and Medicaid Services (CMS)

Illinois Department of Healthcare and Family Services

Abortion Payment Application

Recipient Name _____

Recipient Address _____

Case Identification No. _____ Recipient Identification No. _____

I performed an abortion for the patient named above at

_____ on _____ .

Location (Name, City) Date

The abortion was performed because: (Check one code only)

	Surgical	Mifepristone
The abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.	☐	☐
The recipient reported that the pregnancy was the result of rape.	☐	☐
The recipient reported that the pregnancy was the result of incest.	☐	☐
The abortion was necessary to protect the woman's health.	☐	☐

I understand that completion of this form is for Medical Assistance payment purposes only.

_____ _____

Physician performing abortion (Please Print) Medicaid Provider Number

_____

Street Address

_____ _____ _____

City State Zip

_____ _____

Signature of physician performing abortion Date

Completion mandatory, 305ILCS 5/1-1 et. seq. Penalty non-payment.
Form approved by the Forms Management Center.

COMPLETION OF FORM HFS 2390
ABORTION PAYMENT APPLICATION

Note: If any of the following items are not completed as outlined below, the invoice and the Payment Application Form will be returned to the provider. Entries must be typed or printed in black ink.

ITEM	INSTRUCTIONS
Recipient Names	Must be recipient's first and last name.
Recipient's Address	Must be completed with recipient's address.
Recipient's Case Identification Number	Must be completed with recipient's case identification number.
Recipient I.D. Number	Must be completed with the receipient's I.D. number. Must match recipient's I.D. number on invoice.
Location	Must be the facility name and address where the procedure was performed. If procedure was performed in an office setting, enter name and address of the physician or clinic.
Date	Must be the date service was performed.
Abortion Reason	Circle on procedure code only indicating why and how the procedure was performed. Must match procedure code on the invoice.
Physician Performing Abortion	Print the physician's full name.
Medicaid Provider	Enter the provider's medicaid number or state license number.
Street Address	Enter the provider's office street address.
City, State, Zip	Enter the provider's office city, state and zip code.
Signature of Physician Performing Abortion	This is an original signature in black ink of the physician who performed the abortion.
Date	Enter the date the physician signed the application.

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

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HFS USE ONLY

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	2. PATIENT'S DATE OF BIRTH	AGE	3. INSURED'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX	6. INSURED'S ID AND/OR MEDICARE NO. (INCLUDE ANY LETTERS)
TELEPHONE NO.:	MALE ☐ FEMALE ☐ 7. PATIENT RELATION TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	8. INSURED'S GROUP NO. (GROUP NAME) AND/OR MEDICAID NO.
9. OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER	10. WAS CONDITION RELATED TO A. PATIENTS EMPLOYMENT YES ☐ NO ☐ B. ACCIDENT AUTO ☐ OTHER ☐	11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)	13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW
SIGNED DATE	SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOM: YES ☐ NO ☐ CHECK HERE IF EMERGENCY ☐

17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)	PROVIDER NUMBER	20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)	22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES ☐ NO ☐ CHARGES:

23A. HEALTHY KIDS SERVICES	23B. FAMILY PLANNING	23C. STERILIZATION/ABORTION	23D. PRIOR AUTHORIZATION NUMBER	23E. T.O.S.*
YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐		

23F DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

24. REPEAT	A. DATE OF SERVICE	B. P.O.S.*	C. BRIEFLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	MOD	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	DELETE
1					PRIMARY			
2					SECONDARY			
3								
4								
5								
6								
7								

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I AGREE TO COMPLY WITH THE REQUIREMENTS IN THE CERTIFICATION WHICH APPEARS ON THE REVERSE OF AND IS A PART OF THIS BILL)	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY - SEE BACK) YES ☐ NO ☐	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
SIGNED DATE	30. YOUR PROVIDER NUMBER	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE		
32. YOUR PATIENT'S ACCOUNT NUMBER	33. YOUR PAYEE NUMBER			
34. NUMBER OF SECTIONS	35. ORIGINAL DCN	36. ORIGINAL VOUCHER NUMBER		

37A. TPL CODE	37B. TPL STATUS	37C. TPL AMOUNT	37D. TPL DATE	38A. TPL CODE	38B. TPL STATUS	38C. TPL AMOUNT	38D. TPL DATE

* PLACE OF SERVICE (P.O.S.) AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS:

Completion mandatory, 305 ILCS 5/1-1 et. seq., penalty non-payment

Form Approved by the Forms Management Center

IL 478-1032
Form HCFA 1500
ILLINOIS HFS 2360 (R-7-05)

HEALTH INSURANCE CLAIM FORM

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured"; i. e., items 3, 6, 7, 8, 9 and 11.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE AND CHAMPUS)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536).

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422 510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE AND CHAMPUS INFORMATION

We are authorized by HCFA and CHAMPUS to ask you for information needed in the administration of the Medicare and CHAMPUS programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086.

The information we obtain to complete Medicare and CHAMPUS claims is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare or CHAMPUS and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or Federal agencies as necessary to administer the Medicare and CHAMPUS programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

With the one exception discussed below, there are no penalties under Social Security or CHAMPUS law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of Medicare or CHAMPUS claims. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workers' compensation will pay for treatment. Section 1877(a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

My Signature on the reverse side of this bill certifies that all entries on this claim are true, accurate and complete. I agree that payment received according to the State's Medical Assistance Program pricing limits will be accepted as payment in full and I will not accept additional payment from any person or persons.

I agree to keep and make available such records as are necessary to disclose fully the nature and extent of services provided and to furnish such information regarding any payments claimed as State and Federal officials may request. I understand that payment is made from State and Federal funds and that any false claims, statements, or documents, or concealment of material facts may be cause for prosecution or other appropriate legal action.

Services were provided without discrimination on the grounds of race, color, religion, sex, national origin or handicap in accordance with the Civil Rights Act of 1964 and the Rehabilitation Act of 1973.

PLACE OF SERVICE CODES

"For Medicaid submittal use the code in the column to the left of the description; for Medicare submittals use the code in the column to the right.

Place of Service Codes

1 – Inpatient Hospital – IH
2 – Outpatient Hospital – OH
3 – Doctor Office – O
4 – Patient's Home – H
5 – Day Care Facility (PSY) –
6 – Night Care Facility (PSY) –
7 – Nursing Home – NH
8 – Skilled Nursing Facility – SNF
9 – Ambulance –
0 – Other Locations – OL
A – Independent Laboratory – IL
B – Other Medical/Surgical Facility –
C – Residential Treatment Center – RTC
D – Specialized Treatment Facility – STF

Type of Service Codes

1 – Medical Care
2 – Surgery
3 – Consultation
4 – Diagnostic X-Ray
5 – Diagnostic Laboratory
6 – Radiation Therapy
7 – Anesthesia
8 – Assistance at Surgery
9 – Other Medical Service
0 – Blood or Packed Red Cells
A – Used DME
G — Concurrent Care
M – Alternate Payment for Maintenance Dialysis
Y – Second Opinion on Elective Surgery
Z – Third Opinion on Elective Surgery
C – Chiropractic Care
H – DME Rental
J – DME Purchase
K – DME Prescription
S – Co-Surgeon

MODIFIERS RECOGNIZED IN PROCESSING SERVICE CLAIMS
ILLINOIS HEALTHCARE AND FAMILY SERVICES CLAIMS
Revised 06/07/16

MOD	DESCRIPTION	HOW PAYMENT IS AFFECTED
25	Significant, separately identifiable E&M service same practitioner same day	May allow E&M payment separate from another service; requires supporting documentation
26	Professional component	Pays professional component only (*see practitioner fee schedule, Notes A, B, C)
50	Bilateral procedure	Bill procedure code one time with modifier and quantity "1" to indicate bilaterals performed; use only when note is A or B
51	Multiple procedures	Applies only to billing multiple NDCs (***see Chapter A-200 Practitioner Handbook Appendix A-6)
52	Reduced services	Goes to hand pricing, requires attachment of additional information
53	Discontinued procedure	Not payable; bill only for services completed
57	Decision for surgery	Goes to hand pricing to determine if payable outside surgical package
59	Distinct procedural service	Applies to Medicare crossovers only
62	Two surgeons	Each surgeon is paid at 50% state maximum
73	Discontinued outpatient procedure prior to anesthesia administration	Not payable; bill only for services completed
74	Discontinued outpatient procedure after anesthesia administration	Not payable; bill only for services completed
76	Repeat procedure by same practitioner	Applies to Medicaid claims when billing multiple NDCs (***see Chapter A-200 Practitioner Handbook Appendix A-6), or Medicare Crossover claims.
80	Assistant surgeon	Payment is based on minutes billed
81	Minimum assistant surgeon	Payment is based on minutes billed
82	Assistant surgeon when qualified resident surgeon not available	Payment is based on minutes billed
90	Reference (outside) laboratory	Not payable for APL or inpatient procedures or to independent labs
91	Repeat clinical diagnostic laboratory test	Applies to Medicare crossovers only
AH	Clinical psychologist	Billable only by FQHC and RHC
AJ	Clinical social worker	Billable only by FQHC and RHC
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	Payment is based on minutes billed
AT	Acute Treatment	Sterilization permit not required when procedure performed for acute reason and not for sterilization purposes
E1	Upper left eyelid	Processes separately from same CPT with different eyelid modifier
E2	Lower left eyelid	Processes separately from same CPT with different eyelid modifier

E3	Upper right eyelid	Processes separately from same CPT with different eyelid modifier
E4	Lower right eyelid	Processes separately from same CPT with different eyelid modifier
EP	Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program	Service is processed as a Healthy Kids service
F1	Left hand, second digit	Processes separately from same CPT with different digit modifier
F2	Left hand, third digit	Processes separately from same CPT with different digit modifier
F3	Left hand, fourth digit	Processes separately from same CPT with different digit modifier
F4	Left hand, fifth digit	Processes separately from same CPT with different digit modifier
F5	Right hand, thumb	Processes separately from same CPT with different digit modifier
F6	Right hand, second digit	Processes separately from same CPT with different digit modifier
F7	Right hand, third digit	Processes separately from same CPT with different digit modifier
F8	Right hand, fourth digit	Processes separately from same CPT with different digit modifier
F9	Right hand, fifth digit	Processes separately from same CPT with different digit modifier
FA	Left hand, thumb	Processes separately from same CPT with different digit modifier
FP	Service provided as part of family planning program	Service is processed as a family planning service
GC	Service performed in part by a Resident under the direction of a teaching physician	Identifies service rendered by a Resident but billed under the NPI of the teaching physician
GE	Service performed by a Resident without the presence of a teaching physician under Medicare's primary care exception	Identifies service rendered by a Resident but billed under the NPI of the teaching physician
GN	Outpatient speech therapy	**See Therapists Provider Notice dated 061605 regarding this requirement
GO	Outpatient occupational therapy	**See Therapists Provider Notice dated 061605 regarding this requirement
GP	Outpatient physical therapy	**See Therapists Provider Notice dated 061605 regarding this requirement
GT	Via interactive audio and video telecommunication systems	***See Chapter A-200 Practitioner Handbook, Section A-220.67 Telehealth
GW	Service not related to hospice patient's terminal condition	Processes as service outside hospice rate.
GZ	Item or service expected to be denied as not reasonable and necessary	Not payable
HD	Pregnant/parenting women's program	Service is processed as a postpartum depression screening
HE	Mental health program	Inpatient/outpatient psychiatric consultation or inpatient psychiatric subsequent care rate (**see Physician Provider Notice dated 102903)
HO	Masters degree level	Billable only by FQHC and RHC
LC	Left circumflex coronary artery	Processes separately from same CPT with different coronary artery modifier
LD	Left anterior descending coronary artery	Processes separately from same CPT with different coronary artery modifier
LT	Left side	Processes separately from same CPT with RT modifier
NU	New equipment	Processes as Purchase
P1	Normal, healthy patient	Anesthesia converts to modifying units "0"

P2	Patient with mild systemic disease	Anesthesia converts to modifying units "1"
P3	Patient with severe systemic disease	Anesthesia converts to modifying units "2"
P4	Patient with severe systemic disease that is a constant threat to life	Anesthesia converts to modifying units "3"
P5	Moribund patient not expected to survive without the operation	Anesthesia converts to modifying units "4"
P6	Declared brain-dead patient whose organs are being removed for donor purposes	Anesthesia converts to modifying units "0"
Q5	Service furnished by substitute physician under reciprocal billing arrangement	***See Chapter A-200 Practitioner Handbook, Section A-202.1 Charges
QL	Patient pronounced dead after ambulance called	Not payable
QM	Ambulance service provided under arrangement by a provider of services	Not payable
QW	CLIA waived test	Identifies a waived CLIA test
RC	Right coronary artery	Processes separately from same CPT with different coronary artery modifier
RR	Rental	Processes as rental
RT	Right side	Processes separately from same CPT with LT modifier
SA	Nurse practitioner rendering service in collaboration w/physician	Identifies service rendered by APN but billed under NPI of physician
SL	State supplied vaccine	Processes HPV vaccine to providers not enrolled with VFC (**see Physician Provider Notice dated 03-11-10). Semi-annual ASP pricing updates supercede the rate reimbursement identified in the notice. Refer to the most current Practitioner Fee Schedule for "state max".
T1	Left foot, second digit	Processes separately from same CPT with different digit modifier
T2	Left foot, third digit	Processes separately from same CPT with different digit modifier
T3	Left foot, fourth digit	Processes separately from same CPT with different digit modifier
T4	Left foot, fifth digit	Processes separately from same CPT with different digit modifier
T5	Right foot, great toe	Processes separately from same CPT with different digit modifier
T6	Right foot, second digit	Processes separately from same CPT with different digit modifier
T7	Right foot, third digit	Processes separately from same CPT with different digit modifier
T8	Right foot, fourth digit	Processes separately from same CPT with different digit modifier
T9	Right foot, fifth digit	Processes separately from same CPT with different digit modifier
TA	Left foot, great toe	Processes separately from same CPT with different digit modifier
TC	Technical component	Pays technical component only (*see practitioner fee schedule, Notes A, B, C)
TH	OB treatment/services	Effective for dates of service on or after 02-18-11. Pays hospital fee-for-service for OB triage ONLY when there is no billable APL and appended to CPT code 99211
TT	Individualized service provided to more than one patient in same setting	Processes as coincident visit Long Term care(**see Physician Provider Notice dated 102903)

U1	Local modifier-Blood lead draw	Blood specimen drawn for lead analysis as part of Healthy Kids program (***see Chapter HK-200 Section 202.1)
U2	Local modifier-Home Health nursing assessment visit	Processes as assessment visit only (***see Home Health Handbook Section R-203.1)
U4	Local modifier-Pregnancy resulting from rape	Claim requires Abortion Payment Application, HFS form 2390
U5	Local modifier-Obstetrical/gynecological services	Processes as Ob/Gyn Direct Access service available without a referral
U6	Local modifier-Service provided within 60 days of hospital discharge	Processes as therapy visit within 60 days of hospital discharge(***see Therapy Providers Handbook Section J-211)
U7	Local modifier-Pregnancy resulting from incest	Claim requires Abortion Payment Application, HFS form 2390
UD	Local modifier-340B Drug Provider	Identifies a 340B purchased drug
U8	Local modifier-Pregnancy threatening the mother's life	Claim requires Abortion Payment Application, HFS form 2390

MODIFIERS RECOGNIZED IN PROCESSING SERVICE CLAIMS
ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
Revised 01/01/2017

MOD	DESCRIPTION	HOW PAYMENT IS AFFECTED
25	Significant, separately identifiable E&M service same practitioner same day	May allow E&M payment separate from another service; requires supporting documentation
26	Professional component	Pays professional component only (*refer to practitioner fee schedule, Notes A, B, C)
50	Bilateral procedure	Bill procedure code one time with modifier and quantity "1" to indicate bilaterals performed; use only when note is A or B
51	Multiple procedures	Applies only to billing multiple NDCs (***refer to Chapter A-200 Practitioner Handbook Appendix A-8)
52	Reduced services	Goes to hand pricing, requires attachment of additional information
53	Discontinued procedure	Not payable; bill only for services completed
57	Decision for surgery	Goes to hand pricing to determine if payable outside surgical package
59	Distinct procedural service	Applies to Medicare crossovers only
62	Two surgeons	Each surgeon is paid at 50% state maximum
73	Discontinued outpatient procedure prior to anesthesia administration	Not payable; bill only for services completed
74	Discontinued outpatient procedure after anesthesia administration	Not payable; bill only for services completed
76	Repeat procedure by same practitioner	Applies to Medicaid claims when billing multiple NDCs (***refer to Chapter A-200 Practitioner Handbook Appendix A-8), or Medicare Crossover claims.
80	Assistant surgeon	Payment is based on minutes billed
81	Minimum assistant surgeon	Payment is based on minutes billed
82	Assistant surgeon when qualified resident surgeon not available	Payment is based on minutes billed
90	Reference (outside) laboratory	Not payable for APL or inpatient procedures or to independent labs
91	Repeat clinical diagnostic laboratory test	Applies to Medicare crossovers only
AH	Clinical psychologist	Billable only by FQHC and RHC
AJ	Clinical social worker	Billable only by FQHC and RHC
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	Payment is based on minutes billed
AT	Acute Treatment	Sterilization permit not required when procedure performed for acute reason and not for sterilization purposes
E1	Upper left eyelid	Processes separately from same CPT with different eyelid modifier
E2	Lower left eyelid	Processes separately from same CPT with different eyelid modifier
E3	Upper right eyelid	Processes separately from same CPT with different eyelid modifier
E4	Lower right eyelid	Processes separately from same CPT with different eyelid modifier
EP	Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program	Service is processed as a Healthy Kids service

MODIFIERS RECOGNIZED IN PROCESSING SERVICE CLAIMS
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F1	Left hand, second digit	Processes separately from same CPT with different digit modifier
F2	Left hand, third digit	Processes separately from same CPT with different digit modifier
F3	Left hand, fourth digit	Processes separately from same CPT with different digit modifier
F4	Left hand, fifth digit	Processes separately from same CPT with different digit modifier
F5	Right hand, thumb	Processes separately from same CPT with different digit modifier
F6	Right hand, second digit	Processes separately from same CPT with different digit modifier
F7	Right hand, third digit	Processes separately from same CPT with different digit modifier
F8	Right hand, fourth digit	Processes separately from same CPT with different digit modifier
F9	Right hand, fifth digit	Processes separately from same CPT with different digit modifier
FA	Left hand, thumb	Processes separately from same CPT with different digit modifier
FP	Service provided as part of family planning program	Service is processed as a family planning service
GB	Service no longer covered under global (all-inclusive encounter rate) payment	Applies only to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Encounter Rate Clinics (ERCs) billing private stock vaccines fee-for-service for children age birth through 18 with Title XXI (21) or State-Funded eligibility
GC	Service performed in part by a Resident under the direction of a teaching physician	Identifies service rendered by a Resident but billed under the NPI of the teaching physician
GE	Service performed by a Resident without the presence of a teaching physician under Medicare's primary care exception	Identifies service rendered by a Resident but billed under the NPI of the teaching physician
GN	Outpatient speech therapy	***refer to Therapy Handbook
GO	Outpatient occupational therapy	***refer to Therapy Handbook
GP	Outpatient physical therapy	***refer to Therapy Handbook
GT	Via interactive audio and video telecommunication systems	***refer to Chapter A-200 Practitioner Handbook, Section A-220.6.7 Telehealth
GW	Service not related to hospice patient's terminal condition	Processes as service outside hospice rate.
GZ	Item or service expected to be denied as not reasonable and necessary	Not payable
HD	Pregnant/parenting women's program	Service is processed as a postpartum depression screening
HE	Mental health program	Refer to A-220.6.4 Psychiatric Consultation
HO	Masters degree level	Billable only by FQHC and RHC
JW	Drug amount discarded/not administered	Identifies the drug amount remaining from a single use vial that is discarded/not administered
LC	Left circumflex coronary artery	Processes separately from same CPT with different coronary artery modifier
LD	Left anterior descending coronary artery	Processes separately from same CPT with different coronary artery modifier
LT	Left side	Processes separately from same CPT with RT modifier
NU	New equipment	Processes as Purchase
P1	Normal, healthy patient	Anesthesia converts to modifying units "0"
P2	Patient with mild systemic disease	Anesthesia converts to modifying units "1"
P3	Patient with severe systemic disease	Anesthesia converts to modifying units "2"
P4	Patient with severe systemic disease that is a constant threat to life	Anesthesia converts to modifying units "3"
P5	Moribund patient not expected to survive without the operation	Anesthesia converts to modifying units "4"
P6	Declared brain-dead patient whose organs are being removed for donor purposes	Anesthesia converts to modifying units "0"

MODIFIERS RECOGNIZED IN PROCESSING SERVICE CLAIMS
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Q5	Service furnished by substitute physician under reciprocal billing arrangement	***refer to Chapter A-200 Practitioner Handbook, Section A-202.1 Charges
QL	Patient pronounced dead after ambulance called	Not payable
QM	Ambulance service provided under arrangement by a provider of services	Not payable
QW	CLIA waived test	Identifies a waived CLIA test
RC	Right coronary artery	Processes separately from same CPT with different coronary artery modifier
RR	Rental	Processes as rental
RT	Right side	Processes separately from same CPT with LT modifier
SA	Nurse practitioner rendering service in collaboration w/physician	Identifies service rendered by APN but billed under NPI of physician
SL	State supplied vaccine	Processes HPV vaccine to providers not enrolled with VFC (**refer to Note "M" of the Practitioners Fee Schedule Key). Refer to the most current Practitioner Fee Schedule
T1	Left foot, second digit	Processes separately from same CPT with different digit modifier
T2	Left foot, third digit	Processes separately from same CPT with different digit modifier
T3	Left foot, fourth digit	Processes separately from same CPT with different digit modifier
T4	Left foot, fifth digit	Processes separately from same CPT with different digit modifier
T5	Right foot, great toe	Processes separately from same CPT with different digit modifier
T6	Right foot, second digit	Processes separately from same CPT with different digit modifier
T7	Right foot, third digit	Processes separately from same CPT with different digit modifier
T8	Right foot, fourth digit	Processes separately from same CPT with different digit modifier
T9	Right foot, fifth digit	Processes separately from same CPT with different digit modifier
TA	Left foot, great toe	Processes separately from same CPT with different digit modifier
TC	Technical component	Pays technical component only (*refer to practitioner fee schedule, Notes A, B, C)
TH	OB treatment/services	Pays hospital fee-for-service for OB triage ONLY when there is no billable APL and appended to CPT code 99211
U1	Local modifier-Blood lead draw	Blood specimen drawn for lead analysis as part of Healthy Kids program (***refer to Chapter HK-200 Section 203.1)
U2	Local modifier-Home Health nursing assessment visit	Processes as assessment visit only (***refer to Home Health Handbook Section R-203.1)
U4	Local modifier-Pregnancy resulting from rape	Claim requires Abortion Payment Application, HFS form 2390
U5	Local modifier-Obstetrical/gynecological services	Processes as Ob/Gyn Direct Access service available without a referral
U7	Local modifier-Pregnancy resulting from incest	Claim requires Abortion Payment Application, HFS form 2390
U8	Local modifier-Pregnancy threatening the mother's life	Claim requires Abortion Payment Application, HFS form 2390
U9	Local modifier-Pregnancy endangering the mother's health	Claim requires Abortion Payment Application, HFS form 2390
UB	Local modifier-Psychiatric service rendered at a Community Mental Health Center	Effective for dates of service 07-01-2016 through 06-30-2017 only. Identifies a psychiatric service rendered in partnership with a Community Mental Health Center.
UD	Local modifier-340B Drug Provider	Identifies a 340B purchased drug

* Practitioner Fee Schedule
**Provider Informational Notices
***Provider Handbooks

Practitioner Services- Appendices

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Appendix A-1

Technical Guidelines for Paper Claim Preparation
Form HFS 2360 (pdf), Health Insurance Claim Form

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the Department:

- Use original Department issued claim form. The Department will not accept downloaded, created, reproduced or faxed claim forms.
- Claims that are illegible will be returned to the practitioner.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in CAPITAL letters. The character pitch/font size must be 10-12 printed characters per inch. Handwritten entries should be avoided, as they must be hand keyed which delays processing.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write outside the fields.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and practitioner signature. Stamped signatures are not acceptable.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid or tape should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold claims or fasten attachment with staples.

A sample of the HFS 2360 (pdf) may be found on the Department's Web site. Instructions for completion of this claim follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for the form completion as follows:

Required = Entry always required.

Optional = Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Not Required = Fields not applicable to the provision of practitioner services.

Completion	Item	Explanation and Instructions
Required	**1.**	**Patient's Name** - Enter the participant's name exactly as it appears on the Identification Card or Notice. Separate the components of the name (first, middle initial, last) in the proper order of the name field.
Optional	**2.**	**Patient's Date of Birth** - Enter the month, day and year of birth of the patient as shown on the Identification Card or Notice issued by the Department. Use the MMDDYY format. If the birthdate is entered, the Department will, where possible, correct claims suspended due to participant name or number errors. If the birthdate is not entered, the Department will not attempt corrections. Age – leave blank.
Not Required	3. – 7.	Leave blank.
Required	**8.**	**Medicaid Number** – Enter the nine-digit number assigned to the individual as shown on the Identification Card or Notice issued by the Department. Use no punctuation or spaces. Do **not** use the Case Identification Number.
Not Required	9.	Other Health Insurance Coverage – Leave blank.
Conditionally Required	**10.**	**Was Condition Related to** – If the patient sought treatment for an injury or illness that resulted from employment, type a capital "X" in the Yes box under A, Patient's Employment. If the patient sought treatment for an injury or a condition that resulted from an automobile accident, type a capital "X" in Field 10B, AUTO. If the place of service billed is for Emergency Department Services, type a capital "X" in Field 10B, OTHER.

Completion	Item	Explanation and Instructions
Not Required	11.	Insured's Address – Leave blank.
Required	**12.**	**Recipient's or Authorized Person's Signature** – The participant or authorized representative must sign and enter a date unless the signature is on file with the practitioner/supplier. **If the signature is on file, enter the statement "Signature on File" here**.
Not Required	13.	Leave blank.
Conditionally Required	**14.**	**For prenatal services, enter the date of the Last Menstrual Period (LMP).** Use MMDDYY format.
Not Required	15.	Leave blank.
Conditionally Required	**16.**	**Check here if emergency.**
Not Required	17. – 18.	Leave blank.
Conditionally Required	**19.**	**Name of Referring Practitioner or Other Source** – This field is required when charges are being submitted for a **consultation**. Additionally, a referring practitioner's name is always required when a referring practitioner NPI is entered. **Referring Practitioner Number** – The referring practitioner number is always required when a referring practitioner name is entered. Enter the referring practitioner's NPI.
Not Required	20.	Leave blank
Conditionally Required	**21.**	**Facility Where Services Rendered** - This entry is required when Place of Service Code in Field 24B is other than 11 (office) or 12 (home). Address may be abbreviated.
Not Required	22.	Leave blank.
Conditionally Required	**23A.**	**Healthy Kids Services** - If services rendered were Healthy Kids services, enter a capital X in the Yes box.
Conditionally Required	**23B.**	**Family Planning** - If services were rendered for family planning purposes, enter a capital X in the Yes box.

Completion	Item	Explanation and Instructions
Conditionally Required	**23C.**	**Sterilization/Abortion** - If services rendered were for a Sterilization or Abortion, enter a capital X in the Yes box. When the service is being submitted for payment for an abortion, a completed copy of the HFS 2390 (pdf) must be attached to the claim and submitted in the HFS 1414, Special Approval Envelope. When the service is being submitted for payment for sterilization, a completed copy of the HFS 2189 (pdf) must be attached to the claim and submitted in the HFS 1414, Special Approval Envelope. When the service is being submitted for payment for a hysterectomy, a completed copy of HFS 1977 (pdf) must be attached to the claim and submitted in the HFS 1414, Special Approval Envelope.
Not Required	23D.	Prior Approval – Leave blank.
Required	**23E.**	**T.O.S. (Type of Service)** – Enter the code corresponding to the type of service for which the charges submitted on the claim apply. Only one type of service can be included on a single claim. A separate claim must be prepared for each type of service for which charges are made. The following are the Type of Service Codes acceptable by the Department. 1 Medical Care – Attending Physician or Concurrent Care. 2 Surgery – Surgeon, Assistant Surgeon or Co-Surgeon. 3 Consultation – Consultant. 4 Diagnostic X-Ray – Radiologist. 5 Diagnostic Laboratory – Pathologist. 7 Anesthesia –Anesthesiologist, CRNA 8Advanced Practice Nurse or Physician Assistant acting as Assistant Surgeon.
Optional	**23F.**	**Diagnosis or Nature of Injury or Illness** – Enter the diagnosis or nature of injury or illness description that describes the condition primarily responsible for the patient's treatment. A written description is not required if a valid ICD-10 Code is entered in Item 24D.
Optional	**24.**	**Repeat** – The practitioner may use the repeat indicator to complete the same data fields in multiple service sections. All information other than the date of service must remain the same as the previous service section. The actual date of service must be entered in every service section. When the repeat box is necessary, enter a capital "X." Any other character will be ignored. The repeat indicator cannot be used immediately following a service section which has been deleted.
Required	**24A.**	**Date of Service** - Enter the date the service was rendered. Use MMDDYY format.
Required	**24B.**	**P.O.S. (Place of Service)** – Enter the 2-digit code corresponding to the appropriate place of service.

Completion	Item	Explanation and Instructions
Required	**24C.**	**Procedure Code/Drug Item No.** - Enter the appropriate procedure code or NDC. Refer to Appendix A-7 for information regarding NDC billing.
Conditionally Required	**24C.**	**MOD** – Enter the appropriate two-character modifier for the service performed. A listing of the modifiers recognized in processing HFS claims may be found on the modifier listing for practitioner claims.
Required	**24D.**	**Primary Diagnosis Code** – Enter the specific ICD-10 Code without the punctuation or spaces for the primary diagnosis.
Optional	**24D.**	**Secondary Diagnosis Code** – A secondary diagnosis may be entered. Enter only a specific ICD-10 Code without the punctuation or spaces.
Required	**24E.**	**Charges** – Enter the total charge, in both dollars and cents, for the service. Do not deduct any Third Party Liability payments or copayments from these charges.
Required	**24F.**	**Days/Units** – Unless otherwise stated or allowed enter a quantity of "0001." A four-digit entry other than "0001" is required for the following: • **Anesthesia Service**, enter the duration of time in minutes; e.g., the entry for 1 hour and 10 minutes is 0070. • **Assistant Surgeon services** enter the duration of time in minutes; e.g., the entry for 1 hour and 10 minutes is 0070. • When **mileage** is charged, enter the total number of miles one way; e.g., the entry for 32 miles is 0032. • When billing for **multiples** refer to the practitioner fee schedule key.
Optional		**Delete** - When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only "X" will be recognized as a valid character; all others will be ignored.
Required	**25.**	**Signature of Physician and Date Signed** - After reading the certification statement printed on the back of the claim form, the practitioner or authorized biller (practitioner's name followed by biller's initials) must sign the completed form. **The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable.** Unsigned claims will not be accepted by the Department and will be returned to the practitioner when possible. The date of the practitioner's signature is to be entered in the MMDDYY format. The practitioner's signature should not enter the date section of this field.

Completion	Item	Explanation and Instructions
Required	**26.**	**Accept Assignment** – The practitioner must accept assignment of Medicare benefits for services provided to participants. Enter a capital “X” in the "Yes" box.
Required	**27.**	**Total Charges** - Enter the sum of all charges submitted on the claim in service section 1 through 7. Do not include charges for any deleted sections.
Required	**28.**	**Amount Paid** - Enter the sum of all payments received from other sources. The entry must equal the sum of the amounts as shown in fields 37C and 38C, TPL Amount. If no payment was received enter three zeroes (000). Do not collect primary copayments on Medicaid secondary claims. Do not include HFS copayments or amount previously paid by the Department as primary payment.
Required	**29.**	**Balance Due** - Enter the difference between Total Charges and Amount Paid.
Required	**30.**	**Your Provider Number** – Enter the rendering practitioner’s **NPI**.
Required	**31.**	**Provider Name, Address, ZIP Code** – Enter the practitioner’s name exactly as it appears on the Provider Information Sheet. Enter the street address of the practitioner. If an address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If an address is not entered, the Department will not attempt to make corrections. Enter city, state and zip code of practitioner.
Optional	**32.**	**Your Patient's Account Number** - Enter up to 20 numbers or letters used in your accounting system for identification. If this field is completed, the same data will be reported on the HFS 194-M-2, Remittance Advice.
Required	**33.**	**Your Payee Code** – Enter the one-digit number of the payee to whom the payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Required	**34.**	**Number of Sections** - Enter the number of service lines correctly completed above in Section 24. Do not include **deleted** sections.
Not Required	35. - 36.	Leave blank.

Completion	Item	Explanation and Instructions
Conditionally Required	**37A.**	**TPL Code** – If the patient's Identification Card contains a TPL Code, the numeric three-digit code must be entered in this field. Do not include the leading alpha character. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code. If the participant has more than one third party resource, the additional TPL is to be shown in 38A. – 38D. **Do not attach a copy of the TPL Explanation of Benefits (EOB).** Practitioners providing services to women with a diagnosis of pregnancy or preventive services to children are not required to bill a patient's private insurance carrier prior to billing the Department for these services. **Do not report Medicare Information in the TPL fields.** Refer to Appendix A-2 for information regarding Medicare crossovers. For Medicare denied services with an additional TPL resource involved, please report the following: • Do not report the Medicare information in the TPL field. • Do attach a copy of the Medicare EOB. • Enter other TPL information in the TPL fields. • Do not attach a copy of the other TPL EOB. **Spenddown** – Refer to Chapter 100, Topic 113 for a full explanation of the Spenddown policy. The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) the HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If the HFS 2432 shows a participant liability greater than $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount the actual participant liability as shown on the HFS 2432 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a participant liability of $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

Completion	Item	Explanation and Instructions
Conditionally Required	**37A. (cont.)**	If the HFS 2432 shows a participant liability of greater than $0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows: Claim 1 TPL Code 906 TPL Status 01 TPL Amount the actual participant liability up to total charges TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. Claim 2 TPL Code 906 TPL Status 01 if remaining liability from claim 1 is greater than $0.00 or 04 if remaining participant liability from claim 1 is $0.00. TPL Amount If status code 01 was used in claim 2 status field, enter amount of remaining participant liability after claim 1. If status code 04 was used in claim 2 status field, enter 000. TPL Date the issue date on the bottom right corner of the HFS 2432. Enter in MMDDYY format. If the HFS 2432 shows a participant liability of $0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows: Claim 1 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. Enter in MMDDYY format. Claim 2 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. Enter in MMDDYY format. If claims with spenddown deny, or if one service section on a claim submitted with a split bill is denied, subsequent submitted claims must have the HFS 2432 attached and must be mailed to a consultant for special handling. See mailing instructions.

Completion	Item	Explanation and Instructions
Conditionally Required	**37B.**	**TPL Status** – If a TPL Code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL Code is blank. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the practitioner is advised **by the third party resource** that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the practitioner is advised **by the third party resource** that services provided are not covered. **04 – TPL Adjudicated – spenddown met:** TPL Status Code 04 is to be entered when the patient's HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the practitioner that the third party resource identified on the Identification Card is not in force. **06 – Services not covered:** TPL Status Code 06 is to be entered when the practitioner determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment from the TPL have failed. **10 – Deductible not met:** TPL Status Code 10 is to be entered when the practitioner has been informed **by the third party resource** that non-payment of the service was because the deductible was not met.
Conditionally Required	**37C.**	**TPL Amount** – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter 000. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" field.

Completion	Item	Explanation and Instructions
Conditionally Required	**37D.**	**TPL Date** – A TPL date is required when any status code is shown in field 37B. Use the date specified below for the applicable TPL Status Code: **Code** **Date to be entered** 01 Third Party Adjudication Date 02 Third Party Adjudication Date 03 Third Party Adjudication Date 04 Date from the HFS 2432, Split Bill Transmittal 05 Date of Service 06 Date of Service 07 Date of Service 10 Third Party Adjudication Date
Conditionally Required	**38A.**	**TPL Code** – (See 37A above).
Conditionally Required	**38B.**	**TPL Status** – (See 37B above).
Conditionally Required	**38C.**	**TPL Amount** – (See 37C above).
Conditionally Required	**38D.**	**TPL Date** – (See 37D above).

Mailing Instructions

The Health Insurance Claim Form is a single page or two-part form. The practitioner is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part form should be removed prior to submission to the Department. The practitioner should retain a copy of the claim. Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, HFS 1444, Provider Invoice Envelope, provided by the Department.

Mailing address: Healthcare and Family Services
P.O. Box 19105
Springfield, Illinois 62794-9105

Non-routine claims (claims with attachments, such as Medicare denial EOMB or HFS 2432, Split Billing Transmittal submitted with a one page claim) are to be mailed to the Department in pre-addressed mailing envelope, HFS 1414, Special Approval Envelope, which is provided by the Department for this purpose.

Mailing address: Healthcare and Family Services
P.O. Box 19118
Springfield, Illinois 62794-9118

Non-routine claims, HFS 2432, Split Billing Transmittal submitted with multiple claims are to be mailed to the Department for special handling.

Mailing address: Healthcare and Family Services
P.O. Box 19115
Springfield, Illinois 62794-9115

Forms Requisition - Billing forms may be requested on our Web site or by submitting a HFS 1517 as explained in Chapter 100, General Appendix 10.

Appendix A-2

Technical Guidelines for Paper Claim Preparation Form HFS 3797 (pdf), Medicare Crossover Invoice

To assure the most efficient processing by the Department, please follow these guidelines in the preparation of paper claims for image processing:

- Use original Department issued claim form. The Department will not accept downloaded, created, reproduced or faxed claim forms.
- Claims that are illegible will be returned to the practitioner.
- Claims with extreme print qualities, either light or dark, will not image and will be returned to the practitioner.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in CAPITAL LETTERS. The character pitch/font size must be 10-12 printed characters per inch. Handwritten entries should be avoided, as they must be hand keyed which delays processing.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write outside the fields.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and practitioner signature. Stamped signatures are not acceptable.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid or tape should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- Print in the gray area of attachments, either as part of the original or as a result of photocopying a colored background, is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to the back of the claims. Do not fold claims or fasten attachment with staples.

Do not attach a copy of the Explanation of Medicare Benefits (EOMB) when billing on the HFS 3797. A sample of the HFS 3797 (pdf) may be found on the Department's Web site. Instructions for completion of this invoice follow in the order that entries appear on the form. Mailing instructions follow the claim preparation instructions. **If billing for a Medicare denied or disallowed service, bill on the appropriate HFS Medicaid form and attach the Explanation of Medicare Benefits to the claim.** Refer to Appendix A-2 for billing and mailing information.

The left hand column of the following instructions identifies mandatory and optional items for the form completion as follows:

Required = Entry always required.

Optional = Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Completion	Item	Explanation and Instructions
Required		**Claim Type** – Enter a capital "X" in the appropriate box, using the following guideline when determining claim type: 23 - Practitioner - physicians, optometrists, podiatrists, therapists, audiologists, hospitals (fee-for-service), RHC, FQHC, Imaging Centers 24 - Dental - dental providers 25 - Lab/Port X-Ray - all laboratories and portable X-ray providers 26 - Med. Equip/Supply - medical equipment and supply providers, pharmacies 28 – Transportation - ambulance service providers If provider type is not indicated above, enter a capital "X" in the Practitioner box.
Required	**1.**	**Recipient's Name** - Enter the participant's name (first, middle, last).
Required	**2.**	**Recipient's Birth date** - Enter the month, day and year of birth. Use the MMDDYY format.
Required	**3.**	**Recipient's Sex** – Enter a capital "X" in the appropriate box.

Completion	Item	Explanation and Instructions
Conditionally Required	**4.** **A.** **B.**	**Was Condition Related to** – Participant's Employment - Treatment for an injury or illness that resulted from participant's employment, enter a capital "X" in the "Yes" box. Accident - Injury or a condition that resulted from an accident, enter a capital "X" in Field B, Auto or Other as appropriate. Any item marked "Yes" indicates there may be other insurance primary to Medicare. Identify primary insurance in Field 9.
Required	**5.**	**Recipient's Medicaid Number** – Enter the individual's assigned nine-digit number. Do not use the Case Identification Number.
Required	**6.**	**Medicare HIC (Health Insurance Claim) Number** – Enter the Medicare Health Insurance Claim Number (HICN).
Required	**7.**	**Recipient's Relation to Insured** – Enter a capital "X" in the appropriate box.
Required	**8.**	**Recipient's or Authorized Person's Signature** – The participant or authorized representative must sign and enter a date unless the signature is on file with the practitioner/supplier. **If the signature is on file, enter the statement "Signature on File" here**.
Conditionally Required	**9.**	**Other Health Insurance Information** - If the participant has an additional health benefit plan (other than Medicare or Medicaid), enter a capital "X" in the "YES" box. Enter Insured's Name, Insurance Plan/Program Name And Policy/Group No., as appropriate.
Required	**10A.**	**Date(s) of Service** - Enter the date(s) of service submitted to Medicare. Using the MMDDYY format enter the same date in both the "From" and "To" fields.
Required	**10B.**	**P.O.S. (Place of Service)** – Enter the two-digit POS Code submitted to Medicare.
Required	**10C.**	**T.O.S. (Type of Service)** – Enter TOS as submitted to Medicare. The following are the Type of Service Codes acceptable by the Department. 1 Medical Care – Attending Physician or Concurrent Care. 2 Surgery – Surgeon, Assistant Surgeon or Co-Surgeon. 3 Consultation – Consultant. 4 Diagnostic X-Ray – Radiologist. 5 Diagnostic Laboratory – Pathologist. 6 7 Anesthesia Anesthesiologist, CRNA 8Advanced Practice Nurse or Physician Assistant acting as Assistant Surgeon.

Completion	Item	Explanation and Instructions
Required	**10D.**	**Days or Units** – Enter the number of services (NOS) shown on the Explanation of Medicare Benefits (EOMB). All entries must be four digits, i.e., 0001. Mileage – Enter the total number of miles as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 32 miles is 0032. Anesthesia or Assistant Surgery Services – Enter the total number of units as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 1 unit is 0001.
Required	**10E.**	**Procedure Code** - Enter the procedure code adjudicated by Medicare shown on the Explanation of Medicare Benefits (EOMB).
Required	**10F.**	**Amount Allowed** – Enter the amount allowed by Medicare for the service(s) provided as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10G.**	**Deductible** – Enter the deductible amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10H.**	**Coinsurance** – Enter the coinsurance amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10I.**	**Provider Paid** – Enter the amount the practitioner was paid by Medicare as shown on the Explanation of Medicare Benefits (EOMB).
Conditionally Required	**11.**	**For NDC Use Only** – Required when billing NDC Codes for practitioner purchased and administered injectable medication.
Conditionally Required	**12.**	**For Modifier Use Only** – Enter HCPCS or CPT modifiers for the procedure code entered in Field 10E as shown on the Explanation of Medicare Benefits (EOMB).
Not Required	13A.	Origin of Service – Leave blank.
Not Required	13B.	Modifier – Leave blank.
Not Required	14A.	Destination of Service – Leave blank.
Not Required	14B.	Modifier – Leave blank.
Not Required	15A.	Origin of Service – Leave blank.
Not Required	15B.	Modifier – Leave blank.

Completion	Item	Explanation and Instructions
Not Required	16A.	Destination of Service – Leave blank.
Not Required	16B.	Modifier – Leave blank.
Optional	**17.**	**ICN #** - Enter the Medicare Invoice Control Number, Patient Account Number or Provider Reference Number. This field can accommodate up to 20 numbers or letters. If this field is completed, the same data will appear on the HFS 194-M-2, Remittance Advice, returned to the practitioner.
Conditionally Required	**18.**	**Diagnosis or Nature of Injury or Illness** - Enter the description of the diagnosis or nature of injury or illness that describes the condition primarily responsible for the participant's treatments. A written description is not required if a valid ICD-10-CM Code is entered in Field 18A.
Required	**18A.**	**Primary Diagnosis Code** – Enter the valid ICD-10-CM Diagnosis Code without punctuation or spaces for the services rendered.
Optional	**18B.**	**Secondary Diagnosis Code** – A secondary diagnosis may be entered if applicable. Enter only a valid ICD-10-CM Diagnosis Code without punctuation or spaces.
Required	**19.**	**Medicare Payment Date** – Enter the date Medicare made payment. This date is located on the Explanation of Medicare Benefits (EOMB). Use MMDDYY format.
Conditionally Required	**20.**	**Name and Address of Facility Where Services Rendered** This entry is required when Place of Service (10B) is other than practitioner's office or participant's home. Enter the facility name and address where the service(s) was rendered. When the name and address of the facility where the services were rendered is the same as the biller's name and address as submitted in Field 22, enter the word "Same."
Required	**21.**	**Accept Assignment** – The practitioner must accept assignment of Medicare benefits for services provided to participants for the Department to consider payment of deductible and coinsurance amounts. Enter a capital "X" in the "Yes" box.
Required	**22.**	**Physician/Supplier Name, Address, City, State, ZIP Code**– Enter the practitioner/supplier name exactly as it appears on the Provider Information Sheet to the right of the "Provider Key."
Required	**23.**	**HFS Provider Number** – Enter the rendering provider's NPI.

Completion	Item	Explanation and Instructions
Required	**24.**	**Payee Code** – Enter the single digit number of the payee to whom the payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Conditionally Required	**25.**	**Name of Referring Physician or Facility** – Enter the name of the referring or ordering practitioner if the service or item was ordered or referred by a practitioner. Referring Practitioner – a practitioner who requests an item or service for the beneficiary for which payment may be made under the Medicare program. Ordering Practitioner – A practitioner who orders non-physician services for the Participant such as diagnostic tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.
Conditionally Required	**26.**	**Identification Number of Referring Physician** – This item is required if Field 25 has been completed (Name of Referring Physician or Facility). All claims for Medicare covered services and items that are a result of a practitioner's order or referral must include the ordering/referring practitioner's NPI.
Not Required	27.	Medicare Provider ID Number – Leave blank.
Required	**28.**	**Taxonomy Code** - Enter the appropriate ten-digit HIPAA Provider Taxonomy Code. Refer to Chapter 300.
Conditionally Required	**29A.**	**TPL Code** – If the patient's Identification Card contains a TPL Code, the numeric three-digit code must be entered in this field. Do not include the leading alpha character. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code. If the participant has more than one third party resource, the additional TPL is to be shown in Fields 30A – 30D. **Do not report Medicare information in the TPL fields.** **Spenddown** – Refer to Chapter 100 (pdf) for a full explanation of the Spenddown policy. The following provides examples: When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) the HFS 2432 must be attached to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields.

Completion	Item	Explanation and Instructions
Conditionally Required	**29A. (cont.)**	If the HFS 2432 shows a participant liability greater than $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount the actual participant liability as shown on the HFS 2432 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a participant liability of $0.00, the fields should be coded as follows: TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If the HFS 2432 shows a participant liability of greater than $0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows: Claim 1 TPL Code 906 TPL Status 01 TPL Amount the actual participant liability up to total charges TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. Claim 2 TPL Code 906 TPL Status 01 if remaining liability from claim 1 is greater than $0.00 or 04 if remaining participant liability from claim 1 is $0.00. TPL Amount If status code 01 was used in claim 2 status field, enter amount of remaining participant liability after claim 1. If status code 04 was used in claim 2 status field, enter 000. TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

Completion	Item	Explanation and Instructions
Conditionally Required	**29A. (cont.)**	If the HFS 2432 shows a participant liability of $0.00 and multiple claims are required to report the charges for all services provided the claims should be coded as follows: Claim 1 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. Claim 2 TPL Code 906 TPL Status 04 TPL Amount 000 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If claims with spenddown deny, or if one service section on a claim submitted with a split bill is denied, subsequent submitted claims must have the HFS 2432 attached and must be mailed to a consultant for special handling. See mailing instructions.
Conditionally Required	**29B.**	**TPL Status** – If a TPL Code is shown, a two-digit code indicating the disposition of the third party claim must be entered. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the practitioner is advised **by the third party resource** that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the practitioner is advised **by the third party resource** that services provided are not covered. **04 – TPL Adjudicated – spenddown met:** TPL Status Code 04 is to be entered when the patient's HFS 2432 shows $0.00 liability. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the practitioner that the third party resource identified on the Identification Card is not in force.

Completion	Item	Explanation and Instructions
Conditionally Required	**29B. (cont.)**	**06 – Services not covered:** TPL Status Code 06 is to be entered when the practitioner determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment from the TPL have failed. **10 – Deductible not met:** TPL Status Code 10 is to be entered when the practitioner has been informed **by the third party resource** that non-payment of the service was because the deductible was not met.
Conditionally Required	**29C.**	**TPL Amount** – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter 000. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" field.
Conditionally Required	**29D.**	**TPL Date** – A TPL date is required when any status code is shown in Field 29B. Use the date specified below for the applicable TPL Status Code. Use the MMDDYY format. **Status Code Date to be entered** 01 Third Party Adjudication Date 02 Third Party Adjudication Date 03 Third Party Adjudication Date 04 Date from the HFS 2432, Split Billing Transmittal 05 Date of Service 06 Date of Service 07 Date of Service 10 Third Party Adjudication Date
Conditionally Required	**30A.**	**TPL Code** – (See 29A above).
Conditionally Required	**30B.**	**TPL Status** – (See 29B above).
Conditionally Required	**30C.**	**TPL Amount** – (See 29C above).
Conditionally Required	**30D.**	**TPL Date** – (See 29D above).

Completion	Item	Explanation and Instructions
Required	**31.**	**Provider Signature** - After reading the certification statement printed on the back of the claim form, the practitioner or authorized representative must sign the completed form. The signature must be handwritten in black or blue ink. A stamped or facsimile signature is not acceptable. Unsigned claims will not be accepted by the Department and will be returned to the practitioner. The practitioner's signature should not enter the date section of this field.
Required	**32.**	**Date** – The date of the practitioner's signature is to be entered in the MMDDYY format.

Mailing Instructions

The Medicare Crossover Invoice is a single page or two-part form. The practitioner is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part form should be removed prior to submission to the Department. The practitioner should retain the yellow copy of the claim.

Routine claims are to be mailed to the Department in the pre-addressed mailing envelopes, HFS 824MCR, Medicare Crossover Invoice Envelope, provided by the Department. Should envelopes be unavailable, the HFS 3797 can be mailed to:

Mailing address: Medicare Crossover Invoice
Healthcare and Family Services
Post Office Box 19109
Springfield, Illinois 62794-9109

Non-routine claims (multiple claims submitted with an HFS 2432, Split Bill Transmittal) must be mailed to the Department for special handling.

Mailing address: Healthcare and Family Services
PO Box 19115
Springfield, Illinois 62794-9115

Do not bend or fold claims prior to submission. Do not attach EOMB to claim.

Forms Requisition - Billing forms may be requested on our Web site or by submitting a HFS 1517 as explained in Chapter 100 (pdf), General Appendix 10.

Appendix A-3
Preparation and Mailing Instructions for Form HFS 1409 (pdf), Prior Approval Request

Form HFS 1409 (pdf), Prior Approval Request, revision date (R 03-09) is to be submitted by the provider for certain specified services in order for the services to qualify for reimbursement. Services and items requiring prior approval are identified in this handbook.

A sample of Form HFS 1409 (pdf), Prior Approval Request may be found on the Department's website.

Instructions for Completion

The form is to be typewritten or legibly hand printed. Instructions for completion follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional – In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Not Required = Fields not applicable to the provision of provider services.

Completion	Item	Explanation and Instructions
Required	**1.**	**Recipient ID Number** – Enter the nine-digit recipient identification number assigned to the patient for whom the service or item is requested. This number is found to the right of the patient's name on the back of the Identification Card.
Required	**2.**	**Recipient Name** - Enter the name of the patient for whom the service or item is requested.
Required	**3.**	**Birthdate** - Enter the patient's birthdate.
Required	**4.**	**Provider/NPI #** - Enter the provider number or NPI number as shown on the Provider Information Sheet.
Required	**5.**	**Provider Telephone #** - Enter the telephone number of the provider's office. This information is helpful in instances where the Department needs additional information in order to act upon the request.
Required	**6.**	**Provider Name** – Enter the name of the provider who will provide the service or item.

Completion	Item	Explanation and Instructions
Required	**7.**	**Physician Name** – Enter the name of the physician or other practitioner who signed the order recommending that the patient receive the specific service.
Required	**8.**	**Provider Street Address** – Enter the address of the provider.
Required	**9.**	**Physician Street Address** – Enter the address of the ordering practitioner.
Required	**10.**	**Provider City, State ZIP Code** – Enter the address of the provider.
Required	**11.**	**Physician City, State, ZIP Code** – Enter the address of the ordering practitioner.
Required	**12.**	**Diagnosis Code** – Enter the ICD-10-CM, diagnosis code that corresponds to the description listed in item 14 below.
Conditionally Required	**13.**	**Additional Diagnosis** – Enter additional ICD-10-CM, diagnosis codes, if applicable.
Required	**14.**	**Diagnosis Description** – Enter the written description, which corresponds with the diagnosis code listed in item 12.
Required	**15.**	**Patient Height/Weight** – Enter patient's height and weight.
Required	**16.**	**Procedure Code** – Enter the five-digit HCPCS or CPT code that identifies the specific item/service being requested.
Required		**Description – Briefly describe the services to be provided.**
Required		**Qty – Enter the number of times the service is to be performed.**
Required		**Cat. Serv – Enter the two-digit category of service corresponding to the service.**
Required		**Prov Charge – Enter the total amount to be charged for the service being requested.**
Not Required		Approved HFS Amt – Leave blank.
Conditionally Required		**Begin Date – If a service has already been provided, enter the date the service was provided. If service will not be provided until the prior approval is granted, leave blank.**
Conditionally Required		**End Date – Indicate the ending date of service, if applicable.**
Not Required		Pur/Rent – Leave blank.

Completion	Item	Explanation and Instructions
Not Required		Mod – To be used for modifiers at a later date.
Conditionally Required	**17-20**	To be used for additional procedures. If you list more than five (5) procedures another request must be submitted.
Conditionally Required	**21.**	**Additional Medical Necessity** – To be used for other medical information.
Not Required	22.	Approving Authority Signature – Leave blank.
Required	**23.**	**Provider Signature/Date** – To be signed in ink by the individual who is to provide the service.

Mailing Instructions

Before mailing, carefully review the request for completeness and accuracy. The signed copy of the HFS 1409 (pdf) may be mailed to:

Mailing Address: Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health Services
Post Office Box 19124
Springfield, Illinois 62794-9124

A copy may be retained in the provider's records.

A notification of approval or denial of the service(s) will be mailed to the provider and patient.

FAX INSTRUCTIONS
The signed copy of the HFS 1409 (pdf) may be faxed Monday through Friday, 8:30 AM – 5:00 PM, excepting holidays, to the following number 217-524-0099.

Appendix A-4

Completion of Form HFS 1977 (pdf)
Acknowledgment of Receipt of Hysterectomy Information

Part I

Item	Instructions
Recipient Name	Must be participant's first and last name.
Recipient Identification No.	Must be the participant's nine (9) digit identification number. The number must match participant number on claim.
Physician name	Must be completed with practitioner's name and match Physician's Signature on this form.
Provider No.	Enter the practitioner's NPI.

Part II

Item	Instructions
Acknowledgement	Enter the participant's first and last name.
Recipient or Representative Signature	Recipient's Signature – Must match Recipient Name. Representative Signature – Any signature is acceptable.
Date	Must be completed in the MMDDYY format.
Interpreter Signature	If applicable, an original signature is required.
Date	Must be completed if there is an Interpreter Signature.

Part III

Item	Instructions
Physician Signature	Must be an original signature. Stamped signatures are not acceptable.
Date	Must be completed in the MMDDYY format.

Part IV
Exception Request
Exception #1: The cause of sterility must be stated.

Exception #2: The life threatening emergency situation must be indicated.

Exception #3: The date of surgery must be entered. The date of the procedure must match the date of service on the claim.

If an Exception Request is completed, all items in Part I must be properly completed. The participant signature is not required. The Physician's Signature and Date are required.

Appendix A-5

Completion of Form HFS 2189
Sterilization Consent Form

To facilitate processing a claim to which the attachment of Form HFS 2189 (pdf) is required, all sections must be completed. The terminology regarding the sterilization should be consistent throughout the consent form.

Consent to Sterilization

Completion	Instructions
Required	Physician or clinic name - Must be the name of the practitioner or clinic responsible for giving the participant the required information regarding sterilization.
Required	Name of sterilization operation - Must match the sterilization listed on the claim.
Required	Recipient's birth date - Must be the participant's birth date as listed on the claim in MMDDYY format.
Required	Recipient's name - Must be participant's name. Must match participant's name on claim and other entries for participant name on this form.
Required	Physician's name - Must be name of practitioner or clinic that performed sterilization.
Required	Sterilization Method - Must match the sterilization listed on the claim.
Required	Recipient's signature - Must be participant's full first and last name. Must match name on claim and be an original signature in black or blue ink. Hand-printed signature is acceptable.

Required	Date consent form signed by participant - Must be the date that the participant signed the consent form.
	• Must be at least 72 hours prior to date of sterilization as listed on claim and physician statement on consent form. **No Exceptions**
	• Must be more than 30, but less than 180 days prior to date of sterilization.
	• If less than 30 days:
	  • Practitioner must give explanation as outlined in final paragraph of consent form – giving either the participant's original expected delivery date or an explanation of the emergency abdominal surgery.
	  • When premature delivery is checked, the original expected date must be more than 30, but less than 180 days after consent form was signed.

Optional	Race and Ethnicity Designation

Interpreter's Statement

Completion	Instructions
Conditionally Required	Interpreter's statement - Must specify the language into which the sterilization information has been translated.
Conditionally Required	Interpreter's signature - Must be interpreter's name and an original signature in black or blue ink. Printed signature is acceptable.
Conditionally Required	Date of interpreter's statement - Must be completed if there is an interpreter's signature in MMDDYY format.

Statement of Person Obtaining Consent

Completion	Instructions
Required	Name of individual - Must be the participant's name. Must match name on claim.
Required	Sterilization Operation - Must match the sterilization procedure listed on the claim.
Required	Signature of person obtaining consent - Must be an original signature in black or blue ink.
Required	Date consent was obtained - Must be a date in MMDDYY format.
Required	Facility - Must refer to the location of the practitioner or clinic obtaining the consent.
Required	Facility address - Must refer to the location of the practitioner or clinic obtaining the consent.

Physician's Statement

Completion	Instructions
Required	Name of individual to be sterilized - Must be the participant's name. Must match the name on the claim.
Required	Date of sterilization - Must match the date of sterilization listed on claim in MMDDYY format.
Required	Type of operation - Must match sterilization listed on claim.
Required	Physician's signature – Must be an original signature in black or blue ink of practitioner who performed the sterilization procedure. No stamped signatures are acceptable.
Required	Date - Date of practitioner's signature. Must be either the same date as the participant's consent or later and in MMDDYY format.

Appendix A-6

Completion of Form HFS 2390 (pdf) Abortion Payment Application

If any of the following items are not completed as outlined below, the claim and the Payment Application form will be returned to the practitioner. Entries must be typed or printed in black ink.

Participant Information

Item	Instructions
Recipient Name	Must be the participant's first and last name.
Recipient Address	Must be completed with participant's address.
Case Identification No.	Must be completed with participant's case identification number as shown on the identification card.
Recipient Identification No.	Must be completed with the recipient's 9-digit I.D. number. Must match the recipient's I.D. number on the claim.

Facility/Procedure Information

Item	Instructions
Date	Must be the date the service was performed in MMDDYY format.
Abortion Reason	Check the box for the appropriate reason and type of procedure performed. Must match procedure code on the claim. Mifepristone is to be checked for non-surgical abortions.

Physician Statement

Item	Instructions
Medicaid Provider Number	Enter the practitioner's NPI.
Street Address	Enter the practitioner's office street address.
City, State, ZIP	Enter the practitioner's office city, state and ZIP Code.
Signature of Physician Performing Abortion	Must be an original signature of the practitioner who performed the abortion. No stamped signatures are acceptable.
Date	Enter the date the practitioner signed the application in MMDDYY format.

Appendix A-7

Julian Date Calendar (Perpetual)

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31

Julian Date Calendar (Leap Years)

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
3	003	034	063	094	124	155	185	216	247	277	308	338	3
4	004	035	064	095	125	156	186	217	248	278	309	339	4
5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
7	007	038	067	098	128	159	189	220	251	281	312	342	7
8	008	039	068	099	129	160	190	221	252	282	313	343	8
9	009	040	069	100	130	161	191	222	253	283	314	344	9
10	010	041	070	101	131	162	192	223	254	284	315	345	10
11	011	042	071	102	132	163	193	224	255	285	316	346	11
12	012	043	072	103	133	164	194	225	256	286	317	347	12
13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
18	018	049	078	109	139	170	200	231	262	292	323	353	18
19	019	050	079	110	140	171	201	232	263	293	324	354	19
20	020	051	080	111	141	172	202	233	264	294	325	355	20
21	021	052	081	112	142	173	203	234	265	295	326	356	21
22	022	053	082	113	143	174	204	235	266	296	327	357	22
23	023	054	083	114	144	175	205	236	267	297	328	358	23
24	024	055	084	115	145	176	206	237	268	298	329	359	24
25	025	056	085	116	146	177	207	238	269	299	330	360	25
26	026	057	086	117	147	178	208	239	270	300	331	361	26
27	027	058	087	118	148	179	209	240	271	301	332	362	27
28	028	059	088	119	149	180	210	241	272	302	333	363	28
29	029	060	089	120	150	181	211	242	273	303	334	364	29
30	030		090	121	151	182	212	243	274	304	335	365	30
31	031		091		152		213	244		305		366	31

Appendix A-8
NDC Billing Instructions

The Health Insurance Portability and Accountability Act (HIPAA) standard code set for NDCs is eleven digits. The first segment must include five digits, the second segment must include four digits, and the third segment must include two digits (5-4-2 configuration). For example, 12345-1234-12 is a correctly configured NDC. However, the NDC on the product label might not contain 11 digits. The labeler may have dropped leading zeros in a segment. In this situation, the appropriate number of leading zeros must be added at the beginning of each segment to ensure that the NDC is shown in the 5-4-2 format. Where the zero is added depends upon the configuration of the NDC.

The following table provides examples of incorrectly configured NDCs and the corresponding correctly configured NDC. The segment that is missing the leading zero is bolded in each example.

NDC on Label	Configuration on Label	NDC in Required 5-4-2 Format
05678-**123**-01	5-3-2	05678-0123-01
5678-0123-01	4-4-2	05678-0123-01
05678-0123-**1**	5-4-1	05678-0123-01

The following provides NDC billing instructions.

HIPAA 837P Transactions and Direct Data Entry through the MEDI System
For HIPAA 837P electronic claim transactions, the HCPCS Code is reported in Loop ID 2400 and the NDC is reported in Loop ID 2410. For more detailed information please refer to the billing instructions for electronic claim transactions found in Chapter 300 (pdf). Providers registered to bill through the Direct Data Entry MEDI System can access instructions for the specific claim format [HFS 2360 (pdf), HFS 1443 (pdf)].

Paper Transactions
The HCPCS Code with the charge and the appropriate quantity based on the HCPCS definition should be billed on one service line on the HFS 2360 (pdf). The corresponding NDC must always be reported on the service line directly after the drug HCPCS Code service line. The NDC service line(s) must include the date of service, place of service, NDC Code without dashes, and NDC charge amount of zero. On the HFS 3797 (pdf), the corresponding NDC must be reported in Section 11.

Reporting Quantities

These instructions apply to both paper claims and electronic transactions.

At this time, the Department will use only the HCPCS quantities/units for payment and rebate purposes.

When a provider uses more than one NDC of a drug, the provider must include all NDCs on the claim. The quantity for **each** NDC must be reported separately by repeating the HCPCS Code. Please refer to the **Reporting of Multiple NDCs** section.

Reporting Charges

These instructions apply to both paper claims and electronic transactions.

The provider's charge must be reported for each HCPCS Code. A charge of zero should be reported for each NDC.

Reporting Multiple NDCs
These instructions apply to both paper claims and electronic transactions.

At times, it may be necessary for providers to bill multiple NDCs for a single procedure code. This may happen when two different strengths of the same drug are needed in order to administer the appropriate dose. This will also be necessary when multiple vials of the same drug are used to administer the appropriate dose, and different manufacturers manufacture the vials. Modifiers 76 and 51 are to be submitted as necessary. Refer to the billing examples below and the modifier listing for practitioner claims.

Billing examples of these situations are provided below. The examples apply to both paper claims and electronic transactions.

Procedure for billing one HCPCS and multiple NDCs:

Service Line 1 or Loop 2400:	HCPCS Code Report HCPCS quantity associated with NDC in Service Line 2
Service Line 2 or Loop 2410:	NDC associated with Service Line 1
Service Line 3 or Loop 2400:	HCPCS Code (same as Service Line 1) - Modifier 76 (Repeat Procedure) Report HCPCS quantity associated with NDC in Service Line 4
Service Line 4 or Loop 2410:	NDC associated with Service Line 3
Service Line 5 or Loop 2400: (Multiple Procedures)	HCPCS Code (same as Service Line 1 & 3) - Modifier 51 Report HCPCS quantity associated with NDC in Service Line 6
Service Line 6 or Loop 2410:	NDC associated with Service Line 5

Example 1: Procedure for billing **three (3)** 250 mg vials of ceftriaxone manufactured by two different manufacturers.

Provider will bill **a total quantity of** three (3) HCPCS procedure code units, but will divide those units, as follows:

Service Line 1 or Loop 2400:	J0696 billed with a quantity of 2
Service Line 2 or Loop 2410:	00781320695
Service Line 3 or Loop 2400:	J0696 and modifier 76 billed with a quantity of 1
Service Line 4 or Loop 2410:	00409733701

Reporting Multiple NDCs – Example 1

HCPCS Code	Modifier	HCPCS Code Description and HCPCS Quantity	Drug Administered	HCPCS Quantity Billed	NDCs Used
J0696		Injection, Ceftriaxone Sodium, Per 250 mg (One HCPCS Unit = 250 mg)	Two (2) 250 mg vials	2	00781320695 ceftriaxone 250 mg vial manufactured by Sandoz
J0696	76	Injection, Ceftriaxone Sodium, Per 250 mg (One HCPCS Unit = 250 mg)	One (1) 250 mg vials	1	00409733701 ceftriaxone 250 mg vial manufactured by Hospira

Example 2: Procedure for billing 125 mcg of Aranesp (darbepoetin alfa) using two different vials/strengths of the drug: one (1) 25 mcg syringe and one (1) 100 mcg syringe.

Provider will bill **a total quantity of** 125 HCPCS procedure code units, but will divide those units, as follows:
Service Line 1 or Loop 2400: J0881 billed with a quantity of 25
Service Line 2 or Loop 2410: 55513005704
Service Line 3 or Loop 2400: J0881 with modifier 76 billed with a quantity of 100
Service Line 4 or Loop 2410: 55513002504

Reporting Multiple NDCs - Example 2

HCPCS Code	Modifier	HCPCS Code Description and HCPCS Quantity	Drug Administered	HCPCS Quantity Billed	NDCs Used
J0881		Injection, Darbepoetin alfa, 1 mcg (non-ESRD use) (One HCPCS Unit = 1 mcg)	One 25 mcg/ 0.42 ml syringe	25	55513005704 Aranesp 25 mcg/0.42 ml syringe
J0881	76	Injection, Darbepoetin alfa, 1 mcg (non-ESRD use) (One HCPCS Unit = 1 mcg)	One 100 mcg/ 0.5 ml syringe	100	55513002504 Aranesp 100 mcg/0.5 ml syringe

Hand Priced Drug Procedure Codes

These instructions apply to both paper claims and electronic transactions. Providers must report both the HCPCS Code and NDC for drugs requiring hand pricing. These procedure codes are identified on the Practitioner Fee Schedule. Providers must report the HCPCS Code in the procedure field, and the product name, strength and the dosage administered or dispensed in the description field. The description field is Box 24C on the paper HFS 2360 claim, the "procedure literal description" field for DDE claims, or the NTE segment of Loop 2400 for electronic transactions. On paper claims only, the quantity in the units field must be 1. In the service line immediately following, providers must report the NDC as the procedure code and charge amount as "0."

Appendix A-9

Vaccination Billing Instructions Fee-for-Service (FFS)

Children 0 to 18 years of age (Title XIX [19] Only)

EXAMPLE #1

A Well-Child examination and routine vaccinations are administered in a setting other than an encounter rate clinic.

- Bill the examination/visit using the appropriate CPT procedure code
- Bill the specific VFC vaccine procedure code
- Bill the private stock vaccine procedure code for vaccines not offered through VFC.

Procedure Code	Description	Reimbursement Rate
99xxx	Evaluation and Management Code	Per Practitioner Fee Schedule
90xxx	Specific VFC-provided vaccine	Per fee schedule ***Unit Price*** field
90xxx	Specific non-VFC vaccine (if applicable)	Per fee schedule ***State Max*** field

EXAMPLE #2

A child presents solely to receive a vaccine in a setting other than an encounter rate clinic. The salaried staff member administers the VFC vaccine and/or private stock vaccine.

- Bill the appropriate outpatient visit for evaluation and management not requiring the presence of a physician
- Bill the specific VFC vaccine procedure code
- Bill the private stock vaccine procedure code for vaccines not offered through VFC

Procedure Code	Description	Reimbursement Rate
99211	Evaluation and Management Code	Per Practitioner Fee Schedule
90xxx	Specific VFC-provided vaccine	Per fee schedule ***Unit Price*** field
90xxx	Specific non-VFC vaccine (if applicable)	Per fee schedule ***State Max*** field

Children 0 through 18 years of age (Title XXI [21] and State-Funded)

EXAMPLE #3

A Well-Child examination is performed and routine vaccinations are administered in a setting other than an encounter rate clinic.

- Bill the examination/visit using the appropriate CPT procedure code
- Bill the private stock vaccine using the specific vaccine procedure code. Enter rate for the private stock vaccine plus $6.40 (*Unit Price*)

Procedure Code	Description	Reimbursement Rate
99xxx	Evaluation and Management Code	Per Practitioner Fee Schedule
90xxx	Specific private stock vaccine	Per fee schedule ***State Max*** field plus ***Unit Price*** field; enter rate for private stock vaccine plus $6.40.

EXAMPLE #4

A patient presents solely to receive a vaccine in a setting other than an encounter rate clinic. The salaried staff member administers the private stock vaccine.

- Bill the appropriate outpatient visit for evaluation and management not requiring the presence of a physician
- Bill the private stock vaccine using the specific vaccine procedure code. Enter rate for the private stock vaccine plus $6.40 (*Unit Price*)

Procedure Code	Description	Reimbursement Rate
99211	Evaluation and Management Code	Per Practitioner Fee Schedule
90xxx	Specific private stock vaccine	Per fee schedule ***State Max*** field plus ***Unit Price*** field; enter rate for private stock vaccine plus $6.40.

Appendix A-10

Telehealth Billing Examples

Billing Examples for Telemedicine Services

Example 1: **Originating Site – Physician's office**
Bill HCPCS Code Q3014

Distant Site – Podiatrist's office
Bill the appropriate CPT Code with modifier GT.
Reimbursement will be the fee schedule rate for the CPT Code billed.

Example 2: **Originating Site – Local Health Department**
Bill HCPCS Code Q3014

Distant Site – APN's office
Bill the appropriate CPT Code with modifier GT.
Reimbursement will be the fee schedule rate for the CPT Code billed.

Example 3: **Originating Site – Physician's office**
Bill HCPCS Code Q3014

Distant Site – Local Health Department
Not a valid provider – there is no billable service.

Example 4: **Originating Site – Encounter clinic**
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s).
Reimbursement will be the facility's medical encounter rate.

Distant Site – Encounter clinic
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider.

Example 5: **Originating Site – Encounter clinic**
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s).
Reimbursement will be the facility's medical encounter rate.

Distant Site – Physician's office
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider.

Example 6: **Originating Site – Physician's office**
Bill HCPCS Code Q3014

Distant Site – Encounter clinic
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s).
Reimbursement will be the facility's medical encounter rate. The rendering provider's name and NPI must also be reported on the claim.

Billing Examples for Telepsychiatry Services

Example 1: **Originating Site – Physician's office**
Bill HCPCS Code Q3014

Distant Site – Physician who has completed an approved general or child/adolescent psychiatry residency program
Bill the appropriate CPT Code for services provided.
Reimbursement will be the fee schedule rate for the CPT Code billed.

Example 2: **Originating Site – Encounter clinic**
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s).
Reimbursement will be the facility's medical encounter rate.

Distant Site – Encounter clinic
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider.
Provider rendering the service must be a physician who has completed an approved general or child/adolescent psychiatry residency program.

Example 3: **Originating Site – Physician's office**
Bill HCPCS Code Q3014

Distant Site – Encounter clinic
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s).
Provider rendering the service must be a physician who has completed an approved general or child/adolescent psychiatry residency program.
Reimbursement will be the facility's medical encounter rate.

Example 4: **Originating Site – Encounter clinic**
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT on the detail line(s).
Reimbursement will be the facility's medical encounter rate.

Distant Site – Physician's office
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider.
Provider rendering the service must be a physician who has completed an approved general or child/adolescent psychiatry residency program.

Appendix A-11

Explanation of Information on Provider Information Sheet

The Provider Information Sheet is produced when a provider is initially enrolled in the Department's Medical Assistance Program. It is also generated, in most instances, when there has been a change or update to a provider's enrollment record.

Provider Information Sheets are mailed to the provider as well as to all payees/Billing Providers on file. This sheet should serve as a record of the data on the Department's databases.

If the provider notes that the Provider Information Sheet does not reflect accurate data, the provider should submit corrected information using the IMPACT system. If all the information on the sheet is correct, the provider should retain the document and reference it as needed, such as when completing any Department forms.

Failure of a provider to properly update the IMPACT with corrections or changes may cause an interruption in participation and payments.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix A-10a.

Field	Explanation
Provider Key	This number uniquely identifies the provider and is used internally by the Department. It is directly linked to the reported NPI.
Provider Name And Location	This area contains the **Name and Address** of the provider as carried in the Department's records. The three-digit **County** Code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **Telephone Number** is the primary telephone number of the provider's primary office.
Enrollment Specifics	This area contains basic information concerning the provider's enrollment with the Department. **Provider Type** is a three-digit code and corresponding narrative, which indicates the provider's classification. **Organization Type** is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are: 01 = Individual Practice 02 = Partnership 03 = Corporation 04 = Group Practice

Field	Explanation
Enrollment Specifics	**Enrollment Status** is a one-digit code and corresponding narrative, which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are: B = Active I = Inactive Immediately following the enrollment status indicator are the **Begin** date indicating when the provider was most recently enrolled in Department's Medical Programs and the **End** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **End** date field. **Exception Indicator** may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are: A = Exception Requested by Audits C = Citation to Discover Assets G = Garnishment T = Tax Levy If this item is blank, the provider has no exception. Immediately following the **Exception Indicator** is the **Begin** date indicating the first date when the provider's claims are to be manually reviewed and the **End** date indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank. **AGR** (Agreement) indicates whether the provider has agreed to the Terms & Conditions in IMPACT.
Certification/License Number	This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **Ending** date indicating when the license will expire.

Field	Explanation
Categories of Service	This area identifies special licensure information and the types of service a provider is enrolled to provide. **Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a practitioner is authorized to render to patients covered under the Department's Medical Programs. The possible codes are: 001 – Physician Services 006 – Physician Psychiatric Services 010 – Nursing Services 017 – Anesthesia Services 018 – Midwife Services 026 – Encounter Rate Clinic Services 030 – Healthy Kids Screening Services 045 – Optical Materials 057 – Nurse Practitioner Each entry is followed by the date that the provider was approved to render services for each category listed.
Payee Information	This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **Payee Code,** which is to be used on the claim form to designate the payee to whom the warrant is to be paid. **If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.** **Payee ID Number** is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes. Therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider. The **Medicare/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to crossover Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.
NPI	The National Provider Identification Number contained in the Department's database.

Appendix A-11a
Reduced Facsimile of Provider Information Sheet

STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS) HEALTHCARE AND FAMILY SERVICES RUN DATE: 1/10/15
PROVIDER SUBSYSTEM RUN TIME: 11:47:06
REPORT ID: A2741KD1 PROVIDER INFORMATION SHEET MAINT DATE: 1/10/15
SEQUENCE: PROVIDER TYPE PAGE: 84
PROVIDER NAME

- -PROVIDER KEY- -
036999999

PROVIDER NAME AND ADDRESS
JOHNSON ALBERT
1421 MY STREET
ANYTOWN, IL 62000

PROVIDER GENDER:
COUNTY 200-COOK
TELEPHONE NUMBER - -

PROVIDER TYPE: 010 – PHYSICIAN
ORGANIZATION TYPE: 01 – INDIVIUAL PRACT
ENROLLMENT STATUS B – ACTIV NOCST BEGIN 11/01/14 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL: NONE

CERTIFIC/LICENSE NUM – 036999999 ENDING 01/31/16
PHARMACY AFFIL: 03 – GROUP PRACTICE CLIA #:
LAST TRANSACTION ADD AS OF 01/14/14
NCPDP #:

D.E.A.#: AA1234567
RE-ENROLLMENT INDICATOR: E DATE: 11/15/14

HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /

COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	COS	ELIGIBLITY CATEGORY OF SERVICE	ELIG BEG DATE	TERMINATION REASON
001	PHYSICIAN SERVICES	11/01/14	006	PHYSICIAN PSYCHIATRIC SERVICES	11/01/14	
017	ANESTHESIA	11/01/14	030	HEALTHY KIDS SCREENING SERVICES	11/06/14	

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	ANYTOWN MEDICAL ASSOC	1421 MY STREET	ANYTOWN	IL	62000	363106080-62000-01		11/01/15
	DBA:					TIN #: 01		

*** NPI NUMBERS REGISTERED FOR THIS HFS PROVIDER ARE:
1112223338

********** PLEASE NOTE: *********
* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____ X _____

Appendix A-12
Internet Quick Reference Guide

The Department's handbooks are designed for use via the Web and contain hyperlinks to the pertinent information.

Internet Site
Illinois Department of Healthcare and Family Services
Administrative Rules
All Kids Program
Care Coordination
Claims Processing System Issues
Child Support Enforcement
Dental Program
FamilyCare
Family Community Resource Centers
Health Benefits for Workers with Disabilities
Health Information Exchange
Home and Community Based Waiver Services
Illinois Health Connect
Illinois Veterans Care
Illinois Warrior Assistance Program
Maternal and Child Health Promotion
Medical Electronic Data Interchange (MEDI)
State Chronic Renal Disease Program
Medical Forms Requests
Medical Programs Forms
Non-Institutional Provider Resources
Pharmacy Information
Provider Enrollment Information
Provider Fee Schedules
Provider Handbooks
Provider Notices
Registration for E-mail Notification
Place of Service Codes
Centers for Medicare and Medicaid Services (CMS)

Appendix A-13

Anesthesia Payment Formula

General Anesthesia

Anesthesia units	+	(Modifying Units)	+	(Procedure Anesthesia Value)	X	(multiplier)
A	+	**B**	+	**C**	X	**D**

Epidural Anesthesia

Anesthesia units	X	75% (round down)	+	(Procedure Anesthesia Value)	X	(multiplier)
A	X	**(.75)**	+	**C**	X	**D**

A = Anesthesia units. Value is obtained by dividing the number of minutes by minutes per unit. Units are rounded up to the nearest whole number. For non-Medicare primary anesthesia claims, one unit = 12 minutes. For Medicare primary anesthesia claims, one unit = 15 minutes.

Medicare Crossovers
Electronic claims crossed over directly from Medicare to HFS indicate the quantity as the number of 15-minute units.

Electronic crossover claims submitted by the provider are to indicate the quantity modifier in Loop 2400 SV103 as “UN”, units, or “MJ”, minutes and SV104 as the corresponding number of 15-minute units or the number of minutes.

Paper claims crossed over by the provider are to show the quantity as the number of minutes.

HFS multiplies the unit quantity received by 15 minutes per unit to determine the number of minutes. Once the number of minutes is obtained, HFS divides by 12 minutes per unit and then the anesthesia payment formula is followed.

B = Physical status modifier. HFS-assigned value based on the use these CPT modifiers.

P1= 0 (old value A)
P2= 1 (old value B, E)
P3= 2 (old value C)
P4= 3 (old value D)
P5= 2 (old value F)
P6= 0 (old value G)

C = Anesthesia Value. HFS-assigned value, as shown on Practitioner Fee Schedule.

D = Current multiplier $15.35

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30

	31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a							a
b							b

38		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
	a			
	b			
	c			
	d			

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

NUBC National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-04 NOTICE: **THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:

   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;

   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;

   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;

   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and

   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

Appendix H-1

Explanation of Information on Provider Information Sheet

The Provider Information Sheet is produced when a provider is enrolled in the department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign and date the signature on the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic H-201.5 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any department forms.

The following information will appear on the Provider Information Sheet.

Field	Explanation
Provider Key	This number uniquely identifies the provider, and is used internally by the department. It is linked to the reported NPI(s).
Provider Name And Location	This area contains the **Name and Address** of the provider as carried in the department's records. The three-digit **County** code identifies the county where the hospital is located. It is also used to identify a state if the hospital's location is outside of Illinois. The **Telephone Number** is the primary telephone number of the provider's primary office.
Enrollment Specifics	This area contains basic information reflecting the manner in which the provider is enrolled with the department. **Provider Type** is a three-digit code and corresponding narrative that indicates the provider's classification.

Field	Explanation
Enrollment Specifics	**Organization Type** is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are: 01 = Sole Proprietary 02 = Partnership 03 = Corporation **Enrollment Status** is a one-digit code and corresponding narrative that indicates whether or not the provider is currently an active participant in the department's Medical Programs. Cost report requirements are also indicated. The possible codes are: A = Active, Cost Report Required B = Active, Cost Report Not Required I = Inactive N = Non Participating Immediately following the enrollment status indicator are the **Begin** date indicating when the provider was most recently enrolled in the department's Medical Programs and the **End** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **End** date field. **Exception Indicator** may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are: A = Intent to Terminate B = Expired License C = Citation to Discover Assets D = Delinquent Child Support E = Provider Review F = Fraud Investigations G = Garnishment I = Indictment L = Student Loan Suspensions R = Intent to Terminate/Recovery S = Exception Requested by Provider Participation Unit T = Tax Levy X = Tax Suspensions If this item is blank, the provider has no exception. Immediately following the **Exception Indicator** are the **Begin** date indicating the first date when the provider's claims are to be manually reviewed and the **End** date indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank.

Field	Explanation
Medicare Number	This is the number that the Medicare processing agency uses to identify the hospital.
Categories of Service	This area identifies the types of service a provider is enrolled to provide. **Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the department's Medical Programs. Each entry is followed by the date on which the provider was approved to render services for each category listed. Since there are multiple categories of services for which a general, psychiatric, or rehabilitation hospital may enroll, refer to the instructions for the Provider Enrollment Application (HFS 2243), which defines all applicable categories of services.
Payee Information	This area records the name and address of the entity authorized to receive payments on behalf of the hospital. The payee is assigned a single-digit **Payee Code.**
	Payee ID Number is a sixteen-digit identification number assigned to each payee, for whom warrants may be issued. A portion of this number is used for tax reporting purposes; therefore, no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.
NPI	The National Provider Identification Number contained in the department's database.
Signature	The provider is required to affix an original signature when submitting changes to the Department of Healthcare and Family Services.

Appendix H-1a
Reduced Facsimile of Provider Information Sheet

STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS) HEALTHCARE AND FAMILY SERVICES RUN DATE: 12/16/13
PROVIDER SUBSYSTEM RUN TIME: 11:47:06
REPORT ID: A2741KD1 PROVIDER INFORMATION SHEET MAINT DATE: 12/16/13
SEQUENCE: PROVIDER TYPE PAGE: 84
PROVIDER NAME

- -PROVIDER KEY- -
0000111111111

PROVIDER NAME AND ADDRESS

COUNTY 089-SCOTT
TELEPHONE NUMBER

RE-ENRL IND: N DATE: 11/15/86

PROVIDER TYPE: 030 - GENERAL HOSPITAL
ORGANIZATION TYPE: 03 - CORPORATION
ENROLLMENT STATUS A - ACTIV CST BEGIN 11/15/86 END ACTIVE
EXCEPTION INDICATOR - NO EXCEPT BEGIN END
AGR: YES BILL: NONE

CERTIFIC/LICENSE NUM - ENDING
CLIA #:
LAST TRANSACTION ADD AS OF 04/21/97 MEDICARE #
FACILITY CTL/AFFIL:
FISCAL YEAR END: PSYCH BED COUNT: ACUTE BED COUNT:

INSTITUTION INFORMATION:

INSTITUTION BED CNT: INST BED: BEGIN 02/01/99

HEALTHY KIDS/HEALTHY MOMS INFORMATION: BEGIN DATE: / /

COS	ELIGIBILITY CATEGORY OF SERVICE	ELIG BEG DATE	COS	ELIGIBLITY CATEGORY OF SERVICE	ELIG BEG DATE	TERMINATION REASON

PAYEE CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1								

DBA: VENDOR ID: 01

*** NPI NUMBERS REGISTERED FOR THIS HFS PROVIDER ARE:
XXXXXXXXXX

********** PLEASE NOTE: *********
* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE X

Appendix H-2

UB-04 Requirements for HFS Adjudication of Inpatient, Outpatient, and Renal Dialysis Claims

Instructions for completion of this form follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions. **For detailed form locator information, all providers should have a copy of the UB-04 Data Specifications Manual for reference.** To become a UB-04 Subscriber, refer to the National Uniform Billing Committee (NUBC) website. The UB-04 Data Specifications Manual contains a blank facsimile of the UB-04. Providers may also view a UB-04 facsimile on the department's website. For billing purposes, providers must still submit an original UB-04.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional – In some cases failure to include an entry will result in certain assumptions by the department and will preclude corrections of certain claiming errors by the department.
Conditionally Required	=	Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Appendix H-2a

Completion	Form Locator	Form Locator Explanation and Instructions For Inpatient Claims
Required	**1.**	**Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.
Conditionally Required	**2.**	**Pay-To Name and Address -** Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4. Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information. The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL1.
Optional	**3a.**	**Patient Control Number**
Optional	**3b.**	**Medical Record Number**
Required	**4.**	**Type of Bill** – A four-digit field is required. Do not drop the leading zero in this field.
Optional	**5.**	**Fed. Tax No.**
Required	**6.**	**Statement Covers Period**
Conditionally Required	**10.**	**Patient Birth Date** - If a birth date is entered, the department will, where possible, correct claims suspended due to recipient name and number errors. If a birth date is not entered, the department will not attempt corrections. A birth date is required only if the claim contains a Type of Admission 4 (newborn).
Required	**12.**	**Admission Date**
Conditionally Required	**13.**	**Admission Hour –** An admission hour is required only if the Type of Bill Frequency Code is 1 or 2.
Required	**14.**	**Priority (Type) of Visit**

Completion	Form Locator	Form Locator Explanation and Instructions For Inpatient Claims
Conditionally Required	**15.**	**Source of Referral for Admission -** Code 4 or D is required when a patient is transferred from another hospital or transferred from hospital inpatient in the same facility, resulting in a separate claim to the payer.
Required	**17.**	**Patient Discharge Status**
Conditionally Required	**18-28.**	**Condition Codes -** Required if a condition code applies to this claim, such as C1, C3, AJ, or applicable abortion codes. Condition Code 04 (Information Only Bill) is required when a hospital submits a claim for a Medicare HMO patient to identify those inpatient days for disproportionate share calculation.
Conditionally Required	**31-34.**	**Occurrence Codes and Dates –** Refer to the UB-04 Data Specifications Manual for usage requirements.
Conditionally Required	**35-36.**	**Occurrence Span Code/From/Through** – When reporting non-covered days, providers must indicate the non-covered date span.
Required	**39-41.**	**Value Codes** – Value Code entries, if a non-dollar amount, must be positioned right-justified to the left of the dollar/cents delimiter. Value Code 54 – Required to report birth weight in grams of newborns 14 days of age or less on the admission date. Value Code 66 - Spenddown liability must be reported using Value Code 66 along with a dollar amount to identify the patient's Spenddown liability. The HFS 2432, Split Billing Transmittal, must accompany the claim. Value Code 80 is required for all inpatient claims (the number of days covered by the primary payer). The other value codes below are conditionally required based upon the particular claim. Value Code 81 – The number of days of care not covered by the primary payer. Value Codes applicable to Medicare deductible or coinsurance due.

Completion	Form Locator	Form Locator Explanation and Instructions For Inpatient Claims
Required	**42.**	**Revenue Code –** Enter the appropriate revenue code for the service provided. The 23rd Revenue Line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.
Required	**43.**	**Revenue Description**
Required	**44.**	**HCPCS/Accommodation Rates** – For accommodation revenue codes, dollar values reported must include whole dollars, the decimal, and the cents. Hospitals are required to bill modifiers according to national coding guidelines.
Required	**46.**	**Service Units –** For each accommodation revenue code, enter the total number of covered days associated with that revenue code. If there are no covered days associated with an accommodation revenue code, the hospital must still enter a "0" (zero) in this field.
Required	**47.**	**Total Charges** (By Revenue Code category) For Revenue Code 0001, see FL 42 above.
Conditionally Required	**48.**	**Non-Covered Charges** – Reflects any non-covered charges pertaining to the related revenue code.
Required	**50.**	**Payer** - Illinois Medicaid or 98916 must be shown as the payer of last resort.

Completion	Form Locator	Form Locator Explanation and Instructions For Inpatient Claims
Conditionally Required	**51.**	**Health Plan Identification Number** HFS will require that providers report our legacy three-digit TPL codes and two-digit TPL status codes in this field, until the HIPAA National Plan Identifier is mandated. The format will continue to be the three-digit TPL code, one space, and then the two-digit status code. This is required if there is a third party source. **TPL Code** – The patient's numeric three-digit code must be entered in this field. If payment was received from a third party resource not identified by the department, enter the appropriate TPL Code as listed in Chapter 100, General Appendix 9. **Status** – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force. **06 – Services not covered:** TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed. **08 – Estimated Payment:** TPL Status Code 08 may be entered if the provider has billed the third party, contact was made with the third party, and payment is forthcoming but not yet received. The provider must indicate the amount of the payment estimated by the third party. The provider is responsible for any adjustment, if required, after the actual receipt of the payment from the third party. **10 – Deductible Not Met:** TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met. **99 – Zero or Negative Payment:** TPL Status Code 99 identifies a zero or negative payment by Medicare on a crossover claim.

Completion	Form Locator	Form Locator Explanation and Instructions For Inpatient Claims
Conditionally Required	**54A,B.**	**Prior Payments** – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.
Required	**56.**	**National Provider Identifier – Billing Provider** The NPI is the unique identification number assigned to the provider submitting the bill.
Optional	**57.**	**Other (Billing) Provider Identifier** Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. The HFS legacy number will not be used for adjudication.
Required	**58.**	**Insured's Name** – Enter the patient's name exactly as it appears on the Identification Card or Notice issued by the department.
Required	**60.**	**Insured's Unique Identifier (Recipient Identification Number)** – Enter the nine-digit recipient number assigned to the individual as shown on the Identification Card or Notice issued by the department. Use no punctuation or spaces. Do **not** use the Case Identification Number.
Conditionally Required	**64.**	**Document Control Number –** At the time the department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.
Required	**67.**	**Principal Diagnosis Code and Present on Admission (POA) Indicator -** Enter the specific ICD-9-CM, or upon implementation, ICD-10-CM code without the decimal. If required based on the diagnosis code, the POA indicator is placed in the 8th position shaded area. If the POA indicator is not placed in the shaded areas noted, it will be captured as part of the diagnosis code, which may cause the claim to be rejected.
Conditionally Required	**67A-Q.**	**Other Diagnosis Codes** Enter the specific ICD-9-CM, or upon implementation, ICD-10-CM code without the decimal. If required based on the diagnosis code, the POA indicator is placed in the 8th position shaded area.

Completion	Form Locator	Form Locator Explanation and Instructions For Inpatient Claims
Required	**69.**	**Admitting Diagnosis Code** – Enter the specific ICD-9-CM, or upon implementation, ICD-10-CM code without the decimal.
Conditionally Required	**70a-c.**	**Patient's Reason for Visit –** This field is required if the claim contains Revenue Code 045X, 0516, 0526, or 0762.
Conditionally Required	**72A-C.**	**External Cause of Injury (ECI) Code –** The ICD-9-CM, or upon implementation, ICD-10-CM diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.
Conditionally Required	**74.**	**Principal Procedure Code and Date -** Required if a procedure is performed.
Conditionally Required	**74a-e.**	**Other Procedure Codes and Dates –** Required if there were any additional procedures performed.
Required	**76.**	**Attending Provider Name and Identifiers** The department will adjudicate claims based on the NPI.
Conditionally Required	**77.**	**Operating Physician Name and Identifiers** – Required if a surgical procedure is performed. The department will adjudicate claims based on the NPI.
Conditionally Required	**78-79.**	**Other Provider (Individual) Names and Identifiers –** Refer to the UB-04 Data Specifications Manual for usage requirements. If utilizing this field, the provider must use the two-digit provider type qualifier code in conjunction with the NPI.
Required	**81.**	**Code-Code Field** – HFS Requirement (Needed for Adjudication) Qualifier "B3" – Healthcare Provider Taxonomy Code. Taxonomy codes are identified in Chapter 300, Handbook for Electronic Processing, available on the department's website. This form locator can also be used to report additional codes related to a form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

***Additional notes**

Form Locator 80 Remarks – HFS utilizes this field to assign each claim's unique Document Control Number. Providers do not utilize this field.

Appendix H-2b

Completion	Form Locator	Form Locator Explanation and Instructions for General Outpatient and Outpatient Psychiatric Claims
Required	**1.**	**Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.
Conditionally Required	**2.**	**Pay-To Name and Address** –Report the Pay-To Provider (Payee) NPI, which is registered to the appropriate 16-digit payee number, on Line 4. Payee information is only required when the payee is a different entity than the Billing Provider. Refer to the Provider Information Sheet for payee information. The Pay-To Address is required when the address for payment is different than that of the Billing Provider in FL1.
Optional	**3a.**	**Patient Control Number**
Optional	**3b.**	**Medical Record Number**
Required	**4.**	**Type of Bill** – A four-digit field is required. Do not drop the leading zero in this field.
Optional	**5.**	**Fed. Tax No.**
Required	**6.**	**Statement Covers Period**
Optional	**10.**	**Patient Birth Date** - If the birth date is entered, the department will, where possible, correct claims suspended due to recipient name and number errors. If the birth date is not entered, the department will not attempt corrections.

Completion	Form Locator	Form Locator Explanation and Instructions for General Outpatient and Outpatient Psychiatric Claims
Conditionally Required	**18-28.**	**Condition Codes** – Claims containing an abortion procedure need a corresponding abortion condition code.
Conditionally Required	**35-36.**	**Occurrence Span Code/From/Through** – When reporting non-covered days, providers must indicate the non-covered date span.
Conditionally Required	**39-41.**	**Value Codes** – The value codes below are conditionally required based upon the particular claim. Value Code entries, if a non-dollar amount, must be positioned right-justified to the left of the dollar/cents delimiter. Value Code 66 – Spenddown liability must be reported using Value Code 66 along with a dollar amount to identify the patient's Spenddown liability. The HFS 2432, Split Billing Transmittal, must accompany the claim. Value Code 80 – The number of covered days is required for series claims. Value Codes applicable to Medicare deductible or coinsurance due.
Required	**42.**	**Revenue Code –** Enter the appropriate revenue code for the service provided. The 23rd Revenue Line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

Completion	Form Locator	Form Locator Explanation and Instructions for General Outpatient and Outpatient Psychiatric Claims

Required	**43.**	**Revenue Description –** Refer to the UB-04 Manual for details.
		
		NDC reporting of all drug codes is required. When a provider uses more than one NDC for a drug, the provider must include **all** NDCs on the claim. Duplicate revenue codes identifying the same HCPCS code but different NDCs on the same claim are not to have the HCPCS Units and Charges rolled into the first Revenue Code line. Each Revenue Code line must contain detailed reporting.
		
		• Report the N4 qualifier in the first two (2) positions, left- justified
		• Followed immediately by the 11-character National Drug Code (NDC), in the 5-4-2 format (no hyphens)
		• Immediately following the last digit of the NDC (no delimiter) the Unit of Measurement Qualifier. The Unit of Measurement Qualifier Codes are as follows:
		  • F2 – International Unit
		  • GR – Gram
		  • ML – Milliliter
		  • UN – Unit
		• Immediately following the Unit of Measurement Qualifier, the unit quantity with a floating decimal for fractional units limited to three (3) digits (to the right of the decimal).
		• Any spaces unused for the quantity are left blank.

Required	**44.**	**HCPCS/Accommodation Rates –** Claims containing emergency, observation, or psychiatric department services must identify specific procedure codes. Refer to the final page of the APL on the website. Hospitals are required to bill modifiers according to national coding guidelines. Modifier “UD” is required to denote all 340B-purchased drugs. Modifier “UD” must be the first modifier listed after the HCPCS procedure code.

Completion	Form Locator	Form Locator Explanation and Instructions for General Outpatient and Outpatient Psychiatric Claims
Required	**45.**	**Service Date**
Conditionally Required	**46.**	**Service Units –** Claims for the following services must contain an entry: • Observation claims must contain the number of hours of observation. • For dates of service prior to July 1, 2014, claims containing an expensive drug, as identified on the department's website and associated with Revenue Code 0636, must contain the number of units given. • Series claims for series-billable revenue codes must contain an entry that is at least equal to the number of Covered Days.
Required	**47.**	**Total Charges** (By Revenue Code category) For Revenue Code 0001, see FL 42 above.
Conditionally Required	**48.**	**Non-Covered Charges** – Reflects any non-covered charges pertaining to the related revenue code.
Required	**50.**	**Payer** - Illinois Medicaid or 98916 must be shown as the payer of last resort

Completion	Form Locator	Form Locator Explanation and Instructions for General Outpatient and Outpatient Psychiatric Claims
Conditionally Required	**51.**	**Health Plan Identification Number –** HFS will require that providers report our legacy three-digit TPL codes and two-digit TPL status codes in this field until the HIPAA National Plan Identifier is mandated. The format will continue to be the three-digit TPL code, one space, and then the two-digit status code. Required if there is a third party source. **TPL Code** – The patient's numeric three-digit code must be entered in this field. If payment was received from a third party resource not identified by the department, enter the appropriate TPL Code as listed in Chapter 100, General Appendix 9. **Status** – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank. The TPL Status Codes are: **01 – TPL Adjudicated – total payment shown:** TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box. **02 – TPL Adjudicated – patient not covered:** TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided. **03 – TPL Adjudicated – services not covered:** TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered. **05 – Patient not covered:** TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force. **06 – Services not covered:** TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided. **07 – Third Party Adjudication Pending:** TPL Status Code 07 may be entered when a claim has been submitted to the third party, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed. **08 – Estimated Payment:** TPL Status Code 08 may be entered if the provider has billed the third party, contact was made with the third party, and payment is forthcoming but not yet received. The provider must indicate the amount of the payment estimated by the third party. The provider is responsible for any adjustment, if required, after the actual receipt of the payment from the third party. **10 – Deductible Not Met:** TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met. **99 – Zero or Negative Payment:** TPL Status Code 99 identifies a zero or negative payment by Medicare on a crossover claim.

Completion	Form Locator	Form Locator Explanation and Instructions for General Outpatient and Outpatient Psychiatric Claims
Conditionally Required	**54A,B.**	**Prior Payments** – TPL payments are identified on Lines A and B to correspond to any insurance source in FL 51 Lines A and B.
Required	**56.**	**National Provider Identifier – Billing Provider** The NPI is the unique identification number assigned to the provider submitting the bill.
Optional	**57.**	**Other (Billing) Provider Identifier** Enter the HFS legacy provider number on the line that corresponds to Illinois Medicaid. The HFS legacy number will not be used for adjudication.
Required	**58.**	**Insured's Name** – Enter the patient's name exactly as it appears on the Identification Card or Notice issued by the department.
Required	**60.**	**Insured's Unique Identifier (Recipient Identification Number)** – Enter the nine-digit recipient number assigned to the individual as shown on the Identification Card or Notice issued by the department. Use no punctuation or spaces. Do **not** use the Case Identification Number.
Conditionally Required	**64.**	**Document Control Number –** At the time the department implements the void/rebill process, the DCN will be required when the Type of Bill Frequency Code (FL 4) indicates this claim is a replacement or void to a previously adjudicated claim. Enter the DCN of the previously adjudicated claim.
Required	**67.**	**Principal Diagnosis Code and Present on Admission (POA) Indicator -** Enter the specific ICD-9-CM, or upon implementation, ICD-10-CM code without the decimal. The POA indicator is **not** required for outpatient claims.
Conditionally Required	**67A-Q.**	**Other Diagnosis Codes** - Enter the specific ICD-9-CM, or upon implementation, ICD-10-CM code without the decimal. The POA indicator is **not** required for outpatient claims.

Completion	Form Locator	Form Locator Explanation and Instructions for General Outpatient and Outpatient Psychiatric Claims
Conditionally Required	**70a-c.**	**Patient's Reason for Visit –** This field is required if the claim contains Revenue Code 045X, 0516, 0526, or 0762.
Conditionally Required	**72A-C.**	**External Cause of Injury (ECI) Code –** The ICD-9-CM, or upon implementation, ICD-10-CM diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.
Required	**76.**	**Attending Provider Name and Identifiers -** The department will adjudicate claims based on the NPI.
Conditionally Required	**77.**	**Operating Physician Name and Identifiers –** Required if a surgical procedure is performed. The department will adjudicate claims based on the NPI.
Conditionally Required	**78-79.**	**Other Provider (Individual) Names and Identifiers –** Refer to the UB-04 Data Specifications Manual for usage requirements. If utilizing this field, the provider must use the two-digit provider type qualifier code in conjunction with the NPI.
Required	**81.**	**Code-Code Field** – HFS Requirement (Needed for Adjudication) Qualifier "B3" – Healthcare Provider Taxonomy Code. Taxonomy codes are identified in Chapter 300, Handbook for Electronic Processing, available on the department's website. This form locator can also be used to report additional codes related to a form locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

***Additional notes**

FL 80 - Remarks – HFS utilizes this field to assign each claim's unique Document Control Number. Providers do not utilize this field.

Providers
Children's Mental Health
Community Mental Health Centers
Contact Us
Cost Reports
E-Mail Notification
EDI
EHR Incentive Program
Fee Schedule
Forms Request
Health Information Exchange
Home & Comm. Based Serv. Waivers
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Provider Handbooks
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Provider Releases
Reimbursements
REV
School Based Services
Supportive Living
State Renal Program
Vendor Payments

General Information
Breast Cancer Quality Screening and Treatment Initiative Advisory Board
Brochures
Bureau Directory
Children with Complex Medical Needs Work Group
Cross-Agency Medicaid Commission
Dental Policy Review Committee
Forms
HFS Reports
Hemophilia Advisory Review Board
Inspector General
Medicaid Advisory Committee
Nursing Home Safety Task Force
Phone Directory
Policy Manual
Medical Home
HFS Home

State Links
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New UB-92 Condition Codes for Abortion Procedures (html)

05/23/03

INFORMATIONAL NOTICE

TO: Enrolled Hospitals

RE: New UB-92 Condition Codes for Abortion Procedures

The National Uniform Billing Committee (NUBC) approved a national condition code list relating to abortion procedures. The new codes were effective for dates of service on or after October 1, 2002.

The Department previously used local condition codes A7, A8, and 96 to identify conditions relating to abortion services, and has continued to accept claims containing these condition codes. **However, effective for inpatient admissions or outpatient service dates on or after October 15, 2003, the Department will no longer accept claims containing condition codes A7, A8, or 96.**

The Department only reimburses for abortion procedures performed under limited circumstances, and will not utilize all of the new NUBC condition codes. Only new condition codes AA, AB, AD, and AE will be accepted, pursuant to Department policy regarding payment for abortion services. The appropriate condition code must still be placed within Form Locators 24-30 on the UB-92 claim format.

The condition codes are defined by the NUBC as follows:

AA Abortion Performed Due to Rape
AB Abortion Performed Due to Incest
AD Abortion Performed Due to a Life Endangering Physical Condition Caused By, Arising From or Exacerbated By the Pregnancy Itself
AE Abortion Performed Due to Physical Health of Mother That Is Not Life Endangering

If you have any questions regarding this notice, please contact your hospital's medical assistance consultant in the Bureau of Comprehensive Health Services at 217-782-5565.

Anne Marie Murphy, Ph.D.
Administrator
Division of Medical Programs

Provider Releases & Bulletins Links
All Kids Application Agents
All Medical Assistance Providers
Ambulatory Surgical Treatment Centers
Audiologists
Chiropractors
Community Mental Health Providers
Dentists
Department of Alcohol and Substance Abuse Provider
Durable Medical Equipment Suppliers
Early Intervention Services
Encounter Rate Clinics
Federally Qualified Health Centers
Home Health Agencies
Hospice
Hospitals
Imaging Centers
Laboratory
Local Education Agencies
Local Health Departments
Long Term Care
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Optometrists
Pharmacies
Physicians
Podiatrists
Renal Dialysis Clinics
Rural Health Clinics
School Based Clinics
School Based Health Services (LEA)
Supportive Living
Therapists
Transportation Providers
Waiver

Go [Search Tips]

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS
PART 120 MEDICAL ASSISTANCE PROGRAMS
SECTION 120.66 HEALTHY START - MEDICAID PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

Section 120.66 Healthy Start − Medicaid Presumptive Eligibility for Pregnant Women

a) The purpose of Healthy Start − Medicaid Presumptive Eligibility (MPE) for pregnant women is to encourage early and continuous prenatal care of low income pregnant women who otherwise may postpone or do without that care. Qualified MPE Providers may make presumptive determinations for MPE.

b) A pregnant woman, as defined in Section 5-2(5)(a) and (b) of the Public Aid Code [305 ILCS 5] may be found presumptively eligible by a qualified MPE Provider as long as she has not been previously determined presumptively eligible under this Section or Section 120.68 during the current pregnancy.

c) The presumptive eligibility period shall be the period that:

1) begins with the date on which a qualified provider determines that the family income does not exceed 200 percent of the Federal Poverty Level (FPL) as determined pursuant to Section 120.64; and

2) ends with and includes the earlier of:

A) in the case of a woman who files an application pursuant to 89 Ill. Adm. Code 110.10 by the last day of the month following the month during which the qualified MPE Provider makes the determination that she is presumptively eligible, the day on which a determination is made by the State with respect to the eligibility of the woman for medical assistance under the Illinois State Medicaid Plan; or

B) in the case of a woman who does not file an application as described in subsection (2)(A) of this Section, the last day of the month following the month during which the qualified MPE Provider makes the determination that she is presumptively eligible.

d) Covered Services – Services covered during the presumptive eligibility period under this Section shall include ambulatory care consisting of all outpatient medical care covered by the Illinois State Medicaid Plan.

e) Qualified MPE Providers are those providers that comply with all the following:

1) Participate as a Medicaid provider under the Illinois State Medicaid Plan;

2) Enter into and abide by the terms of the Healthy Start – Medicaid Presumptive Eligibility Provider Agreement with the Department;

3) Furnish services of the type provided by outpatient hospitals, rural health clinics or freestanding, maternity clinics as described in section 1905(a)(2) or 1905(a)(9) of the Social Security Act (42 USC 1396d); and

4) Meet one or more of the following requirements:

A) Receives funding as a community or migrant health center program (sections 330 and 330A of the Public Health Service Act (42 USC 201 et seq.);

B) Receives funding under Title V of the Social Security Act (42 USC 701-713);

C) Participates in Illinois' perinatal health services program (77 Ill. Adm. Code 640);

D) Receives a grant under the Supplemental Nutrition Program for Women, Infants and Children (WIC) (section 17 of the Child Nutrition Act of 1966 (42 USC 1771));

E) Receives a grant under the Commodity Supplemental Food Program (section 4(a) of the Agriculture and Consumer Protection Act of 1973 (PL 93-86)); or

F) Is an Indian Health Service provider or a health program facility operated by a tribe or tribal organization under the Indian Self-Determination Act (25 USC 450).

f) Duties of the Department and qualified MPE Providers

1) The Department shall:

A) provide such forms as are necessary for a qualified MPE Provider to submit an MPE enrollment and such forms as are necessary for a pregnant woman to make application for medical assistance pursuant to 89 Ill. Adm. Code 110.10;

B) provide information on how to make MPE determinations and assist women in completing and filing applications for medical assistance; and

C) process MPE enrollments as submitted by qualified MPE Providers.

2) A qualified MPE Provider who determines that a pregnant woman is presumptively eligible for medical assistance under this Section shall:

A) notify the Department of the determination within 5 business days after the date on which the determination is made;

B) inform the woman at the time the determination is made that:

i) her coverage is temporary and will end on the last day of the month following the month in which the MPE determination has been made;

ii) services covered are limited to ambulatory care;

iii) she must complete and submit an application for medical assistance in order to be considered for full coverage; and

C) assist the woman to apply for medical assistance prior to the end of her presumptive eligibility period.

(Source: Added at 40 Ill. Reg. 2784, effective January 20, 2016)

Table of Contents

State/Territory Name: IL

State Plan Amendment (SPA) #: 13-015

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

December 13, 2013

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

ATTN: Theresa Eagleson

RE: TN 13-015

Dear Ms. Hamos:

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

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

--Effective Date: February 1, 2014

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

Sincerely,

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

Enclosure

cc: Mary Doran, HFS
Beth Green, HFS

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

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 13-015
2. STATE: ILLINOIS
3. PROGRAM IDENTIFICATION: Title XIX of the *Social Security Act* (Medicaid)
4. PROPOSED EFFECTIVE DATE: February 1, 2014

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

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

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

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

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

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

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

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

10. SUBJECT OF AMENDMENT:
Medicare & Medicaid Alignment Initiative

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

12. SIGNATURE OF AGENCY OFFICIAL:

13. TYPED NAME: Julie Hamos

14. TITLE: Director of Healthcare and Family Services

15. DATE SUBMITTED: 09-30-2013

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/30/13

18. DATE APPROVED: 12/13/13

PLAN APPROVED—ONE COPY ATTACHED

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

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Verlon Johnson

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM CMS-179 (07/92)

Instructions on Back

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

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

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

B. General Description of the Program and Public Process.

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

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

1. The State will contract with an

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

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

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

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

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

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

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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

Citation	Condition or Requirement

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

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

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

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

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

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

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

1932(a)(1)(A)

5. The state plan program will ☐ /will not ☑ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ☐ / voluntary ☑ enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory)

   ii. county/counties (voluntary)

   Greater Chicago Region:
   Cook, DuPage, Kane, Kankakee, Lake, Will

   Central Illinois Region:
   Champaign, Christian, DeWitt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell, Vermilion,.

   iii. area/areas (mandatory)_____

   iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)

42 CFR 438.50(c)(1)

1. ☑ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. ☐ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. ☑ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A
42 CFR 431.51
1905(a)(4)(C)

4. ☑ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

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

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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

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

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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

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

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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

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

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

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

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

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

   i. The state will ☐ / will not ☑ use a lock-in for managed care.

   ii. The time frame for recipients to choose a health plan before being auto-assigned will be 60 days.

   iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

   During the enrollment process, potential enrollees will be sent an explanatory letter, an initial enrollment packet and a second enrollment letter. The second enrollment letter will specify the demonstration plan (MCO) to whom the potential enrollee will be assigned if no choice is made. If no choice is made and a client is enrolled through passive enrollment, the MCO will send a welcome packet to the enrollee that includes all basic information, including an explanation of the Demonstration, a summary of important topics, such as how to get needed care, a benefits summary, and information about the complaint, grievance and appeal processes.

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

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

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

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

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

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

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

The assignment algorithm may take into consideration:

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

Citation	Condition or Requirement

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

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

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

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

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

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

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

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

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

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

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

5. ☑ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

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

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will ☐ /will not ☑ use lock-in for managed care.

2. The lock-in will apply for 0 months (up to 12 months).

3. Place a check mark to affirm state compliance.

   ☑ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

   Not applicable. An Enrollee may request to disenroll from the Demonstration at any time for any reason.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

☑ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

All medically necessary services provided under Medicare Part A, Part B and Part D, and all services provided under Illinois State Plan excluding ICF/MR services, are included in the Demonstration, unless otherwise excluded or limited below. Also included are all Home and Community Based Waiver Services for individuals on the following waivers: Persons who are Elderly; Persons with Disabilities; Persons with HIV/AIDS; Persons with Brain Injury; and Supportive Living Facilities Waiver.

Citation	Condition or Requirement

Special requirements regarding the Medicare hospice benefit:

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

Specific Illinois State Plan services that are excluded include:

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

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

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

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

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

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

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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

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

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

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

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

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

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

OMB #: 0938-0707
Exp. Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Illinois
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Julie Hamos Position/Title: Director, Healthcare and Family Services
Name: Theresa Eagleson Position/Title: Administrator, Division of Medical Programs, HFS
Name: Lynne Thomas Position/Title: Chief, Bureau of All Kids, HFS

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements **(Section 2101)**

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ~ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ~ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. ☒ A combination of both of the above.

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

The State assures that expenditures for child health assistance were not claimed prior to receiving legislative authority to operate the Phase I State Plan and Phase II State Plan Amendment. The Phase I State Plan was approved on 1/5/98 and did not require legislative authority. The Phase II State Plan Amendment was approved on 8/12/98. The State received legislative authority for Phase II on 8/12/98.

1.3 ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

The State assures that it complies with all applicable civil rights requirements, including Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR, part 80, part 84 and part 91, and 28 CFR part 35.

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective Date Phase I: 1/5/98
Effective Date Phase II: 8/12/98
Effective Date Amendment (elimination of 3-month waiting period): 7/1/02
Effective Date Amendment #3 (unborn children): 1/1/03
Effective Date Amendment #4 (eligibility to 200%): 7/1/03
Effective Date Amendment #5 (presumptive eligibility for children): 4/19/04
Effective Date Amendment #6 (fluoride dental varnish): 6/1/05-withdrawn
Effective Date Amendment #7 (rescind amendment #3): 9/1/05- withdrawn
Effective Date Amendment #8 (eligibility to 300%): 7/1/08-pending
(CHIPRA Section 214 option): 4/1/09-pending
(postpartum coverage): 4/1/09-pending
Effective Date Amendment #9 (increased cost sharing): 7/1/12-pending
Effective Date Amendment #10 (cost sharing): 4/1/13
Implementation Date Phase I: 1/1/98
Implementation Date Phase II: 10/1/98
Implementation Date Amendment (elimination of 3-month waiting period): 7/1/02
Implementation Date Amendment #3 (unborn children): 1/1/03
Implementation Date Amendment #4 (eligibility to 200%): 7/1/03
Implementation Date Amendment #5 (presumptive eligibility for children): 4/19/04
Implementation Date Amendment #6 (fluoride dental varnish): withdrawn
Implementation Date Amendment #7 (rescind amendment #3): withdrawn
Implementation Date Amendment #8 (eligibility to 300%): 7/1/08-pending
(CHIPRA Section 214 option): 4/1/09-pending
(postpartum coverage): 4/1/09-pending
Implementation Date Amendment #9 (increased cost sharing): 7/1/12-pending
Implementation Date Amendment #10 (cost sharing): 4/1/13

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

Illinois has chosen to target children who are under the age of 19 and who are from families with incomes at or below 133 percent of the federal poverty level (FPL). Health benefits coverage will be provided to these children through a Medicaid

expansion that will cover children who are between ages 0 and 19 and who are from families with incomes above the March 31, 1997 Medicaid eligibility standard and at or below 133 percent of the FPL. The expansion will serve an additional 40,400 children. Illinois will implement this expansion on January 5, 1998.

Estimated Number of Optional Targeted Low Income Children and Estimated Number of Potentially Medicaid-Eligible Children By Age and Family Income Relative to the Federal Poverty Level: Illinois. 1993 – 1996 Average				
POVERTY LEVEL	AGE			TOTAL
	0 – 5	6 – 13	14 – 17	
186 – 200	2,800	5,400	3,700	11,900
151 – 185	13,300	17,100	11,200	41,600
134 – 150	6,300	8,000	5,300	19,600
100 – 133		17,500	10,600	28,100
50 – 99				
< 50	(52,500)	(40,400)	(12,300	
TOTAL				113,500

Illinois did not identify a reason to further target children by race, ethnicity or geography. In addition, an estimated 105,200 children are potentially eligible for Medicaid (under the income standards in effect March 31, 1997) and will be targeted for enrollment in the Medicaid program through intensive community-based outreach efforts.

These estimates were derived by aggregating the 1993 through 1996 Current Population Surveys and cross-tabulating age (in single years) by income relative to the federal poverty level, controlling for insurance status. Insurance status was determined by an algorithm that combined the responses to several survey items in order to determine that the child was uninsured.

Effective August 12, 1998, Illinois began enrolling children under Phase II of its Children's Health Insurance Program. Phase II expands the new children's health insurance program, KidCare, under Title XXI for children under 19 years of age with family incomes above 133% FPL and at or below 185% FPL.

With the implementation of KidCare, the State has created a continuum of insurance plans with varying degrees of family financial responsibility. In an effort to reduce the stigma of being on Medicaid and to create health plans that resemble the private sector, KidCare includes five plans. These include:

1) **KidCare Assist – Children with family income at or below 133% of the FPL enroll and receive services through the State's Medicaid Program under Title XIX or through the Medicaid Phase I expansion under Title XXI. This program is publicly known as KidCare Assist. No monthly co-payments or premiums are charged under KidCare Assist. This plan is currently in place under the State's approved Medicaid State Plan and Title XXI State Plan.**

2) **KidCare Moms and Babies – Pregnant women and their babies up to age one with family income at 200% of the FPL or less, receive benefits with no monthly premiums or co-payments. This program is publicly known as KidCare Moms and Babies. This plan is currently in place under the State's approved Medicaid State Plan.**

3) **KidCare Share – KidCare Share provides benefits for children with family income over 133% through 150% of the FPL, who are not covered by KidCare Moms and Babies. Under KidCare Share, no monthly premiums are imposed, but modest co-payments for prescriptions, office visits, emergency room visits are required. Co-payments are not required for well-baby visits, well-child visits, or immunizations. This plan is currently in place under the State's approved Title XXI State Plan.**

4) **KidCare Premium – KidCare Premium provides benefits for children with family income above 150% through 185% of the FPL, who are not covered by KidCare Moms and Babies. KidCare Premium imposes modest premiums and co-payments. Co-payments are not required for well-baby visits, well-child visits, or immunizations. This plan is currently in place under the State's approved Title XXI State Plan.**

5) **KidCare Rebate – KidCare Rebate is the fifth plan and is not included under this State Plan. KidCare Rebate is available to those with family income above 133% through 185% of the FPL whose children are insured. KidCare Rebate reimburses part or all of the cost of private health insurance for children.**

The KidCare Share and KidCare Premium Plans provide benefits that mirror the benefits provided for children under the State's approved plan under Title XIX of the Social Security Act, except for home and community-based waiver services and abortion services. KidCare Share and KidCare Premium utilize the same provider

networks, including essential community providers. KidCare Share, KidCare Premium and KidCare Rebate are not considered to be an entitlement.

KidCare Rebate is further encouraging coverage of children from working families by providing an insurance rebate to families who have enrolled their children in employer sponsored or private insurance. The rebate is capped at the average Medicaid payment minus the average KidCare premium. This rebate serves as an "anti-crowd out" strategy to discourage employees from dropping current coverage to take advantage of other KidCare plans. This rebate plan is NOT included in this Title XXI State Plan and the following sections of this State Plan will address only KidCare Share and KidCare Premium. At a later date, the State may amend this plan to seek federal financial participation for portions of KidCare Rebate.

KidCare Moms and Babies is currently operating under Illinois' approved Title XIX State Plan. KidCare Assist is currently operating under the approved Medicaid State Plan and under the approved State Plan for Title XXI.
The Department's original submission of this State Plan estimated that 61,200 children with family income above 133% and at or below 185% of the FPL had no health insurance and would be potentially eligible for benefits under Phase II. The census data provided in the initial Title XXI State Plan may be under-counting the number of uninsured children in Illinois. Around 100,000 children could qualify under Phase II. Because of the unreliability of these estimates, the Illinois *Children's Health Insurance Program Act*, which implemented KidCare, requires the Department to commission a population study to establish regional estimates of the number of children:

1) **with and without health insurance coverage;**
2) **who are eligible for Medicaid;**
3) **who are eligible for Medicaid and enrolled;**
4) **with access to dependent coverage through an employer; and,**
5) **with access to dependent coverage through an employer and enrolled.**

The study shall also attempt to determine, for the population of children potentially eligible for coverage under KidCare:

1) **the extent of access to dependent coverage;**
2) **the extent to which children are enrolled in private coverage; and**
3) **the amount of cost sharing related to such coverage.**

Upon completion of this study, more accurate estimates will be available.

The State estimates that 20,000 children with income between 185% and 200% FPL will be eligible as a result of the fourth amendment to the Title XXI plan.

Effective January 1, 2003, Illinois began covering unborn children whose mothers are not eligible for Medicaid and whose family income is between 0 and 200% of the FPL.

Effective July 1, 2006, the Covering All Kids Health Insurance Act 94-0693 authorized a state funded expansion which eliminated the income limit for KidCare Premium resulting in 7 additional premium levels. The KidCare program was renamed All Kids. KidCare Share became All Kids Share, and KidCare Premium became All Kids Premium Level 1.

Effective July 1, 2011, Public Act 096-1501 eliminated All Kids Premium Levels 3-8, limiting enrollment to children in families with income at or below 300 percent of the federal poverty level.

Effective July 1, 2012, Public Act 097-0689 increased cost sharing for children receiving All Kids Share.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Outreach to low income children and pregnant women for the Medicaid program is conducted the State's Maternal and Child Health (Title V) program in the Illinois Department of Human Services. *The Family Case Management* program conducts outreach and case management activities for low-income families that include a pregnant woman, infant or young child. Medicaid matching funds are claimed for outreach activities and for case management activities conducted with Medicaid-eligible families for Medicaid-covered services. The program has been operating since 1986 and has been a Medicaid-MCH partnership since 1990. The program's current budget is $45.7 million, of which $4.1 million is used for outreach activities.

Family Case Management activities are carried out by local agencies: local health departments, community health centers, other FQHCs and other community-based organizations. "Outreach" activities include any activity to find and inform potential program participants of the health services available through the Medicaid program. Outreach, therefore, can include community campaigns as diverse as door-to-door canvassing, production and

distribution of handbills, design and publication of newspaper announcements, and production and broadcast of public service announcements or paid advertising on radio or television. Projects also target outreach activities to employers that do not offer health insurance coverage for their employees. Presentations are made to church groups, service clubs, and other community groups. Local agencies develop networks of community health care providers, hospitals, clinics, emergency rooms, pharmacies and other agencies to distribute information on the Medicaid program. The primary objective of outreach activities is to inform potential program participants of available services, eligibility criteria and methods of accessing services (for example, the name, address and phone number of the provider). This is not to preclude the use of nontraditional methods of outreach.

Once identified through outreach activities, the Family Case Management program then helps eligible families to enroll in Medicaid. Many of the local provider agencies are also qualified to conduct Medicaid Presumptive Eligibility determinations for pregnant women. The Family Case Management providers either are WIC providers or have a linkage with the WIC Program. WIC identifies potentially eligible Medicaid clients and refers them for eligibility determination. Local providers have also established good working relationships with the eligibility determination staff at local DHS offices and can assist families in making appointments for eligibility interviews and in providing or arranging transportation and child care if necessary.

The Family Case Management program services about 140,000 families each year. This total includes currently Medicaid-eligible families as well as targeted low income children who will become eligible through the Medicaid expansion under Title XXI.

<u>Health care services</u> – The Maternal and Child Health program pays for primary health care services to Medicaid ineligible targeted low income children through two programs: Family Case Management, and a "Maternal and Child Health Mini-Block Grant" to the Chicago Department of Health.

A portion of the grant funds awarded to each Family Case Management agency is earmarked for primary care services. These funds may be used to purchase health care for either pregnant women or children. To use these funds, the family must be ineligible for Medicaid and not have insurance that will cover primary care services. The Chicago Department of Health uses its "Mini-Block Grant" to pay for primary health care services provided

through its community-based clinics to uninsured women of reproductive age (for family planning services), pregnant women (for prenatal care) and children (for pediatric primary care). All of these funds are used only for ambulatory, preventive and primary care; they are not used for specialty or inpatient care. During SFY'97, these programs used $1.6 million to pay for approximately 85,200 pediatric encounters.

In Illinois, 106 FQHC site locations provide medical services to families with little or no income. The FQHC staff identify potentially eligible Medicaid clients and assist them in completing the eligibility process. In 1991, the Department of Healthcare and Family Services implemented procedures for Medicaid eligibility application processing for pregnant and postpartum women and children under age 19 at designated locations other than the local DHS offices. Those locations include FQHCs and disproportionate share hospitals.

In Illinois' continuing effort to improve the health status of school-aged children, the Project Success Program coordinates social and health services with parental involvement in approximately 200 designated school sites throughout the State. Project Success sites refer potentially eligible Medicaid children for eligibility determination. Additionally, sixteen school based/linked clinics provide services to school-aged children, their siblings and preschool aged children in the district. The clinics are required to assess income levels and refer those children who appear to be Medicaid eligible for eligibility determination while at the same time providing needed medical services.

In addition, Illinois has established All Kids Application Agents (AKAAs) that assist families in completing the State's All Kids Application. AKAAs receive a technical assistance payment for each complete application that results in enrollment of children into any of the All Kids plans. Organizations that have been enrolled as AKAAs include hospitals, Federally qualified health centers (FQHCs), local health departments, faith based organizations, Women, Infant and Children (WIC) program sites, Family Case Management agencies, Community Action agencies, Early Intervention agencies, Child Care Resource & Referral agencies, and licensed insurance agents.

Organizations must enter into a written agreement with the State and participate in a training session before becoming a AKAA.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-

private partnership:

The State of Illinois is not directly involved in a public-private partnership concerning health insurance for children. A local public-private partnership, however, operates in suburban Cook County. The Suburban Primary Health Care Council operates the Access to Care Program in suburban Cook County. This public-private partnership includes the Community and Economic Development Association of Cook County, Inc,; the Cook County Department of Public Health; the Northwest Suburban Health Care Council; and the Park Forest Health Department. Approximately 4,500 uninsured or under-insured children from suburban Cook County (outside of Chicago) will be served during 1997.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

Illinois' Title XXI program will be fully integrated with the State's Medicaid program. Procedures currently employed in the Illinois Medicaid program will be used for the identification of third party coverage for optional targeted low income children.

Coordination with public programs is attained through the single application process for all plans. The dual approach of providing eligible children with either All Kids Share and <u>All Kids Premium Levels 1-2</u>, or All Kids Rebate assures coordination with private sector programs.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

As a Medicaid look-alike, the All Kids Share and All Kids <u>Premium Levels 1-2</u> deliver child health assistance through fee-for-service, <u>Primary Care Case</u>

Management and prepaid providers included in the current Illinois Title XIX State Plan and any future approved amendments. Prepaid providers include Health Maintenance Organizations, Managed Care Community Networks. The same methods for assuring the delivery of insurance products and services that are used for Title XIX are used for Title XXI. These methods are covered in detail in the response to 7.1.

Any child who appears to qualify for Family Health Plans coverage under Title XIX and Title XXI up to 200% FPL is determined presumptively eligible for the respective Title XIX and Title XXI program. Presumptively eligible children will receive services through the same delivery system under the applicable state plan and receive the same benefit package as described under the state plan. Services provided after an application is submitted but prior to the determination of presumptive eligibility will be covered as a Health Services Initiative for children determined presumptively eligible under both Title XIX and Title XXI. This Health Services Initiative will be funded under the State's ten percent Title XXI administration cap and will assist in improving the health of children by ensuring that they have access to healthcare services.

Special Health Services Initiative
Illinois will use additional CHIP funds, up to 10 percent of the Federal CHIP expenditures (after administrative costs for the CHIP population for other child health assistance as authorized under 2105(a)(2) of the Act). Such assistance will cover the costs of uncompensated postpartum care for providers who provided services for mothers of newborns deemed eligible for Medicaid. The postpartum services covered are consistent with the comprehensive benefit package provided under Illinois' Medicaid program in terms of the amount, duration and scope of services except as noted in section 6.2.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

All Kids Share and All Kids Premium Levels 1-2 employ all utilization controls from the Title XIX program, including prior approval controls, peer reviews, Medical Management Information System edits, and all existing post-audit and review procedures. Section 7.1 provides a more detailed explanation of these utilization controls.

Section 4. Eligibility Standards and Methodology. **(Section 2102(b))**

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.**

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. ~ Geographic area served by the Plan: **The plan will be statewide.**

4.1.2. ☒ Age: **Under 19 years of age. Effective January 1, 2003, unborn children are included whose mothers are not eligible for Medicaid beginning with the confirmation of the mother's pregnancy.**

4.1.3. ☒ Income: **The child's family income is above 133% and at or below ~~200%~~300% of the federal poverty level net income. Effective January 1, 2003, the family income for unborn children is between 0% and at or below 200% of the federal poverty level. Family income considers all persons living in the household, including those that are not applying for benefits. Certain income that is exempt under Title XIX is exempt under Title XXI. Net income is pre-tax income minus the following disregards if applicable: This includes the exemption of certain employment-related costs: $90 per wage earner or self employment expenses, child care ~~costs~~ expenses up to $175 per child age 2 and older and up to $200 per child under age 2, the first $50 of child support received, the amount of child support paid and earned income of children who are not minor parents.**

4.1.4. ~ Resources (including any standards relating to spend downs and disposition of resources): **No asset limitation is applied. Met spend down cases are not eligible for All Kids Share or All Kids Premium Levels 1-2.**

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in state): **The child must be a resident of the State of Illinois and a U.S. citizen, ~~or~~ qualified alien or otherwise eligible as specified in section 4.1.10 who is lawfully present in the United States. Qualified aliens are non-citizens who meet one of the following categories:**

1) **Unmarried dependent children of a United States Veteran honorably discharged or a person on active military duty,**
2) **Refugees under Section 207 of the Immigration and Nationality Act,**
3) **Asylees under Section 208 of the Immigration and Nationality**

Act,

4) **Persons for whom deportation has been withheld under Section 243(h) of the Immigration and Nationality Act,**
5) **Persons granted conditional entry under Section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980,**
6) **Persons lawfully admitted for permanent residence under the Immigration and Nationality Act, or**
7) **Parolees, for at least one year, under Section 212(d)(5) of the Immigration and Nationality Act.**

~~**A child in categories (6) or (7) above, who enters the United States on or after August 22, 1996, is not eligible for five years beginning on the date of entry into the United States.**~~

4.1.6. ~ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. ☒ Access to or coverage under other health coverage: **Eligibility for benefits will require that:**

1) **The child is not a member of a family that is eligible for health benefits covered under the State of Illinois health benefits plan on the basis of a member's employment with a public agency;**
2) **The child is not found to be eligible for Medicaid under Title XIX.**

4.1.8. ☒ Duration of eligibility: **The duration of eligibility will be for 12 months unless terminated for one of the reasons described below. The twelve months of eligibility commences when the first child in a household is determined to be eligible, not when an additional child is added. Eligibility is determined at least every 12 months. Eligibility is terminated if;**

1. **The child loses his or her Illinois residency,**
2. **The child attains 19 years of age**
3. **The child becomes eligible for and is enrolled in Medicaid under Title XIX,**
4. **The child becomes an inmate of a correctional facility or a patient in a mental institution,**
5. **The child's family becomes eligible for health benefits coverage under a State of Illinois health benefits plan on the basis of a member's employment with a public agency,**
6. **The child is found to have other significant health benefits,**
7. **Applicable premium payments are not made, or**

8. The child's parent or adult who is legally responsible for the child's health care makes a written requested to terminate coverage.

4.1.9. ☒ Other standards (identify and describe): **At the time of application: a) the child is not a patient in an institution for mental diseases, or b) the child is not an inmate of a public institution. In addition, program eligibility is limited by amounts appropriated for All Kids Share and All Kids Premium Levels 1-2. If the plan's enrollment reaches levels that indicate that fiscal year costs for those currently enrolled are approaching the appropriation, the State will stop taking new applications. The State will again take applications once enrollment levels are reduced or funding becomes available. c) the Social Security number or proof of application for a Social Security number must be provided for applicants who are requesting coverage. Individuals on the application that are not requesting coverage are not required to provide Social Security numbers.**

4.1.10 ☒ Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C §1641);

(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA)(8 U.S.C. : §1182 (d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:

(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a respectively;

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and

pending applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(vi) Aliens currently in deferred action status; or

(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. §1158) or for withholding of removal under section 241(b)(3) of the INA (8U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such as applicant under the age of 14 who has had an application pending for at least 180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. §1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

__X__ The State elects the CHIPRA section 214 option for children up to age 19

_____ The State elects the CHIPRA section 214 option for pregnant women through the 60-day postpartum period

4.1.10.1 ☒ The State provides assurance that for individuals whom it enrolls in CHIP under the CHIPRA section 214 option that it has verified, both at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify

satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

A combined application is used for all All Kids plans as described in Section 2.1. Through a single application, children are reviewed for eligibility under all of the five plans and placed into the appropriate plan. If the review finds a child to be eligible under Title XIX, that child is enrolled in a Title XIX funded plan. Applications are reviewed by both local offices and a central processing unit. Face-to-face interviews are not required under any of the All Kids plans.

To determine eligibility for All Kids Share and All Kids Premium Levels 1-2 under Title XXI, the total gross income of the family is counted, less allowable deductions and exemptions as defined in the Title XIX State Plan. For All Kids Share and All Kids Premium Levels 1-2, the Department defines a family as the child applying for the program and the following persons who live with the child:

1) The child's parent(s).
2) The spouse of the child's parent(s).
3) Children under age 19 of the parent(s) or the parent's spouse.
4) The spouse of the child.
5) The children of the child.

The number of persons in the family determines the applicable income standard.

If the monthly countable income of a child is above 133 percent and at or below 150 percent of the Federal Poverty Level for the applicable income standard, the child is enrolled in All Kids Share.

If the monthly countable income of a child is above 150 percent and at or below ~~185~~ 200 percent of the Federal Poverty Level for the number of persons in the income standard, the child is enrolled in All Kids Premium Level 1.

If the monthly countable income of a child is above 200 percent and at or below 300 percent of the Federal Poverty Level for the number of persons in the income standard, the child is enrolled in All Kids Premium Level 2.

All applicants are notified in writing, regarding the outcome of their eligibility determination.

Eligibility determinations made by the fifteenth day of the month are effective in the first day of the following month. Eligibility determinations made after the fifteenth day of the month are effective no later than the first day of the second month following that determination. A child eligible for All Kids Share or Premium Level 1 may obtain coverage for the period of time beginning two weeks prior to the date of initial application and continuing until coverage under All Kids ~~Share or Premium~~ is effective.

~~Monthly~~ Medical identification cards are issued for each family with a child enrolled under All Kids Share and All Kids Premium Levels 1-2.

The duration of financial eligibility for All Kids Share and All Kids Premium Levels 1-2 is 12 months. The 12 months of financial eligibility commences when the first child in a family is covered under a plan. Children added to a plan after the eligibility period begins are eligible for the balance of the 12 month eligibility period. Before any 12 month period of eligibility ends, families are allowed to reapply to determine eligibility for another 12 months.

Illinois is committed to prompt review of All Kids applications. The state standard for approving or denying requests for Medicaid under Title XIX is 45 days. This will also be the target for applications under Title XXI. The Department has established a central unit dedicated to processing All Kids applications and All Kids applications are also processed by eligibility staff working for the Illinois Department of Human Services at 129 local offices throughout Illinois. Most of the increase in applications resulting from All Kids outreach efforts are received centrally in Healthcare and Family Services. The Department has hired 111 permanent and 55 temporary staff for its Bureau of All Kids in Springfield. This fall, a second site opened in Chicago to perform initial data input and currently has 37 staff. The State is committed to increasing staffing further as necessary to handle All Kids applications expeditiously. Note, all eligibility determinations are made by State employees.

The State has also streamlined the eligibility data system to make All Kids eligibility determination processing by the Department significantly more efficient.

4.3.1. Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

~ Check here if this section does not apply to your state.

The State does not have an enrollment cap for state fiscal year 2003. HFS staff monitor All Kids Share and Premium spending and compare spending to appropriated amounts. If spending is at a level close to the level that staff estimate could not be sustained throughout the state fiscal year, the Department will institute an enrollment cap. Similarly, if the Governor's budget office or the legislature directs the Department to reduce All Kids Share and Premium spending because of fiscal problems, HFS will institute an enrollment cap. In either case, the cap will have no effect on current enrollees, unless they leave the program.

If All Kids Share/Premium enrollment approaches levels that cannot be sustained through the end of the year or if the state's fiscal situation requires a slow down in new enrollments, Illinois will stop enrolling children into All Kids Share or Premium until the situation is resolved. Using the public notice timeframe options under Title XXI, Illinois will notify the public before starting an enrollment cap. Public notice of this change would be accomplished through statewide press, All Kids Application Agents, and community partners. Illinois will also notify the Centers for Medicare and Medicaid Services as soon as possible before implementing an enrollment cap. An All Kids Share and Premium enrollment cap would only apply to new enrollees. If such a cap were implemented, those currently enrolled would remain in All Kids Share/Premium as long as they continued to be eligible and met program requirements.

Once new enrollments are stopped, all applications received will be processed and those families determined eligible for Medicaid will be enrolled. Applications for families determined eligible for All Kids Share or Premium will be returned to the families. The State will use the same methods to notify the public when new enrollments begin again.

4.3.2. ☒ Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Children who apply for Family Health Plans coverage under Title XIX and Title XXI are determined presumptively eligible based on family income as reported by the applicant during the application process. This includes all applications for children's health coverage submitted by methods approved by the Illinois Department of Healthcare and Family Services.

Qualified entities determine, on the basis of information submitted by the family as part of an application for children's health coverage, that the gross family income of the child does not exceed applicable income levels under the Title XIX and XXI State Plans. Qualified entities shall include state employees involved in enrolling children in programs under Title XIX and Title XXI of the Social Security Act and may include All Kids Application Agents.

Children whose income is at or below the maximum income level under Title XIX are presumptively eligible under Title XIX. Children with income over the maximum income level under Title XIX and at or below ~~the maximum income level under~~ 200% of the Federal Poverty Level under Title XXI are presumptively eligible for All Kids Share under Title XXI. Both insured and uninsured children may be determined presumptively eligible. For children later identified as having insurance, presumptive eligibility will end for those children when the state determines that they are insured.

Children who are clearly not citizens or qualified aliens, based on information submitted by the family as part of an application for children's health coverage, are not presumed to be eligible. Children whose citizenship or immigration status is unclear are made presumptively eligible. In addition, children who have been made presumptively eligible in the last 12 months are not eligible for a subsequent period of presumptive eligibility. Children who are made presumptively eligible for All Kids Share under Title XXI have no co-payment or premium responsibilities during the presumptive eligibility period. Children with presumptive eligibility receive the full benefit package that is allowed for under the applicable State Plan.

The presumptive eligibility period begins on the date the presumptive eligibility determination is made by the qualified entity. Presumptive eligibility ends when the regular eligibility determination is made by the State and this action is implemented in the system.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-

income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

The single application enrollment process described above only allows those not eligible for Medicaid or those not having creditable coverage to be enrolled into All Kids Share or All Kids Premium plans.

The single application contains a question regarding insurance that must be answered for all children for whom health benefits are requested. When this information indicates that an otherwise eligible child has health insurance, the child is not denied, but is enrolled in All Kids Rebate. The annual review process is very similar to the single application process. The renewal form contains insurance and income questions and individuals are assigned to appropriate plans following the same steps as the single application process.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

The single application process described above assures that all children applying for All Kids are considered for eligibility under Title XIX. Where they are found to be eligible for Medicaid, they are enrolled in All Kids Assist under Title XIX or Title XXI as appropriate. A child who is pregnant at the time of application for All Kids or an infant whose mother is eligible under Title XIX at the time of birth is enrolled in Moms and Babies.

If a child enrolled in All Kids Share or All Kids Premium Level 1 becomes pregnant, she is terminated from either plan and enrolled under Moms and Babies (Title XIX funded) under the following circumstances: 1) upon the request of the pregnant child or her family she is reviewed for Title XIX eligibility, and if found eligible, is enrolled in Moms and Babies; 2) upon reapplication for All Kids Share or All Kids Premium Level 1, a pregnant child is enrolled in Moms and Babies when the 12 month eligibility period for All Kids Share or All Kids Premium Level 1 ends; or 3) upon the family seeking to enroll the infant in All Kids, the State reviews the mother's status and if determined to be eligible under Title XIX, both mother and infant are enrolled in Moms and Babies.

When an All Kids Share or Premium Level 1 enrolled child becomes

pregnant and is therefore likely to be eligible for Medicaid under Title XIX, she will be enrolled in Moms and Babies after her family income has been reviewed to determine that she in fact meets the Moms and Babies financial eligibility criteria. The time it takes to complete the review will depend on the responsiveness of the pregnant girl and her family. Once any necessary information is obtained, the financial review can be completed in a day or two. Once Medicaid eligibility is determined, it may be established retroactively for three months, pursuant to Medicaid policy. She will also be disenrolled from All Kids at that time; therefore, benefits will continue in an uninterrupted fashion.

The State has great concern that coverage not be interrupted because a family fails to provide information necessary to make a determination of the child's eligibility for Medicaid when her eligibility for All Kids Share or Premium Level 1 remains in force. Therefore, the State will maintain the child's enrollment in All Kids Share or Premium Level 1 until either she is enrolled in Medicaid or she is otherwise disenrolled from the program as described in Section 4.1.8. The State will claim FFP under Title XXI for services she receives while she is enrolled in All Kids Share or Premium Level 1.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

The single application process ensures that children who are not eligible for Medicaid are reviewed for eligibility for All Kids Share, All Kids Premium Levels 1-2 and All Kids Rebate before an application is denied.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The State is implementing the State funded All Kids Rebate plan to subsidize employer-sponsored or private insurance. The All Kids Rebate plan serves as a significant "anti-crowd-out" strategy. This plan was designed to bring fairness to families who would be otherwise eligible for All Kids Share or All Kids Premium Level 1, but who, because they made the effort to insure their children, would be ineligible for coverage

under the Children's Health Insurance Program. By providing these families with a subsidy to offset the costs of health insurance for their children, the rebate encourages families to retain their private coverage. The rebate also encourages employers to continue offering coverage to their employees' dependents.

In addition, under All Kids Share and All Kids Premium Level 1, the State utilizes the same methods used under Title XIX to identify any third party payers.

The State will monitor the effect of All Kids on private insurers and modify the program if it appears that, because of availability of All Kids Share and All Kids Premium Level 1, persons or employers are inappropriately dropping privately funded coverage.

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

The incentive for persons or employers inappropriately dropping privately funded coverage is reduced by requiring a waiting period of 12 months following the loss of insurance coverage for All Kids Premium Level 2. The following exceptions to this policy apply:

- **The child lost health insurance when a parent's employment ended;**
- **The child exhausted the health insurance plan's lifetime maximum limit;**
- **The child has or had insurance purchased under the provisions of COBRA in the past 12 months;**
- **The child lost medical benefits under the Family Health Plans (All Kids Assist, Share, Premium Level 1 or Rebate) in the past 12 months; or**
- **The child has health insurance provided by the child's noncustodial parent, and the child's custodian is unable to access such health insurance benefits for the child.**

Children who lost insurance within 12 months of the

application for Premium Level 2 because a parent lost employment are reviewed at the first renewal to determine if affordable health insurance is available. At the renewal, the family is asked to complete a questionnaire regarding the availability and cost of group health insurance that may be available to them. If insurance is available, the Department compares the total monthly cost of the insurance premiums for all children in the family unit to the family's monthly income. If the insurance cost is equal to or less than 3% of the family's income, the insurance is determined affordable and the child is not renewed for All Kids Premium Level 2.

In addition, under All Kids Premium Level 2, the State utilizes the same methods used under Title XIX to identify any third party payers.

The State will monitor the effect of All Kids on private insurers and modify the program if it appears that, because of availability of All Kids Premium Level 2, persons or employers are inappropriately dropping privately funded coverage.

4.4.4.3. ☒ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

The incentive for persons or employers inappropriately dropping privately funded coverage is reduced by requiring a waiting period of 12 months following the loss of insurance coverage for All Kids Premium Level 2. The following exceptions to this policy apply:

- **The child lost health insurance when a parent's employment ended;**
- **The child exhausted the health insurance plan's lifetime maximum limit;**
- **The child had or has insurance purchased under the provisions of COBRA in the past 12 months; or**
- **The child lost medical benefits under the Family Health Plans (All Kids Assist, Share, Premium Level 1 or Rebate) in the past 12 months;**
- **The child has health insurance provided by the child's noncustodial parent, and the child's custodian is unable to**

access such health insurance benefits for the child.

Children who lost insurance within 12 months of the application for Premium Level 2 because a parent lost employment are reviewed at the first renewal to determine if affordable health insurance is available. At the renewal, the family is asked to complete a questionnaire regarding the availability and cost of group health insurance that may be available to them. If insurance is available, the Department compares the total monthly cost of the insurance premiums for all children in the family unit to the family's monthly income.

Premium Level 2- If the insurance cost is equal to or less than 3% of the family's income, the insurance is determined affordable and the child is not renewed for All Kids Premium Level 2.

In addition, under All Kids Premium Level 2, the State utilizes the same methods used under Title XIX to identify any third party payers.

The State will monitor the effect of All Kids on private insurers and modify the program if it appears that, because of availability of All Kids Premium Level 2, persons or employers are inappropriately dropping privately funded coverage.

4.4.4.4. ~ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Any American Indian or Alaska Native child who applies for All Kids and who meets the eligibility requirements will be enrolled in All Kids. No premiums or co-payments are required for American Indian or Alaska

Native children.

There is a single American Indian health center in the State, which is located in Chicago. This health center is recognized as a Federally Qualified Health Center (FQHC) under the Department's Title XIX program. The facility provides primary care services and makes referrals for other services. At the inception of All Kids, the Department consulted with this facility concerning All Kids outreach and enrollment strategies that would be appropriate for reaching American Indian Children.

Subsequent attempts to solicit input from American Indian groups have been unsuccessful.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

Illinois will conduct an outreach campaign and target an enrollment strategy to children throughout the State who are likely to be eligible either for Medicaid under Title XIX or for expanded Medicaid under Title XXI. This strategy will encourage these children to enroll, utilize and stay in the health care system. This will be achieved in the following manner:

1) **Healthcare and Family Services (HFS) will review its automated records and notify the families of eligible children who are currently in the Medicaid system as unmet spenddown of their eligibility under the new income thresholds and will enroll the children.**

2) **HFS will develop a new simplified application process and the procedures to support widespread offsite enrollment.**

3) **MPE and MCH offsite enrollment sites including FQHCs, disproportionate share hospitals, local health departments and WIC sites will be utilized to conduct offsite enrollment of uninsured children into the new program.**

4) **County health departments, Family Case Management and WIC sites will be asked to utilize existing records on the Cornerstone system of the Department of Human Services to review their records and identify children who are in their programs and likely to be eligible for health benefits**

coverage.

5) HFS will send a notice to all non-assistance Child Support families informing them of the program and of locations where the family could enroll the child.

6) Outreach will be coordinated with the Illinois child care resource and referral networks and larger child care of Head Start providers.

7) School districts will be recruited for identifying children likely to be eligible for health benefits coverage, and wherever possible, offsite enrollment, according to the school census of the number of children receiving free and reduced cost lunch. This will be coordinated with Project Success and School Attendance Initiative sites.

8) Special efforts will be made to identify eligible:

a) migrant children through community agencies such as the Illinois Migrant Council or migrant health clinics;
b) homeless children through community-based organizations such as those who provide shelter or emergency food services, and clinics which target these populations;
c) children with special health care needs through the Division of Specialized Care for Children and through children's hospitals; and,
d) children in rural areas through the efforts of county health departments, rural health clinics and FQHCs.

9) Community-based organizations will be asked to disseminate information about the program and the referral process to potentially eligible families. These organizations include, but are not limited to:

- **Project SUCCESS sites;**
- **Places of worship;**
- **Day care facilities, Child Care Resource and Referral Networks;**
- **Early Intervention sites;**
- **Head Start, Early Head Start sites;**
- **Community-based organizations (YWCA, etc.); and**
- **HFS's Neighborhood Education Contractors**

10) Other efforts to promote the program will include a program fact sheet and a provider notice explaining the new eligibility levels and a listing of enrollment sites.

In addition to the tasks already described, Illinois is conducting an outreach

campaign to increase public awareness of the State's health care programs for children. The campaign has been developed with the assistance of the Outreach Advisory Committee. This committee includes representatives from social services agencies, churches, schools, provider groups, community groups, fraternal organizations, local government employer groups, HCFA and State agency personnel.

This outreach campaign is designed to reach eligible children in All Kids Share, All Kids Assist, All Kids Premium, Moms and Babies and All Kids Rebate. Outreach to all of these plans will be accomplished by 1) identifying targeted populations; 2) publicizing the available benefits; 3) motivating families to take advantage of available plans; and 4) providing applications and assisting people with the application process. The enrollment process itself is more accessible and streamlined by expanding the number of offsite enrollment locations, using a combined application for all plans, and through the use of mail-in applications. Through this coordinated approach, all outreach efforts target all children potentially eligible under both Titles XIX and XXI.

Other specific outreach activities that are being implemented include the following:

1. **Distribute informational brochures and implement a toll-free number for interested parties to learn more about the plans and receive assistance in completing and submitting applications;**

2. **Develop a media campaign to promote public awareness of the plans. The campaign will include radio, print and promotional advertising. The State is investing considerable resources into making materials attractive, interesting and easy to follow;**

3. **Educate employers, unions and trade associations about the plan;**

4. **Establish strong community outreach through churches, immigrant organizations and community based organizations. Medical providers, including doctor's offices, local health departments, emergency rooms, Federally Qualified Health Centers and Rural Health Clinics are also being enlisted. To assist community providers, the Department has developed an income screening tool that persons in the community can use to determine whether families appear to be eligible for All Kids and for which plan they may be eligible;**

5. **Complete an electronic cross-match of participants in the WIC, school lunch and child care programs to identify families who meet the income criteria for All Kids, but have not enrolled. Families in an unmet spend-down status are**

invited to apply;

6. **Pilot the use of eligibility for the free lunch program as a determination of presumptive eligibility for All Kids Assist;**

7. **Establish educational partnerships to assist the State in promoting public awareness of All Kids. Such partnerships will include Americorp and Vista programs, Headstart programs, Project Success (a program that coordinates social services through local schools), and coordination with the Illinois Departments of Human Services, Commerce and Community Affairs, Aging, Natural Resources, Revenue, and the State offices of Secretary of State, Attorney General and Comptroller, as well and through legislative offices.**

8. **Therefore, the Department may release a Request for Proposals to contract with multiple entities to identify and implement creative outreach strategies to locate and enroll identified hard-to-reach populations that may be eligible for All Kids and Medicaid. If implemented, the Department will provide multiple small grants for this project and has committed up to $500,000 in total spending. Hard-to-reach populations that may be targeted through these grants include:**

   a) **Children in families with limited English proficiency and other language barriers such as illiteracy;**
   b) **Children with special needs. This includes children who are visually impaired, hearing impaired, and children with other chronic conditions such as emotionally, physically, or developmentally challenged children;**
   c) **Families who are difficult to reach because of various cultural barriers;**
   d) **Families who have multiple jobs;**
   e) **Families whose members are healthy and are, therefore, not motivated to apply for health insurance coverage;**
   f) **Families residing in rural areas of the State where medical provider services are limited or non-existent;**
   g) **Migrant children;**
   h) **Homeless children; and**
   i) **Other hard-to-reach populations that may be defined by the contractors.**

9. **Effective April 12, 1999, the State began reimbursing All Kids Application Agents $50 for each completed All Kids application that results in enrollment in the program.**

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.**

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ~ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ~ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ~ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ~ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☒ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

The benchmark plan is actuarially equivalent to the State employees group health plan. The actuarial report is attached.

6.1.3. ~ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."

6.1.4. ~ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ~ Comprehensive coverage for children under a Medicaid

Section 1115 demonstration project

6.1.4.3. ~ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ~ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ~ Coverage that is the same as defined by ☐existing comprehensive state-based coverage☐

6.1.4.6. ~ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ~ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

All Kids Share and All Kids Premium Levels 1-2 mirror the benefits of the Medicaid program in terms of the amount, duration and scope of services covered, except as noted below. The only exceptions are that home and community-based waiver services that are provided to Medicaid eligible persons as an alternative to institutionalization are not a part of All Kids Share or All Kids Premium Levels 1-2, and no abortion services are included. All Kids Share and All Kids Premium Levels 1-2 include the following services in all primary, preventive, acute and chronic circumstances:

6.2.1. ☒ Inpatient services **(Section 2110(a)(1))**

6.2.2. ☒ Outpatient services **(Section 2110(a)(2)), including emergency services**

6.2.3. ☒ Physician services **(Section 2110(a)(3))**

6.2.4. ☒ Surgical services **(Section 2110(a)(4))**

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**

6.2.7. ☐ Over-the-counter medications **(Section 2110(a)(7)) Over-the-counter medications are only covered if prescribed by a physician.**

6.2.8. ☒ Laboratory and radiological services **(Section 2110(a)(8))**

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies **(Section 2110(a)(9))**

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18. **(Section 2110(a)(10))**

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19. **(Section 2110(a)(11)**

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

6.2.13. ☒ Disposable medical supplies **(Section 2110(a)(13))**

6.2.14. ~ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

All services available under the State's Title XIX State Plan that are provided to participants of home and community based waivers are included under All Kids Share and All Kids Premium Levels 1-2. Only the specialized services unique to these waivers are excluded from these plans. The waiver programs themselves have been specifically excluded for the following reasons:

1) All Kids Share and All Kids Premium Levels 1-2 are designed to be broadly applicable and are not intended to focus on the unique circumstances addressed through the home and community based waivers;

2) Each of the waiver programs have specialized eligibility objectives, several of which include income standards above those allowed under All Kids Share and All Kids Premium Levels 1-2; and

3) All of the waiver programs have enrollment caps.

6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**

6.2.16. ~ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

No abortion services are covered by All Kids Share and All Kids Premium Levels 1-2. A child who is pregnant when she applies is not enrolled in these plans but instead enrolled under Title XIX if income is at or below 200% of the FPL. If a child who becomes pregnant while she is enrolled under All Kids Share or All Kids Premium Level 1 chooses to have an abortion, she must enroll under Title XIX to have abortion services covered. Abortion service limitations are defined in

the Illinois Medicaid State Plan.

6.2.17. ☒ Dental services **(Section 2110(a)(17))**

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. ☒ Case management services **(Section 2110(a)(20))**
Limited to children diagnosed with mental illness and children under the age of three who are receiving early intervention services.

6.2.21. ~ Care coordination services **(Section 2110(a)(21))**

6.2.22. ☒ Physical therapy, occupational therapy, speech therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

6.2.23. ☒ Hospice care **(Section 2110(a)(23))**

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

Home health care services
Audiology services
Optometric services
Family planning services
All EPSDT services
Chiropractic services
Podiatric services
Renal dialysis
Services of Intermediate Care Facilities for the Mentally Retarded,
skilled pediatric nursing facility services
Early Intervention services, including case management, for children who meet eligibility requirements established in the State's approved plan pursuant to Part C of the Individuals with Disabilities Education Act

6.2.25. ~ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))** **Non-emergency medical transportation is limited to children in All Kids Share and All Kids Premium Level 1.**

6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services) (See instructions) **(Section 2110(a)(27))**

6.2.28. ~ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ~ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ~ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system**. **The state may cross reference section 6.2.1 - 6.2.28.** **(Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers

receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** **(Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ~ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

The Department will submit a separate amendment regarding family coverage. Any questions related to family coverage will be addressed in that amendment.

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2 The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

Not applicable at this time.

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

~ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

The Department has established access to quality care, and the appropriateness of care, as performance measures for All Kids Share and All Kids Premium Levels 1-2. These performance goals and methods of assuring their attainment are more fully

described in Section 9. Methods to measure quality and appropriateness of care include the following:

Managed Care

For clients enrolled in managed care, the Department establishes and provides monitoring and oversight to ensure that quality control requirements are met. Managed Care Entities (MCEs) are required to have a quality assurance system in place that focuses on quality improvement. System activities include:

- **Collecting systematic data on performance and patient results;**
- **Monitoring health care services through medical records review, clinical studies, physician peer review, and monitoring of health outcomes;**
- **Developing and monitoring of health education and outreach for clients**
- **Establishing and monitoring member services to handle client issues;**
- **Establishing mechanisms for preauthorization and review of denials;**
- **Monitoring access standards;**
- **Monitoring fraud and abuse;**
- **Establishing and monitoring a client grievance and complaint resolution system;**
- **Evaluating client satisfaction;**
- **Providing information to providers, evaluating provider satisfaction and resolving provider concerns; and**
- **Establishing procedures for ongoing quality improvement with written procedures for taking appropriate remedial action and correcting deficiencies.**

The Department has established quality control mechanisms for managed care which include ongoing monitoring of contract compliance, including the areas of covered services; service delivery; access standards; health education and outreach; pharmacy formulary; linkages to other services; records requirements; care standards; encounter reporting on encounters and quality assurance/improvement activities; marketing; member services; health outcomes, including measuring HEDIS indicators; minimum required performance standards; and financial stability. The Department contracts with a Quality Assurance Organization to assist in the oversight of managed care under both Title XIX and Title XXI. The Contractor's responsibilities include but are not limited to, medical records review, technical assistance, health outcome analysis and quality assurance monitoring of each managed care entity.

Primary Care Case Management (PCCM)

For client enrolled in PCCM, the Department has established and provides monitoring and oversight to ensure that the quality improvement initiatives and outreach and education efforts for both client and providers under the contract are met.

Client Initiatives
- Educating clients on the importance of EPSDT appointments
- Assisting clients that are due for a Healthy Kids checkup with making an appointment with their PCP.
- Sending annual reminder notices (based on recipient's birthday) for Healthy Kids appointments due.
- Performing outreach to clients who missed appointments.
- Assisting parents in finding primary care providers and specialists for their children through the Illinois Health Connect Client Helpline.
-Evaluating Client Satisfaction.

Provider Initiatives
- Providing providers with access to the following Quality Improvement Tools to assist providers in improving quality for clients: Monthly Panel Rosters, Claims History Report, Semi-annual Provider Profiles, and a Bonus for High Performance program.
- Quality Assurance Nurses in the field meeting with providers to discuss their provider profiles and to help connect providers to various resources.
- Provider Service Representatives in the field working with providers on a one-to-one basis through outreach and education efforts. The education efforts are necessary to assist providers in understanding the components and frequency of well-child exams under EPSDT, appropriate billing and coding for preventive care, and resources available to coordinate care for kids.
- On-going communication and feedback from providers through training initiatives, committee meetings, webinar sessions, pilot projects, and conducting provider satisfaction surveys.

Fee-For-Service
Quality assurance mechanisms in the fee-for-service Medicaid system are listed below. These are employed under fee-for-service for All Kids Share and All Kids Premium Levels 1-2. Through these mechanisms, quality problems are identified and addressed. Providers found to have quality problems are asked to prepare quality improvement plans.

1. **Staff from the Division of Medical Programs watch for provider abuses of the Medicaid system. Such abuses are referred to the Office of the Inspector General (OIG) for review.**
2. **OIG has many tasks to assure medical quality.**
   a. **Face-to-face client surveys regarding quality of care and access to care.**
   b. **Investigations of referrals from within HFS; the Department of State Police; the Department of Public Health; and from the state's peer review organization.**
   c. **Audits of providers who fall outside accepted norms for claims activity.**

d. Peer review coordination of medical necessity and over-utilization issues.

3. **The state's Medical Management Information System (MMIS) includes many edits to prevent abuse and excessive billings. New ones are created regularly.**
4. **HFS operates a toll-free hotline for clients to report any problems or concerns they may have.**
5. **The Department's peer review organization, conducts prepay and postpay medical records reviews on certain hospital inpatient and outpatient claims.**
6. **Special reviews are conducted on pharmacy claims to identify duplicate therapy, refill-too-soon, potential drug interactions, and abnormal dosages. Prior approval is required for high risk medication and drugs likely to be abused.**
7. **Prior approval is required for durable medical equipment and many medical supply items.**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards

The Department has established quality control mechanisms, including the monitoring of contract compliance, covered services, service delivery, access standards, health education and outreach, coordination with other services, and quality assurance and improvement activities. Specific goals for maintaining quality standards and measures of their attainment are described in Section 9.

7.1.2. ☒ Performance measurement

Performance measures include improving the health status of children by reducing infant mortality, lead poisoning, and school absenteeism; extending health coverage to more Illinois children; and assuring appropriateness of, and access to, necessary health care. These performance measurements and specific criteria for assessing their attainment are more fully described in Section 9.

7.1.3. ☒ Information strategies

The Department is expanding its client health care hotline and promoting the hotline as a place for families to call with concerns and questions. The Department is also incorporating a satisfaction survey for families participating in All Kids. Under both of these efforts, information is being collected and used to directly monitor and improve health care access and quality.

7.1.4. ☒ Quality improvement strategies

The Department is establishing procedures for ongoing quality improvement in written procedures for taking appropriate remedial action and correcting deficiencies.

7.2. Describe the methods used, including monitoring, to assure access to covered services, including a description of how the state will assure the quality and appropriateness of the care provided. The state should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care: **(2102(a)(7)(B)) (42CFR 457.495)**

In addition to the methods described in Sections 7.2 and 9, the State maintains a toll-free telephone hotline that provides assistance in explaining programs and benefit coverage, completing applications for assistance, locating providers for health care services, and allows recipients to identify any problems, including accessing health services and emergency room services. The Department also uses surveys to identify patterns that may be indicative of problems in accessing necessary medical services. The Department believes the State's current Medicaid network is adequate to add an additional 100,000 children. However, to increase access even further, the Department has significantly reformed its payment methodology for outpatient and physician services, effective July 1, 1998. To more accurately reflect the resources used in outpatient services, the Department increased from four to twelve the number of reimbursement groupings. Along with the increase in reimbursement groups, total reimbursement rates on outpatient services were increased by 42%. The Department has also significantly increased physician reimbursement rates. Overall the Department increased physician rates by 10% with certain basic procedures receiving increases as high as 61%. Dental rates have also been increased an average of 50%.

The Department closely monitors provider capacity in order to assure appropriate access. Initiatives undertaken to increase provider capacity and access include:

- **contracting with a physician referral provider in portions of Cook County and surrounding counties;**
- **FQHC rate increases;**
- **Physician referrals through the All Kids hotline; the hotline handles approximately 1,000 physician referral calls a month;**
- **continued support of the American Academy of Pediatrics project to educate pediatricians and pediatric office staff about All Kids in order to encourage them to enroll with All Kids; and**
- **increased dental rates and an improved dental referral system with Doral Dental.**

The State employs staff specialists to recruit and provide technical assistance to medical providers. A provider hotline answers questions and provides member eligibility information and preventive health profiles, listings of preventive health services received by covered patients, upon request. Provider Handbooks and notices are available in hard copy and on the Healthcare and Family Services' website.

Access to services is further assured through freedom of choice of providers in the fee-for-service delivery system. Managed care is voluntary in ~~three~~ 16 of the 102 counties in the State.

The State collaborates with provider organizations representing physicians and other providers of care. Provider organizations inform their membership of State initiatives and encourage participation.

The following table displays estimates of average payments that are made by the State All Kids Share and All Kids Premium Level 1:

Healthcare and Family Services
Sample of Average Weighted Payments per Service
For Children 0-18 (Adjusted to FY'99 Dollars)

	Liability	Services	Avg Payment
Physicians	**$ 1,375,679**	**58,190**	**$ 23.64**
Other Practitioners	**50,750**	**3,046**	**16.66**
Hospital Inpatient	**16,592,020**	**3,256**	**5,095.83**
Hospital Outpatient	**125,385**	**4,850**	**25.85**
Prescribed Drugs	**3,293,634**	**149,441**	**22.04**
Com. Hlth Centers	**953,423**	**26,799**	**35.58**
Home Health Care	**1,373,824**	**4,528**	**303.41**
TOTAL	**$23,764,715**	**250,110**	**$ 95.02**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

In addition to the methods described in Sections 7.2 and 9, the State pays enhanced rates for certain maternal and child health services to providers who meet certain participation requirements.

Healthcare and Family Services collaborates with sister agencies on initiatives related to access to care for children. The Department of Human Services provides case management services, including assisting participants in accessing health care services, to pregnant women and families of infant and high risk older children who are eligible for All Kids. Children who receive WIC services are referred for preventive and primary care. The Department works in cooperation with the Department of Public Health to ensure a

coordinated effort at increasing the rate of childhood immunizations, lead screening, lowering infant mortality and improving birth outcomes.

As detailed in Section 9, the State measures its performance in several key preventive areas for children, including, but not limited to percent of children with an identified primary health care provider, rate at which primary and preventive health care providers participate in the program, EPSDT participation rate, immunization rate, lead screening rate, rate of ambulatory sensitive hospitalizations, and rate of enrolled pregnant teens delivering a very low birth weight baby.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR §457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

The same methods used for assuring access to covered services in Title XIX are used in Title XXI. The State has adopted the definition of emergency services assigned in 42CFR 457.402 in Title XIX and Title XXI. No prior authorization is required for emergency services.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

Under the fee-for-service delivery system, enrollees may see any enrolled provider. The State's managed care contract specifically addresses complex and serious medical conditions as well as access/timeliness standards. Managed care contractors are required to provide covered services, which could mean making referrals to out-of-network providers when the network is not adequate for the enrollee's condition. The methods used to monitor access to services are described in 7.1.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

The State assures that decisions on services requiring prior authorization are made within 14 days after receipt of a request for services in the managed care delivery system. In the fee-for-service delivery system, the State renders decisions within 21 or 30 days as required by Administrative Rules and

consent decrees for all services other than pharmaceuticals. There is a process in place for expedited approvals whereby decisions must be made within twenty-four hours of receipt.

Section 8. Cost Sharing and Payment (Section 2103(e))

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.**

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☒ **YES, All Kids Share and All Kids Premium Levels 1-2 impose cost sharing under this plan. Coverage for unborn children does not impose any cost sharing.**

8.1.2. ~ NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: **A family with a family income above 133% and at or below 150% of the FPL (All Kids Share) has no premium requirements, as required by federal law. A family with an income above 150% through 200% of the FPL (All Kids Premium Level 1) is charged a monthly premium of $15 for one child, $25 for two children, ~~and~~ $30 for three ~~or more~~ children, $35 for four children and $40 for five or more children.**

A family with an income above 200% through 300% of the FPL (All Kids Premium Level 2) is charged a monthly premium of $40 for one child and $80 for two or more children.

8.2.2. Deductibles: **None.**

8.2.3. Coinsurance or co-payments: **Co-payment requirements under All Kids comply with federal regulations.**

A family with a family income above 133% and through 150% of the FPL (All Kids Share) has ~~a $3.65 $2 co-payment for medical visits, $2 $0 co-payment for generic and $3.65 $2 co-payment for brand prescriptions.~~ the following co-payents:

- **Co-payments for practitioner office visits, outpatient hospital**

encounters and a 1-day to 30-day supply of brand name prescription drugs shall be adjusted annually and shall be equal to the nominal co-payment amount under Title XIX of the Social Security Act as defined in 42 CFR 447.54 and which, for federal fiscal year 2013, is $3.90;

- **Co-payment per prescription for a 1-day to 30-day supply of generic drugs, including over-the-counter drugs, is $2.00;**
- **Co-payment for inpatient hospitalization is a daily amount equal to the non-institutional nominal rate under Title XIX of the Social Security Act as defined in 42 CFR 447.54 which shall not exceed the institutional rate in 42 CFR 447.54, and which, for federal fiscal year 2013, is $3.90; and**
- **There is no co-payment for emergency room.**

A family with an income above 150% through 200% of the FPL (All Kids Premium Level 1) has ~~a $5 co-payment for medical visits, a $3 co-payment for generic and $5 co-payment for name brand prescriptions, and a $25 co-payment for non-emergency use of the emergency room.~~ the following copayments:

- **Co-payments for practitioner office visits, outpatient hospital encounters and a 1-day to 30-day supply of brand name prescription drugs are $5.00;**
- **Co-payment for inpatient hospitalization is $5.00 per day;**
- **Co-payment per prescription for a 1-day to 30-day supply of generic drugs, including over-the-counter drugs, is $3.00; and**
- **Co-payment for non-emergency use of the emergency room is $25.00.**

A family with an income above 200% and through 300% of the FPL (All Kids Premium Level 2) has a $10 co-payment for medical visits, a $3 co-payment for generic and $7 for brand name prescriptions, $100 per inpatient hospital admission, $30 per emergency room visit and 5% of the All Kids payment rate for outpatient hospital services.

All families have an annual copayment cap for all copayments; the copayment caps are listed by program level below.

- **All Kids Share and All Kids Premium Level 1 is $100 per family;**
- **All Kids Premium Level 2 is $500 per child for hospital services;**

No copayments are charged for well-baby, well-child, or immunization services in any plan. In addition, no copayments are charged for visits to health care professionals or hospitals solely for lab or radiology services or routine

preventive and diagnostic dental services. American Indian/Alaska Native children are not required to make copayments or pay premiums.

8.2.4. Other: ~~**Co-payment requirements under KidCare comply with federal regulations. A family with a family income above 133% and below 150% of the FPL (KidCare Share) has a $2 co-payment for medical visits and prescriptions, including use of the emergency room. A family with an income above 150% through 200% of the FPL (KidCare Premium) has a $5 copayment for medical visits, a $3 copayment for generic and $5 co-payment for name brand prescriptions, and a $25 copayment for non-emergency use of the emergency room. No copayments are charged for well-baby, well-child, or immunization services in any plan. In addition, no copayments are charged for visits to health care professionals or hospitals solely for lab or radiology services or routine preventive and diagnostic dental services. American Indian/Alaska Native children are not required to make copayments or pay premiums.**~~

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

Potential enrollees are notified of cost sharing requirements during the enrollment process and through outreach efforts. The combined application and the Fact Sheet describe cost-sharing requirements. The application requires applicants to attest that they understand and will comply with the requirements. The All Kids brochure and Member Handbook both describe cost-sharing requirements, including the cumulative maximum. All of these documents are available in hard copy form and on the All Kids website, www.allkids.com

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and**

457.505(e))

~~**With a maximum premium of thirty dollars per month, or $360 per year, and a copayment cap of $100 per year, the maximum cost sharing that can ever be imposed equals $460 per year. The $460 limit does not mathematically approach 5% of an eligible family's income under KidCare. This can be illustrated by applying the maximum total cost sharing against the minimum income possible under KidCare Share.**~~

~~**The minimum annual income for a child qualifying under KidCare Share is $11,784 (2002 FPL for a family of one ($8860) multiplied by 133%). The $460 maximum cost sharing represents 3.9% of the person's income. This example is used only as an illustration, since no premiums would be imposed at this income level.**~~

~~**The State's $100 annual cap for on family copayments is tracked by each family. Once a family has paid $100 in copayments within a year, the family submits receipts to the State. The State then confirms the cap was reached by tallying the receipts submitted and immediately generates a written notice to the family. Such a designation is made on a client data system and the family's next monthly medical card indicates that they have reached the copayment cap. The Department's Recipient Eligibility Verification system is also updated to reflect that the copayment cap has been reached. Families that make a copayment before they receive notification from the Department may recover their copayment from the provider.**~~ **All Kids copayment limits for Share and Premium Levels 1 are established as a family cap for all individuals, both children and adults, who are enrolled in All Kids or FamilyCare coverage of parents and other caretaker relatives. Copayment limits for children enrolled in All Kids Premium Level 2 are established by individual child.**

All copayment caps are set low enough to assure that very few, if any, families would ever come close to paying 5 percent of income for a child's medical care during the child's 12 month period of eligibility. In addition, to account for the rare possibility that copayments for a child's care could exceed the cap, all families receive information at enrollment and at any time that cost sharing for the child changes such as at the annual renewal, of both their cost sharing obligations and copayment annual limits. Families receive a co-pay tracking form with instructions for collecting all receipts and listing co-payments. When the limit is reached, the family sends the copay tracking form with receipts to the All Kids unit for processing.

Upon receiving the copayment tracking form and receipts from a family, the All Kids Unit confirms the cap was reached by tallying the receipts submitted and immediately generates a written notice to the family. Such a designation is also made in the data system. The Department's electronic eligibility verification systems are updated to reflect that the copayment cap has been reached. Families that make a

copayment before the system is updated or before they receive notification from the Department may recover their copayment from the provider.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

The All Kids application contains a question on race/ethnicity with a check box for American Indian/Alaska Native. If this box is checked, the children will be coded in the Department's system as American Indian/Alaska Native. This coding ensures that no co-payment messages appear on the medical card. All AI/AN families are notified that they are not required to pay co-payments or premiums. Health care providers have been notified that they are not required to pay co-payments or premiums. All Kids outreach materials, including the application, brochure, and fact sheet state that co-payments and premiums are not required for AI/AN children. The Member Handbook also includes this information.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

Co-payments are optional on the part of providers. Many providers do not impose co-payments, including managed care organizations. However, if an enrollee refused to pay a co-payment, the provider can refuse to provide services. Providers are paid for covered services using established rates minus the copayment for All Kids Share, Premium Level 1 and Premium Level 2.

If an enrollee fails to pay a premium for 2 months, the All Kids premium case is cancelled. Once cancelled, the family is not eligible for All Kids Share, Premium or Rebate for 3 months. After the 3-month period, the family can reapply and, if eligible, must pay any unpaid premiums and the first month's premium before they can again receive benefits.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**

Upon approval for All Kids Premium Levels 1-2, a statement is sent informing the family of the monthly premium amount, the due date, and the children covered. The initial statement informs the family that

the premium must be paid even if the children do not receive services during the month of coverage. Statements are sent to families monthly. If an account becomes past due, the message on the monthly statement changes. If an account is 31-60 days past due, the statement (which is mailed on the 5th day of the month) informs the family that the premium must be paid by the end of the month to avoid cancellation of insurance coverage. If an account is more than 61 days past due, the statement informs the family that the account will be turned over to a collection agency if payment is not received by the end of the month. In reality, if payment is received and posted by the 10th of the following month, the coverage will continue.

The All Kids Member Handbook includes information on the consequences of not paying premiums.

☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**

Upon approval and at annual renewal, families receive a notice that informs them that they can report decreases in family income. The All Kids Member Handbook also encourages families to report decreases in income. If, during the disenrollment process, the family reports a decrease in family income, the case will be reviewed to assess whether the family will be eligible for a plan with less or no cost sharing.

☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**

If a decrease in income is reported by the family, the child's eligibility will be reviewed and the child will be enrolled in All Kids Assist, All Kids Share or All Kids Premium Level 1, depending on family income, and continued eligibility. All Kids Assist requires no cost sharing, All Kids Share requires minimal co-payments and All Kids Premium Levels 1-2 require a small monthly premium and co-payments based on family income.

☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

As described in Section 12.1, enrollees are afforded the opportunity for an impartial review on eligibility and enrollment matters.

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

Illinois has established five strategic objectives:

1. **Improve the health status of Illinois' children;**
2. **Extend health benefits coverage to optional targeted, low income children;**
3. **Improve access to quality health care for optional targeted low income children enrolled in the Title XXI program;**
4. **Assure appropriate health care utilization by optional targeted low income children enrolled in the Title XXI program; and**
5. **Implement a statewide outreach and public awareness campaign regarding the**

importance of preventive and primary care for well-children and the availability of health benefits coverage through XXI.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

1. Improve the health status of Illinois' children.
1.1 Reduce the infant mortality rate.
1.2 Reduce the prevalence of childhood lead poisoning exceeding 25mg/dL.
1.3 Reduce school absenteeism in grades K-8.

2. Extend health benefits coverage for optional targeted low income children.
2.1 By January 1, 2000, increase the percentage of children enrolled in the program who are eligible at the Medicaid standard in effect on March 31, 1997. Illinois will conduct a baseline survey. For this calculation, an unduplicated count of children enrolled at any time during calendar year 1999 will be compared to the number enrolled during the baseline year. The performance goal will be to enroll one-third of the number of children identified by the survey as eligible but not enrolled.
2.2 By January 1, 2000, enroll in Title XXI at least 50 percent of the estimated 40,400 optional targeted low income children with family income above the Medicaid standard in effect on March 31, 1997, but at or below 133 percent of the FPL.
2.3 By January 1, 2000, it is the State's goal to enroll in All Kids at least 50 percent of the children whose family income is at or below 185% of the FPL. The actual number of children represented within this goal will be determined upon the completion of the population study described in Section 2.1.

2.4 By January 1, 2000, enroll in Title XXI at least 50 percent of the estimated 40,400 optional targeted low income children with family income above the Medicaid standard in effect on March 31, 1997, but at or below 133 percent of the FPL.
2.5 By January 1, 2000, it is the State's goal to enroll in All Kids at least 50 percent of the children whose family income is at or below 185% of the FPL. The actual number of children represented within this goal will be determined upon the completion of the population study described in Section 2.1.

2.6 By January 1, 2000, reduce the rate per year of hospitalizations of enrolled children for the ambulatory care sensitive conditions of childhood asthma and dehydration/non-infectious gastroenteritis as compared to the baseline population.

2.7 By January 1, 2000, reduce the rate of enrolled pregnant teens who deliver a very low birthweight baby as compared to the baseline population.

3. Improve access to quality health care for optional targeted low income children enrolled in the Title XXI program.
3.1 By January 1, 2000, 60 percent of the enrollees will have an identified primary health care provider (medical home).
3.2 By January 1, 2000, increase by 5 percent the rate at which primary and preventive health care (EPSDT) providers participate in the program.

4. Assure appropriate health care utilization by optional targeted, low income children enrolled in the Title XXI program.
4.1 By January 1, 2000, 80 percent of enrolled children will be appropriately immunized at age two.
4.2 By January 1, 2000, 80 percent of enrolled children will participate in EPSDT and receive a well-child visit, as measured by the HCFA 416 participation ratio.
4.3 By January 1, 2000, reduce the rate per year of hospitalizations of enrolled children for the ambulatory care sensitive conditions of childhood asthma and dehydration/non-infectious gastroenteritis as compared to the baseline population.
4.4 By January 1, 2000, reduce the rate of enrolled pregnant teens who deliver a very low birthweight baby as compared to the baseline population.

5. Implement a statewide outreach and public awareness campaign regarding the importance of preventive and primary care for well-children and the availability of health benefits coverage through Title XXI.
5.1 Launch a statewide outreach campaign through the coordinated efforts of the Illinois Departments of Healthcare and Family Services and Human Services.
5.2 Increase the number of community based sites certified by DPA to accept eligibility applications for forwarding to and eligibility determination by the local DHS office.

By January 1, 2000, it is the State's goal to enroll in All Kids at least 50 percent of the children whose family income is at or below 185% of the FPL. The actual number of children represented within this goal will be determined upon the completion of the population study described in Section 2.1.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:

(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Illinois will measure performance by establishing a baseline for each performance goal through various methods including: conducting a baseline population-based survey; using State vital records, hospital discharge and claims information; and using other Medicaid and non-Medicaid data bases that provide relevant information. For each performance goal, the method of measurement will be established and reports will be generated to monitor, on an ongoing basis, Illinois' progress toward meeting the goal.

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☒ The reduction in the percentage of uninsured children.

9.3.3. ☒ The increase in the percentage of children with a usual source of care.

9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☒ Other child appropriate measurement set. List or describe the set used.
See 9.3.7/

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. ☒ Immunizations
- 9.3.7.2. ☒ Well child care
- 9.3.7.3. ☒ Adolescent well visits
- 9.3.7.4. ~ Satisfaction with care
- 9.3.7.5. ~ Mental health
- 9.3.7.6. ~ Dental care
- 9.3.7.7. ☒ Other, please list:

Infant mortality
Childhood lead poisoning
School absenteeism
Hospitalization of enrolled children for ambulatory sensitive conditions of gastroenteritis/dehydration and asthma

Very low birthweight babies born to adolescents

9.3.8. ~ Performance measures for special targeted populations.9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

In the first year of the program, Illinois will finalize the overall design and plan for the required annual assessment of the effectiveness of the elements of the State plan. Illinois will focus first upon further refining what is known about the demographic characteristics of children in families whose income is below 200 percent of poverty. The State will seek to collect sufficient baseline data to complete the chart for the State's annual report as proposed in this draft Title XXI plan.

Illinois will also establish the baseline levels for all performance measures established in Section 9 of the Plan. Most performance measures selected by the State are related to established data reporting systems. The data for establishing baseline levels will be drawn from existing data sources such as vital records, Medicaid claims records, hospital discharge data and school attendance records among others. Where necessary, Illinois will supplement existing data sources by conducting a population-based survey.

The first year's annual assessment will report the results of efforts made to establish baseline levels for all measures and will report the State's progress in providing health benefits coverage to optional targeted low income children. In subsequent years, the annual assessment will provide updated information on performance on all measures. State staff will complete each year's annual assessment and will monitor ongoing progress toward meeting all performance goals.

In the first year of the program, the State will develop specifications for an evaluation of the program. The results of the evaluation will be submitted to the Secretary of DHHS by March 31, 2000. The evaluation will include an assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage. This evaluation will include a comprehensive examination of the characteristics of children receiving health benefits coverage under the plan and will encompass such factors as ages of

children, family income, and the children's health insurance status after their eligibility for the Title XXI program ends.

Through analysis of the patterns of utilization of services under the plan and the effectiveness of the plan as demonstrated through the performance measures established in Section 9, the evaluation will assess the overall quality and outcome of health benefits coverage provided under the plan. The provision of services, as an expansion of Medicaid, will be fully encompassed by all quality control mechanisms in place in Illinois' Medical Assistance program.

The evaluation will also include a complete description of the policy and processes established by the State for the Title XXI program. This will include the amount and level of assistance provided by the State and the mechanisms by which such assistance was provided; the service area; any time limits for coverage; the State's choice of health benefits coverage and other methods used for providing child health assistance; and the sources of non-Federal funding used for the program.

The State's plan will be considered effective if it achieves the performance goals established in Sections 9.2.1 and 9.2.2.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the

design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

State staff have conducted an exhaustive set of discussions with a wide variety of interested parties concerning the implementation of Title XXI. These efforts have occurred in four principle forums as described below: All recommendations received through these avenues were considered in the development of Illinois' Title XXI plan.

Governor's Office
In September and October, 1997, staff of the Office of the Governor, Directors of the Departments of Healthcare and Family Services and Public Health and the Secretary of the Department of Human Services held a lengthy series of meetings with a wide variety of consumer advocacy and provider groups to discuss how Illinois should implement Title XXI. The organizations that participated in the meetings include:

Advocacy Groups
Voices for Illinois Children
Maternal and Child Health Coalition
Don Moss & Associates (United Cerebral Palsy)
Campaign for Better Health Care
Southside Health Consortium
Chicago Hispanic Health Coalition
Rural Health Association
Illinois Public Health Association

Government Groups
Chicago Department of Health
Cook County Bureau of Health Services
DuPage County Health Department
Will County Health Department
Illinois Association of Public Health Administrators

Health Care Provider Groups
Illinois State Medical Society
Illinois Hospital and Health Systems Association
Illinois Primary Health Care Association
Illinois Association of Health Maintenance Associations
Children's Memorial Hospital
Blue Cross/Blue Shield of Illinois
St. Louis Children's Hospital
Cardinal Glennon Hospital
LaRabida Hospital
Wyler's Children's Hospital

Rush Presbyterian St. Luke's Children's Hospital
Lutheran General Children's Hospital
Christ Hospital
Human Resource Development Institute
Lawndale Christian Health Center
Metropolitan Chicago Healthcare Council
Illinois Alcoholism and Drug Dependence Association
Rush Prudential HMO

Others
Head Start Collaboration Project
Project Success
Chicago Public Schools
National Association of Social Workers
Children's Home and Aid Society of Illinois
Illinois State Chamber of Commerce
Illinois Retail Merchants Association
Federation of Independent Business
Illinois Manufacturers Association
Shattuck and Associates

Illinois General Assembly
On October 29, 1997, the Illinois House of Representatives Children and Youth Committee, held a public hearing to hear testimony concerning Title XXI. The Departments of Healthcare and Family Services and Human Services participated both in presenting testimony and witnessing the testimony of other interested parties.

A special legislative task force has been formed to consider Title XXI program options. The Children's Health Insurance Task Force includes four members of the Senate, four members of the Illinois House of Representatives, representatives of the Office of the Governor, advocates and members of the medical community. At the task force's first meeting on December 17, 2997, the details of this plan were discussed. The task force will continue to meet to discuss options for further expansion of child health insurance under Title XXI.

Health and Medicine Policy Research Group Seminar
On September 11, 1997, the Medicaid Administrator and the Assistant Secretary of the Department of Human Services participated in a half-day seminar hosted in Chicago by the Health and Medicine Policy Research Group, an independent organization generally concerned with issues of access to health care by low income individuals. The seminar was widely advertised throughout Chicago and well over a hundred individuals participated. The seminar included a lengthy audience participation period during which participants were able both to comment to and

question the State's representatives concerning Illinois' opportunities for implementing the children's health insurance program.

Medicaid Advisory Committee

Title XXI was the subject of lengthy discussions by two the Department of Healthcare and Family Services' Medical Assistance Advisory groups. All meetings of both groups are open to the public. On September 19, 1997 as a result of lengthy discussion, the Medicaid Advisory Committee resolved in part that "… the MAC recommends to the Director of HFS that he support the earliest feasible expansion of Medicaid eligibility to take full advantage of the immediate availability of federal funds at a 35% (state) match."

Title XXI was also discussed at three meetings of the Managed Care Subcommittee of the MAC on September 2, 1997, October 7, 1997, and November 4, 1997. These meetings were each attended by approximately 50 interested parties in addition to committee members. At each meeting, the Department presented updated information concerning the opportunities presented by the new law and the possibilities for program design. Committee members as well as interested parties asked questions and made comments concerning the direction they thought the state should take in program design.

In addition to the advisory committees already described, the Department held public hearings on this proposed State Plan in both Chicago and Springfield. The Department submitted state administrative rules to implement the program. Prior to the adoption of any state administrative rule, state law requires a public notice process, the consideration of any comments, and a public hearing. The Outreach Advisory Committee will continue to assist the Department in implementing All Kids.

Ongoing public involvement will be accomplished in the following ways:

- **Legislative changes will be debated in the Illinois General Assembly**
- **Public input through the State's Administrative Rules process**
- **News coverage**
- **Continued partnerships with advocacy groups such as Covering Kids Illinois**
- **Ongoing relationship with All Kids Application Agents who are hospitals, Federally qualified health centers, local health departments, community based organizations, faith based organizations, WIC sites, Family Case Management agencies, Community Action agencies, Early Intervention agencies, Child Care Resource & Referral agencies, and licensed insurance agents**
- **Input from the Medicaid Advisory Committee**
- **Input from the State Medical Advisory Committee**

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures

required in 42 CFR '457.125. **(Section 2107(c)) (42CFR 457.120(c))**

Only one Indian Health Care facility currently operates in Illinois. Pursuant to Section 1861 of the Social Security Act, this facility is recognized as a FQHC under the Department's Title XIX program. Under All Kids, this facility will continue to operate as a fully integrated FQHC, providing primary care services itself and referrals for other services. The Department has consulted with this facility concerning All Kids outreach and enrollment strategies that are appropriate for reaching American Indian children.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in '457.65(b) through (d). **For SPA #8, an Informational Notice dated 6/27/06 *All Kids Health Insurance-Cost Sharing* which announced the All Kids expansion effective 7/1/06 was distributed to all FQHCs including American Indian Health Services of Chicago.**

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

☒ Planned use of funds, including --
- Projected amount to be spent on health services;
- Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child and expected enrollment.

☒ Projected sources of non-Federal plan expenditures, including any requirements

State source funding will be from the State's General Revenue Fund (GRF) and local funds from Cook County. The primary sources into GRF are personal income taxes, corporate income taxes, and sales tax receipts.

Dollars shown in millions

	FFY09	FFY10	FFY11	FFY12	FFY13*
State's Allotment	$198.6	$360.7	$273.2	$285.1	$275.6
Allotment Carried Over From Prior Year(s)	$0.0	$96.9	$198.2	$236.2	$256.2
SUBTOTAL (Allotment + Funds Carried Over)	$198.6	$457.6	$471.4	$521.3	$531.8
Reallocated Funds (Redistributed or Retained that are Currently Available)	$0.0	$0.0	$0.0	$0.0	$0.0
2009 CHIPRA Allotment Balance	$145.9	$0.0	$0.0	$0.0	$0.0

TOTAL (Subtotal + Reallocated funds)	$344.5	$457.6	$471.4	$521.3	$531.8
EOY Allotment balance/(deficit)	**$96.9**	**$198.2**	**$236.2**	**$256.2**	**$109.3**
State's Enhanced FMAP Rate	65.22%	65.14%	65.12%	65.00%	65.00%

Assumptions: See Bottom

COST PROJECTIONS OF APPROVED SCHIP PLAN					
Benefit Costs					
CHIPRA 214 Lawfully Present effective 04-01-2009					
Managed care	$0.0	$0.0	$0.0	$0.0	$0.0
Fee for Service	$0.0	$0.0	$0.0	$0.7	$1.0
Total	$0.0	$0.0	$0.0	$0.7	$1.0
CHIPRA 214 Legal Permanent Resident < 5 Years effective 04-01-2009					
Managed care	$0.0	$0.0	$0.0	$0.1	$1.5
Fee for Service	$0.0	$0.0	$0.0	$22.3	$31.2
Total	$0.0	$0.0	$0.0	$22.4	$32.7
CHIPRA Children 200-300% FPL effective 04-01-2009					
Managed care	$0.0	$0.0	$0.0	$0.0	$0.2
Fee for Service	$0.0	$0.0	$0.0	$0.0	$106.0
Total	$0.0	$0.0	$0.0	$0.0	$106.2
CHIPRA Postpartum Health Services Initiative effective 04-01-2009					
Managed care	$0.0	$0.0	$0.0	$0.0	$0.7
Fee for Service	$0.0	$0.0	$0.0	$0.0	$56.8
Total	$0.0	$0.0	$0.0	$0.0	$57.5
Prenatal State Plan Amendment - Effective 1-1-2003					
Managed care	$5.0	$5.7	$5.0	$7.3	$10.5
Fee for Service	$173.0	$165.0	$155.4	$124.0	$215.6
Total	$178.0	$170.7	$160.4	$131.3	$226.1
MCHIP expansion					
Managed care	$4.0	$4.7	$4.6	$4.7	$5.8
Fee for Service	$96.3	$104.9	$106.0	$131.0	$138.3
Total	$100.3	$109.6	$110.6	$135.7	$144.1
SCHIP children 134%-200% FPL - Direct Coverage					
Managed care	$1.5	$1.7	$1.5	$2.2	$5.0
Fee for Service	$84.8	$104.5	$76.4	$98.7	$74.1
Total	$86.3	$106.2	$77.9	$100.9	$79.1

Presumptive Eligibility - Matched at 50% -Not in Admin cap calculation	$1.3	$0.0	$0.0	$0.0	$0.0
Presumptive Eligibility - Matched at 65%	$1.3	$1.2	$1.0	$1.0	$1.0

Total Benefit Costs	**$367.2**	**$387.7**	**$350.0**	**$392.0**	**$590.2**
(Offsetting beneficiary cost sharing payments)	($4.7)	($4.6)	($4.7)	($5.2)	($5.2)
Net Benefit Costs	**$362.5**	**$383.1**	**$345.3**	**$386.8**	**$585.0**
Administration Costs					
Personnel	$6.6	$5.9	$6.8	$8.4	$10.3
General administration	$5.6	$4.9	$5.5	$10.0	$12.2
Contractors/Brokers (e.g., enrollment contractors)	$0.0	$0.0	$0.0	$0.0	$0.0
Claims Processing	$0.0	$0.0	$0.0	$0.0	$0.0
Outreach/marketing costs	$0.0	$0.0	$0.0	$0.0	$0.0
Other	$3.0	$3.3	$2.4	$2.1	$2.5
Health Services Initiatives - Presumptive Eligibility	$1.4	$1.1	$1.1	$0.6	$58.2
Total Administration Costs	**$16.6**	**$15.2**	**$15.8**	**$21.1**	**$83.2**
Federal Title XXI Share	$247.6	$259.5	$235.1	$265.1	$434.3
State Share	$131.6	$138.8	$125.9	$142.8	$233.9
TOTAL COSTS OF APPROVED SCHIP PLAN	**$379.1**	**$398.3**	**$361.1**	**$407.9**	**$668.2**

TOTAL ADMINISTRATION COSTS	$16.6	$15.2	$15.8	$21.1	$83.2
10% Title XXI Administrative Cap	$40.3	$42.6	$38.4	$43.0	$65.0
Room Under 10% Administration Cap	$23.7	$27.4	$22.6	$21.9	($18.2)

TOTAL PROGRAM COSTS (State Plan and Administration)	**$379.1**	**$398.3**	**$361.1**	**$407.9**	**$650.0**

Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	$344.5	$457.6	$471.4	$521.3	$531.8
Current FFY allotment	$198.6	$360.7	$273.2	$285.1	$275.6
Previous FFY allotment available	$0.0	$96.9	$198.2	$236.2	$256.2
Reallocate allotments from previous FFY	$0.0	$0.0	$0.0	$0.0	$0.0
CHIPRA	$145.9	$0.0	$0.0	$0.0	$0.0
Total Federal Title XXI Program Costs (State Plan + Administration)	$247.6	$259.5	$235.1	$265.1	$422.5
Total Federal Title XXI Funding after costs	$96.9	$198.2	$236.2	$256.2	$109.3
Current FFY allotment	$96.9	$198.2	$236.2	$256.2	$109.3
Previous FFY allotment available	$0.0	$0.0	$0.0	$0.0	$0.0
Reallocate allotments from previous FFY	$0.0	$0.0	$0.0	$0.0	$0.0

Unused Title XXI Funds Expiring (Allotment or Reallocated)	$0.0	$0.0	$0.0	$0.0	$0.0
Increased state $	$0.0	$0.0	$0.0	$0.0	$0.0
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	$96.9	$198.2	$236.2	$256.2	$109.3

Budget Table Assumptions and Notes

a.

PMPM FFY 2010*			
Population	**Family Income**	**Fee-for-Service**	**Capitated Managed Care****
Children eligible in Premium Level 2	Greater than 200%, less than or equal to 300% FPL	$120	N/A
Children eligible under CHIPRA section 214	Greater than 133%; less than or equal to 200%	$61	$92
Postpartum services under the health services initiative	Less than or equal to 200%	$331	$379

* Per member per month calculations are based on the cost of the service at the time the service was provided.
**The managed care pmpm includes the costs of services carved out of managed care contracts, e.g., pharmacy, dental and vision, that were provided to individuals enrolled in managed care as well as the MCO capitation rate.

b.

Average Number of Enrollees FFY 2010			
Population	**Family Income**	**Fee-for Service**	**Capitated Managed Care**
Children eligible in Premium Level 2	Greater than 200%, less than or equal to 300% FPL	15,193	N/A
Children eligible under CHIPRA section 214	Greater than 133%; less than or equal to 200%	1,185	42
Postpartum services under the health services initiative	Less than or equal to 200%	18,418	305

c. Source of funding is described in Section 9.10 on page 58.

d. FFY 2009, 2010, 2011 and 2012 are actual spending and FFP earned against the CHIP allotments. Actuals are based on most current report of spending.

Costs for the FFY 2013 include all pending SPA expenditures for the four fiscal years. Expenditures are claimed against the most recent allotment and therefore reflect the actual FFY and allotment for which the costs will be claimed.

Enrollment growth is based on historical trends for each group.

e. May include expenditures funded by the Robert Wood Johnson Foundation MaxEnroll Grant.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. ☒ The progress made in reducing the number of uncovered low-

income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.**

11.1 ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

~ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR '457.1120.

The Medicaid fair hearing process is used for All Kids Share and All Kids Premium Levels 1-2 participants. Appeals may be filed regarding any eligibility and enrollment matter, including denial of eligibility, failure to make a timely determination of eligibility and suspension or termination of enrollment, including disenrollment for failure to pay cost sharing. Appeals can be filed in writing, by fax or in person or by calling a toll-free telephone number. Appeals must be filed within 60 calendar days after the decision (action) being appealed. Benefits are continued if the enrollee requests that benefits be continued and files the appeal by the date of change or the 10th calendar day after the decision being appealed, whichever is later. A pre-hearing review must be held within 7 days after the appeal is filed. If the decision is not changed during the pre-hearing review, a pre-hearing meeting, an informal meeting with the enrollee, must take place within 10 days after the appeal is received. If the decision is not changed or the enrollee does not withdraw the appeal, an appeal hearing is held with a neutral hearing officer presiding. The enrollee or their representative must attend the hearing and has the opportunity to review documents to be used at the hearing, both before and during the hearing. During the hearing, the enrollee has the opportunity to present the case or have it presented by their representative, bring witnesses, present arguments without interference, question or prove wrong any testimony or evidence, confront and cross-examine adverse witnesses, and submit evidence. The final hearing decision must be approved by the HFS Director and sometimes also by the DHS Secretary, and must be put into effect within 90 days of the date the appeal is filed, barring any approved hearing delays. The enrollee is notified of the final hearing decision in writing.

Denial and cancellation notices include the reason for denial or cancellation, and an explanation of appeal rights including time frames for review, and how to request a review. Notices are automatically centrally generated the day after the determination is made and are mailed within 1-3 days of being generated. Cancellation notices include information on how to request continuation of benefits during appeal. The All Kids application includes an explanation of appeal rights and how to request a review. The All Kids Member Handbook includes an explanation of appeal rights including time frames, how to request a review, a description of the appeal process, and an appeal form.

There is not an expedited review process for health service matters under the fee-for-service delivery system. If an appeal is filed on a decision, and there is an immediate need for health services, the services will be provided during the appeal process. Under the managed care delivery system, the appeal process includes expedited review for health service matters. The managed care plan must make a decision or request additional information needed to make a decision within twenty-four hours of receipt of the appeal. If additional information is requested, the managed care plan must make a decision within twenty-four hours after receipt of the information.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR '457.1120.

The Medicaid fair hearing process is used for All Kids Share and All Kids Premium Levels 1-2 participants under fee-for-service. Appeals may be filed regarding health services matters using the process described in Section 12.1 above.

The managed care delivery system complies with the fair hearing process in the Balanced Budget Act of 1997 and State law (Section 45 of the Managed Care Reform and Patient Rights Act) and meets the requirements of 42 CFR 457.1130(b). Appeals may be filed regarding health services matters and final decisions may be appealed by the enrollee to the State under its appeals process described in Section 12.1 above.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR '457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Not applicable.

Lee, Kyong

From: Lorie Chaiten <lchaiten@ACLU-il.org>
Sent: Friday, November 03, 2017 1:41 PM
To: Dellamorte, Gina; Norwood, Felicia
Cc: Amy Meek; Hursey, Teresa; McGady, Shawn; Doran, Mary
Subject: [External] RE: Abortion coverage under Medicaid
Attachments: All Materials with Index and Bookmarks.pdf

Dear all,
Thank you for making the time to meet yesterday. We look forward to working together as implementation of HB 40 moves forward.

As promised, I am attaching a pdf of the binder we brought to the meeting. In addition, on the question of whether other states that provide coverage beyond Hyde seek reimbursement for abortions from the federal government, I am sending links to two Guttmacher reports. The most recent is "Public Funding for Family Planning and Abortion Services, FY 1980–2015" (https://www.guttmacher.org/sites/default/files/report_pdf/public-funding-family-planning-abortion-services-fy-1980-2015.pdf). The relevant table starts on page 14. Illinois appears to be one of only 4 (out of the 17 states with policies/court orders to provide abortion coverage for Medicaid enrollees using state funding) to obtain reimbursement for abortions from the federal government, and the only one of the 17 states that obtained reimbursement for any significant number. In FY 2015, the federal government reimbursed for 58 abortions performed in Illinois. The only other states among the 17 were Arizona (6 abortions), Minnesota (4 abortions), and Montana (1 abortion). The other 13 states did not obtain federal reimbursement for a single abortion in FY 2015. (As you can see from the table, it's also pretty rare even among the states that do not provide state funding for abortion coverage). There is also an earlier report (that has FY 2010 numbers) at https://www.guttmacher.org/sites/default/files/report_pdf/public-funding-fp-2010.pdf -- this reflects essentially the same patterns.

Thank you again.
Lorie

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Chicago, IL 60601
312-201-9740 x324
lchaiten@aclu-il.org

From: Dellamorte, Gina [mailto:Gina.Dellamorte@illinois.gov]
Sent: Thursday, October 19, 2017 10:18 AM

To: Lorie Chaiten
Cc: Amy Meek ; Hursey, Teresa ; McGady, Shawn ; Doran, Mary
Subject: RE: Abortion coverage under Medicaid

Lorie,

Good Morning.

Director Norwood has availability on November 2nd at 10am at the 401 South Clinton address.

Please let me know if this will work for you and I well send out an invite.

Thank you.

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Sent: Monday, October 16, 2017 5:10 PM
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Subject: RE: Abortion coverage under Medicaid

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I'll have my Chicago assistant, Gina, get back to you with some dates that work with our schedules.

It will likely be near the end of October/first part of November.

Felicia

Felicia F. Norwood
Director
Illinois Department of Healthcare and Family Services
Chicago Office: 312-793-4792
Springfield Office: 217-782-7755

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Cc: Amy Meek <ameek@ACLU-il.org>
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Lorie,

Good Morning.

Director Norwood has availability on November 2nd at 10am at the 401 South Clinton address.

Please let me know if this will work for you and I well send out an invite.

Thank you.

From: Norwood, Felicia
Sent: Monday, October 16, 2017 5:10 PM
To: Lorie Chaiten
Cc: Amy Meek; Dellamorte, Gina; Hursey, Teresa; McGady, Shawn; Doran, Mary
Subject: RE: Abortion coverage under Medicaid

Lorie,

It's been incredibly busy as we get ready to roll out the new MCO contracts and also work on other year-end priorities.

I'll have my Chicago assistant, Gina, get back to you with some dates that work with our schedules.

It will likely be near the end of October/first part of November.

Felicia

Felicia F. Norwood
Director
Illinois Department of Healthcare and Family Services
Chicago Office: 312-793-4792
Springfield Office: 217-782-7755

From: Lorie Chaiten [mailto:lchaiten@ACLU-il.org]
Sent: Monday, October 16, 2017 4:57 PM
To: Norwood, Felicia
Cc: Amy Meek
Subject: [External] RE: Abortion coverage under Medicaid

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Director, Women's and Reproductive Rights Project
Roger Baldwin Foundation of the ACLU of IL
150 N. Michigan Ave. #600
Chicago, IL 60601

312-201-9740 x324
lchaiten@aclu-il.org

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Cc: Amy Meek <ameek@ACLU-il.org>
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lchaiten@aclu-il.org

Lee, Kyong

From: Norwood, Felicia
Sent: Thursday, November 02, 2017 9:50 AM
To: Hursey, Teresa; Doran, Mary
Subject: FW: Abortion coverage under Medicaid
Attachments: Proposed Agenda for November 2.docx

I think I sent this to you before, but wanted to make sure you had a copy for our meeting.

Felicia F. Norwood
Director
Illinois Department of Healthcare and Family Services
Chicago Office: 312-793-4792
Springfield Office: 217-782-7755

From: Lorie Chaiten [mailto:lchaiten@ACLU-il.org]
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Lee, Kyong

From: Hursey, Teresa
Sent: Tuesday, October 31, 2017 6:02 PM
To: Doran, Mary; Eckert, Jane
Subject: FW: Abortion coverage under Medicaid
Attachments: Proposed Agenda for November 2.docx

Please try to find a few minutes on my calendar tomorrow for Mary and I to discuss

---

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Sent: Tuesday, October 31, 2017 12:12 PM
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Lee, Kyong

From: Doran, Mary
Sent: Tuesday, October 31, 2017 12:39 PM
To: Barger, Sara
Subject: FW: Abortion coverage under Medicaid
Attachments: Proposed Agenda for November 2.docx

Looks like they have created a checklist for us.

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Lee, Kyong

From: McGady, Shawn
Sent: Wednesday, October 04, 2017 8:44 AM
Cc: Hoffman, John K.
Subject: Re: Fact sheet on HB40

Hi John,

I just spoke with Kantas. Give me a call on my cell when you have a chance. I am at home today

630-306-6026
Sent from my iPhone

On Oct 4, 2017, at 8:12 AM, Kantas, Christopher <Christopher.Kantas@illinois.gov> wrote:

> John,
> Please call me to discuss this latest version 217-299-5518.
>
> Sent from my iPhone
>
> On Oct 3, 2017, at 5:48 PM, Hoffman, John K. <John.K.Hoffman@illinois.gov> wrote:
>
> > All –
> > Per our discussion, updated version.
> > John
> >
> > **From:** Bossert, Richard
> > **Sent:** Tuesday, October 03, 2017 1:09 PM
> > **To:** Hoffman, John K.; Kantas, Christopher; Englehart, Hud; Wilson, Nicole J.
> > **Cc:** Rothermich, Tyson; Popish, Dana
> > **Subject:** Re: Fact sheet on HB40
> > Latest HFS draft with CMS/SEGIP added.
> >
> > **From:** "Hoffman, John K." <John.K.Hoffman@illinois.gov>
> > **Date:** Tuesday, October 3, 2017 at 1:05 PM
> > **To:** "Kantas, Christopher" <Christopher.Kantas@illinois.gov>, "Englehart, Hud" <Hud.Englehart@illinois.gov>, Richard Bossert <Richard.Bossert@illinois.gov>, "Wilson, Nicole J." <Nicole.J.Wilson@illinois.gov>
> > **Subject:** RE: Fact sheet on HB40
> > Latest draft attached.
> > Rich, let me know how you want to integrate your pieces, or feel free to add them in.
> > Thanks.
> > John
> >
> > **From:** Kantas, Christopher
> > **Sent:** Tuesday, October 03, 2017 12:39 PM
> > **To:** Hoffman, John K.; Englehart, Hud; Bossert, Richard; Wilson, Nicole J.
> > **Subject:** RE: Fact sheet on HB40

John,
This is a version that we redlined. Can you cross reference it with you most recent draft to make sure it includes your latest version? Give me a call to discuss as well, however, I am off campus from 1-3 today.
Thank you,
Chris

From: Hoffman, John K.
Sent: Tuesday, October 03, 2017 12:34 PM
To: Englehart, Hud <Hud.Englehart@illinois.gov>; Kantas, Christopher <Christopher.Kantas@illinois.gov>; Bossert, Richard <Richard.Bossert@illinois.gov>; Wilson, Nicole J. <Nicole.J.Wilson@illinois.gov>
Subject: RE: Fact sheet on HB40
All –
Please find an updated draft of the fact sheet, after more discussion with staff. I'd like to emphasize again that this continues to be a work in progress, requiring ongoing analysis and decisions.
John

From: Hoffman, John K.
Sent: Tuesday, October 03, 2017 8:58 AM
To: Englehart, Hud; Kantas, Christopher; Nicole Wilson; Bossert, Richard
Subject: Re: Fact sheet on HB40
Thank you. Attached please find a draft fact sheet, as we discussed. Policy, legal and Medical staff at HFS are continuing to review language, but given the priority level of this, I thought it would be best to begin circulating it around. Rich, if it would make sense, your components could be added.

As we talked about, this reflects the fact that there are still policy decisions to be made and can be expanded on as answers are finalized. I'll send any alterations as soon as I get any. Let me know what else you need from me.

John

From: Englehart, Hud
Sent: Tuesday, October 3, 2017 5:57 AM
To: Hoffman, John K.; Kantas, Christopher; Nicole Wilson; Bossert, Richard
Subject: FW: Fact sheet on HB40

FYI.

On 10/2/17, 3:27 PM, "Senger, Darlene J." <Darlene.J.Senger@illinois.gov> wrote:

Darlene J. Senger

Deputy Chief Of Staff of Legislative Affairs
Office of the Governor
100 W. Randolph Street

Suite 16-100

312-814-4550 office
312-802-8594 cell

-----Original Message-----
From: Kantas, Christopher
Sent: Monday, October 02, 2017 2:39 PM
To: Lucci, Michael <Michael.Lucci@illinois.gov>; Senger, Darlene J. <Darlene.J.Senger@illinois.gov>
Subject: RE: Fact sheet on HB40

This is the bill summary prepared with HFS. I do not have a separate fact sheet prepared per se.

-----Original Message-----
From: Lucci, Michael
Sent: Monday, October 02, 2017 2:32 PM
To: Senger, Darlene J. <Darlene.J.Senger@illinois.gov>; Kantas, Christopher <Christopher.Kantas@illinois.gov>
Subject: Re: Fact sheet on HB40

Chris could you share your fact sheet on HB 40?

From: Senger, Darlene J.
Sent: Monday, October 2, 2017 2:29 PM
To: Lucci, Michael
Subject: FW: Fact sheet on HB40

Does Chris have something?

Darlene J. Senger

Deputy Chief Of Staff of Legislative Affairs Office of the Governor
100 W. Randolph Street
Suite 16-100

312-814-4550 office
312-802-8594 cell

-----Original Message-----
From: Firstlady1.Diana
Sent: Monday, October 02, 2017 2:14 PM
To: Englehart, Hud <Hud.Englehart@illinois.gov>
Cc: Senger, Darlene J. <Darlene.J.Senger@illinois.gov>; McEnaney, Jane <Jane.McEnaney@illinois.gov>
Subject: Fact sheet on HB40

Has this been completed? Pretty sure Bruce needs this for legislator calls

Lee, Kyong

From: Casey, Mike P.
Sent: Thursday, September 28, 2017 5:15 PM
To: Moody, David; Tripp, Jamie
Cc: Casey, Mike P.
Subject: RE: abortions

This came up as a press inquiry earlier this week. Please coordinate with Teresa Hursey and John Hoffman regarding our final response. Thanks

---

From: Moody, David
Sent: Thursday, September 28, 2017 4:16 PM
To: Tripp, Jamie
Cc: Casey, Mike P.
Subject: abortions

Jamie,

Cory called and wanted to know if we had an estimate for the number of abortions and the cost for HB40.

David

Lee, Kyong

From: Carr, Jodi C.
Sent: Thursday, September 28, 2017 4:21 PM
To: McGady, Shawn
Subject: FW: ACTION ON BILLS LIST
Attachments: ACTION ON BILLS 09-28-2017.doc

I will add on Monday. Ugh.

Jodi Carr Babcock
Office of the Director
Healthcare and Family Services
217/782-7755 or 217/557-3254

From: Eckert, Jane
Sent: Thursday, September 28, 2017 4:19 PM
To: Carr, Jodi C.
Subject: FW: ACTION ON BILLS LIST

HB40

From: Paine, Renee [mailto:Rpaine@ILSOS.NET]
Sent: Thursday, September 28, 2017 4:11 PM
To: Caruso, Therese; Coombes, Terri; Devlin, Harry W; Gerdes, Arlene; Haupt, Henry; ISL Information Line; Price, Jackie; Richno, Lissa; Riseling, Mary; Ryan, Angela; Schmidt, Ellen; Thompson, Jennifer; Weisbaum, Dave; Adam Zerkel; Andrea Creek; Bobbi Keehner; Chris Cray; Craigg; Hatchett, Shirley; Janet Osteen; Kim Geiger; Lisa Riley; Mike Ziri; Monique Garcia; Cortez-Hun, Nicola G; Patrick Barry; Rhonda; Sheila; Tim Mapes; Wayne Hedenschoug; Gwen Peebles; Helen Mack; Eckert, Jane; Londeree, Vicki; Lori Bottrell; Mart, JD; Snyder, Peggy; Sally Smith; Bria Scudder; Brian Mackey; Catherine Whaley; G Randazzo; Holifield, Tony; John Novak; Sinclair, Laura; Randall Witter; THOMPSON REUTERS; Timms, Jennifer; Beth Martin; EXT Flynn, Daniel; Doug Finke; Ed Stasiewicz; EXT Morphew, James; Jane; Sweat, Jason; Jennifer Walling; Wooldridge, Jennifer; JIM DODGE; Kevin Morphew; Konjit Gomar; Mark Warnsing; Michael Nordman; Patterson, Nicki; Nicole Truong; Schuh, Patty; Patton, Becky; Brunsman, Rose; Sean Flynn; Sheleda Doss; Catherine Shannon; Fornoff, Chad; Christy Gutowski; David Gross; Kasey Chong; Kevin Fitzpatrick; Kristen Houch; Kristin Richards; Luke Geary/Pressroom; Ray Long; RICK MILLARD; Sara Meek; Tom Cullen; Tyler Hunt; Amanda Nicole Vinicky; Amy Larson; Amy Lavigna; Andrew Freiheit; Andrew Maloney; Caitlin Groh; EXT Leach, Carolyn; Godfrey, Clay; Craig Wall; David Eldridge; Dena Blodgett; Eric Lane; Heather Wier; Ian Watts; Illinois State Bar Association; J. Cox; O'Day, Jaclyn; Poeschel, Jake; Jason Keller; Jo Johnson; John E. Byrne; Julie Larkin; Kathy Astrom; Hermes, Kristen; Walsh, Kyle; Lara Mbayed; Marty Morris; Melissa Earles; Taylor, Michael H.; N. Korecki; EXT Flynn, Neil; Hawkinson, Rebecca A.; Reena Tandon; Robert Bae; Roth, Ryan P; Sophia Tareen; Stacey Hohman; Tony Arnold
Subject: [External] ACTION ON BILLS LIST

specifically states them to be the views of the Office of the Illinois Secretary of State.
****

ACTION ON BILLS

JESSE WHITE

SECRETARY OF STATE

INDEX DEPARTMENT
111 E. MONROE, SPRINGFIELD, IL 62756
(217) 782-7017

100th General Assembly

FILED BY THE GOVERNOR: September 28, 2017 - 4:00 PM

BILLS	PUBLIC ACT 100-	ACTION	DATE FILED	PAGES
H 0040	0538	APPROVED	9/28/2017	39

Lee, Kyong

From: Moody, David
Sent: Thursday, September 28, 2017 4:16 PM
To: Tripp, Jamie
Cc: Casey, Mike P.
Subject: abortions

Jamie,

Cory called and wanted to know if we had an estimate for the number of abortions and the cost for HB40.

David

Lee, Kyong

From: Firstlady1.Diana
Sent: Thursday, September 28, 2017 2:57 PM
To: Norwood, Felicia
Subject: Hb40

Felicia somehow you were not looped in and the presser is at 3. This was such a close hold that no one knew who was in charge of telling you

Lee, Kyong

From: Griff, Holly
Sent: Tuesday, September 26, 2017 8:13 PM
To: Firstlady1.Diana
Cc: Rasmussen, Kristina; Hutton, Jean; Lucci, Michael; Senger, Darlene J.; Englehart, Hud; Hummel, Brian; Childress, Trey; Norwood, Felicia; hud.englehart@liinois.gov
Subject: Re: Hb40

All set

> On Sep 26, 2017, at 6:01 PM, Firstlady1.Diana <Firstlady1.Diana@illinois.gov> wrote:
>
> Hud should also be on this call and the ABAWD waiver call.
>
>> On Sep 25, 2017, at 9:14 AM, Griff, Holly <Holly.Griff@illinois.gov> wrote:
>>
>> Adding Felicia - we will use dial in: 888-494-4032,[redacted] at 10:30 am on Wednesday, 9/27.
>>
>> -----Original Message-----
>> From: Firstlady1.Diana
>> Sent: Monday, September 25, 2017 9:08 AM
>> To: Griff, Holly
>> Cc: Rasmussen, Kristina; Hutton, Jean; Lucci, Michael; Senger, Darlene J.; Englehart, Hud; Hummel, Brian; Childress, Trey
>> Subject: Re: Hb40
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>>> Subject: Hb40
>>>
>>> Holly,
>>>
>>> Does the gov have availability this week to do a staff briefing on Hb40?
>>>
>>> KR
>>>
>>> Sent from my iPhone
>>>
>>>

>>> State of Illinois - CONFIDENTIALITY NOTICE: The information contained in this communication is confidential, may be attorney-client privileged or attorney work product, may constitute inside information or internal deliberative staff communication, and is intended only for the use of the addressee. Unauthorized use, disclosure or copying of this communication or any part thereof is strictly prohibited and may be unlawful. If you have received this communication in error, please notify the sender immediately by return e-mail and destroy this communication and all copies thereof, including all attachments. Receipt by an unintended recipient does not waive attorney-client privilege, attorney work product privilege, or any other exemption from disclosure.
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Lee, Kyong

From: Firstlady1.Diana
Sent: Tuesday, September 26, 2017 6:01 PM
To: Norwood, Felicia
Cc: Bastedo, Emily
Subject: HB40 meeting

Do you have estimates of cost savings as well as expenses for HB40? I know that you were asked not to provide that when scoring the bill but it seems important to get it on the table.

Lee, Kyong

From: O'Brien, Paula
Sent: Tuesday, September 26, 2017 11:05 AM
To: McGady, Shawn
Subject: Dan Weber

Please call Dan Weber with House Rep. Staff re: technical question with HB40 217-558-0006

Paula OBrien
HFS – Office of the Director
201 South Grand Avenue East
Springfield, Illinois 62763-0002
217-785-9806
paula.obrien@illinois.gov

Lee, Kyong

From: Burklow, Keith
Sent: Tuesday, September 26, 2017 9:38 AM
To: Benning, Kimberly; Jenkins, Dan; Hoffman, John K.
Subject: RE: Medicaid / abortion (Public radio)

Here is some background:

Illinois Medicaid covers abortions only under certain circumstances; Rape, Incest, to Protect the Life of the Mother (under federal law) and to Protect the Health of the Mother (under an old IL circuit court decision). All abortion claims must have a signed certification from the physician as to the reason. Kim's attachment provides the numbers and dollar amounts for each category. We only receive federal match for the first three categories and the amounts are not significant.

We don't see any abortion claims for reasons other than those above, so Federal Finance has no way to project how many non-payable abortions Medicaid recipients may receive.

Keith Burklow

-----Original Message-----
From: Benning, Kimberly
Sent: Tuesday, September 26, 2017 9:03 AM
To: Jenkins, Dan
Cc: Burklow, Keith
Subject: RE: Medicaid / abortion (Public radio)

You're welcome.

-----Original Message-----
From: Jenkins, Dan
Sent: Tuesday, September 26, 2017 9:02 AM
To: Benning, Kimberly
Cc: Burklow, Keith
Subject: RE: Medicaid / abortion (Public radio)

Thanks Kim. I'll pass this on to John Hoffman and see if he has any additional questions.

-----Original Message-----
From: Benning, Kimberly
Sent: Tuesday, September 26, 2017 8:52 AM
To: Jenkins, Dan
Cc: Burklow, Keith
Subject: RE: Medicaid / abortion (Public radio)

Dan,

Attached is correspondence on a prior request for abortion data from last November.
Since there was not a specified time frame mentioned, I am pulling what I have readily available.
Does the information in the attachments answer the question?

Please let me know if you need different or additional information.

Thank you,

Kim
-----Original Message-----
From: Jenkins, Dan
Sent: Tuesday, September 26, 2017 8:21 AM
To: Benning, Kimberly
Subject: RE: Medicaid / abortion (Public radio)

Yes. That's fine.

Thanks.

-----Original Message-----
From: Benning, Kimberly
Sent: Monday, September 25, 2017 4:57 PM
To: Jenkins, Dan
Subject: RE: Medicaid / abortion (Public radio)

Yes, I can put something together.
When do you need the information? Is tomorrow ok?

-----Original Message-----
From: Jenkins, Dan
Sent: Monday, September 25, 2017 4:23 PM
To: Benning, Kimberly
Subject: FW: Medicaid / abortion (Public radio)

Kim - do you know who would have the number of abortions and cost for a given year to answer the email below?

-----Original Message-----
From: Casey, Shanan
Sent: Monday, September 25, 2017 4:22 PM
To: Jenkins, Dan; Staley, Kathleen
Subject: RE: Medicaid / abortion (Public radio)

BFF has them.

-----Original Message-----
From: Jenkins, Dan
Sent: Monday, September 25, 2017 4:21 PM
To: Casey, Shanan; Staley, Kathleen
Subject: FW: Medicaid / abortion (Public radio)

Do we already have numbers (occurrences and cost) on abortions? See below.

-----Original Message-----
From: Hoffman, John K.
Sent: Monday, September 25, 2017 3:26 PM
To: Jenkins, Dan; Doran, Mary; McGady, Shawn
Cc: Hursey, Teresa; Casey, Mike P.; Moody, David
Subject: Medicaid / abortion (Public radio)

Dan and Mary --

Please see below? Can you offer information on abortion coverage and payments under current Medicaid rules? Any timeframe that makes the most sense should work.

Shawn -- Do we have a public figure we have been using on how much HB40 would cost?

Thanks.

John

_____
From: Amanda Vinicky <avinicky@wttw.com>
Sent: Monday, September 25, 2017 2:01:29 PM
To: Hoffman, John K.
Subject: [External] Medicaid / abortion

Hey John-

Somehow I have the wrong phone number saved for you.
(I also reached out to Rich Bossert on this).
Wanting to get my facts straight on HB40 issues.
Does Illinois ever cover abortion for Medicaid recipients now? Only when medically necessary? Or under what circumstances?
If so, how often (number of cases annually) does that happen?
If so, how much does the state spend on abortions for Mediciad recipients?
Does HFS have cost projections for if HB40 as passed becomes law?

-Amanda

Sent from my iPhone

Lee, Kyong

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-Amanda

Sent from my iPhone

Lee, Kyong

From: Carr, Jodi C.
Sent: Monday, September 25, 2017 9:36 AM
To: McGady, Shawn
Subject: hb40

Now it says passed both houses

Jodi Carr Babcock
Office of the Director
Healthcare and Family Services
217/782-7755 or 217/557-3254

Lee, Kyong

From: Griff, Holly
Sent: Monday, September 25, 2017 9:14 AM
To: Firstlady1.Diana
Cc: Rasmussen, Kristina; Hutton, Jean; Lucci, Michael; Senger, Darlene J.; Englehart, Hud; Hummel, Brian; Childress, Trey; Norwood, Felicia
Subject: RE: Hb40

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>
>

Lee, Kyong

From: Dellamorte, Gina
Sent: Monday, September 25, 2017 9:11 AM
To: Norwood, Felicia
Subject: Return Call

Chris Kantas called 217-299-5518

Regards HB40

Lee, Kyong

From: Norwood, Felicia
Sent: Thursday, September 21, 2017 7:49 AM
To: Hoffman, John K.
Subject: Re: [External] POLITICO Illinois Playbook: JB pounces on RAUNER's HB40 indecision — KWAME's all in for AG — STATE could lose $153B under ACA repeal

Thanks for the heads up.

Felicia F. Norwood
Director

On Sep 21, 2017, at 7:37 AM, Hoffman, John K. <John.K.Hoffman@illinois.gov> wrote:

> Director --
>
> FYI, in case you haven't seen, Politico makes reference to the HB40 video from April.
>
> John
>
> ---
>
> **From:** Natasha Korecki <illinoisplaybook@politico.com>
> **Sent:** Thursday, September 21, 2017 6:23 AM
> **To:** Hoffman, John K.
> **Subject:** [External] POLITICO Illinois Playbook: JB pounces on RAUNER's HB40 indecision — KWAME's all in for AG — STATE could lose $153B under ACA repeal
>
> 09/21/2017 07:21 AM EDT
>
> **By Natasha Korecki (nkorecki@politico.com; @natashakorecki) and Kristen East (keast@politico.com; @kristenicoleast)**
>
> **Good Thursday morning, Illinois.**
>
> **THE BUZZ -** Gov. Bruce Rauner's ongoing struggle with the politics of a controversial abortion bill hasn't gone unnoticed by potential opponents.
>
> **Today, J.B. Pritzker** is seizing on Rauner's indecision with HB40 by releasing a new statewide TV ad where the billionaire Democrat declares if he's elected, HB40 will be the first bill he signs.
>
> We have a first look at the ad, **"Stand Up"**: Watch

Earlier this month, Pritzker collected 4,000 postcards from throughout the state in support of HB40 and delivered them to Governor Rauner's office along with the bill's co-sponsors Sen. Heather Steans and Rep. Sara Feigenholtz. Video showing them delivering to Thompson Center here.

What's missing? Both of these videos discuss only one part of the proposed legislation, neglecting to mention that HB40 also calls for the expansion of public funding of abortions to Medicaid recipients and to state health plans. Both Pritzker's new TV ad and the Facebook video only talk about the language in the bill that aims to reverse a so-called "trigger law" that's on the books in Illinois.

As it happens, Rauner has said he support a bill only containing the "trigger law," language. It's the public funding expansion that he's rejected. Recall the video his administration released in April in which Dept. of Healthcare and Family Services' Felicia Norwood said: "Because expanding taxpayer funding of abortion is an extremely divisive issue, Gov. Rauner says he will veto House Bill 40 ... the administration does not support expanding taxpayer funding for elective procedures."

WORTH NOTING - We'll again point out that Democrats haven't sent him the bill. A procedural hold is still on that legislation, keeping it in the Senate. Personal PAC's Terry Cosgrove last week told us it won't be sent until Rauner vows to sign the bill as is. As we first reported Tuesday, Rauner now says he's undecided on the legislation, a change from his vow to veto it.

KWAME's IN - State Sen. Kwame Raoul made his candidacy for Illinois Attorney General official on Wednesday. "I think I have the strongest record than anyone I've heard mentioned," he said in an interview. He ticked off his work on criminal justice reform; a bill aimed at repeat gun offenders, his partnership with Rauner as well as with Republican leaders in the House and Senate. Raoul said he was the point person to negotiate concealed carry legislation and adding background checks as well as legislation requiring reporting of lost and stolen weapons. "I think I have the best record to hit the ground running."

On AG's range of responsibilities, Raoul said he wouldn't shy away from any type of prosecution within the office's jurisdiction. He also defended Lisa Madigan against those who criticize her for not doing enough to take on public corruption. "It's unfair to criticize Lisa Madigan. You can only do what you're resourced to do. Sometimes federal prosecutors are better equipped than the Attorney General."

- "Raoul enters AG race, apologizes for 'Miss America' comment," by the State Journal-Register's Bernard Schoenburg: "State Sen. Kwame Raoul, D-Chicago, who says he will run for attorney general in 2018, on Wednesday apologized for how he referred to Republican candidate Erika Harold when discussing the office last week. 'I've seen the reaction to the comment that I made, and I don't blame anybody for being offended,' Raoul told The State Journal-Register. 'If I read them without the full context of our full conversation, I would have the same reaction. ... I take full responsibility for the bad characterization.' Raoul told the newspaper on Friday, after Democratic Attorney General Lisa Madigan announced she would not seek another term, that 'I think Lisa would have acquitted herself well against Miss America. I don't know what's behind the attorney general's decision ... but I doubt seriously it was any fear of Erika Harold.' Harold, of Urbana, was the 2003 Miss America, and is also a graduate of Harvard Law School, and now practices law." Story here

Welcome to the POLITICO Illinois Playbook! We welcome your tips, events, announcements. Send to nkorecki@politico.com or @natashakorecki SUBSCRIBE to Illinois Playbook

HEALTH CARE

- "How Graham-Cassidy would play out in Illinois," by Crain's Chicago Business' Nona Tepper: "Federal health care funding to Illinois would be slashed by $153 billion, or 34 percent, from 2020 to 2036 if

lawmakers approve the latest GOP proposal to repeal and replace the Affordable Care Act. That's the analysis by Washington-based consultancy Avalere Health as a proposal by Republican Sens. Lindsey Graham and Bill Cassidy progresses on Capitol Hill. The plan would cut federal funding to Illinois insurance programs by $8 billion, or 5 percent, from 2020 to 2026, and $18 billion, or 11 percent, from 2020 to 2027, according to Avalere ... 'I have expressed my concerns to members of Congress and members of the administration about the changes to the ACA and very significant negative impacts it could have on the people of Illinois,' Gov. Bruce Rauner said today at a news conference. Rauner said the proposed bill would have a 'big impact, negative impact' on Illinoisans who receive insurance through Obamacare." Story here

- "Illinois submits big Obamacare rate increases to the feds," by Chicago Tribune's Lisa Schencker: "Hundreds of thousands of Illinois consumers who buy health insurance on the state's Obamacare exchange will likely see average rates increase by 16 percent to 37 percent next year for the lowest-priced plans, according to a new analysis. The Illinois Department of Insurance submitted rates to the federal government Wednesday that would increase the average cost of the lowest-priced silver plans by 35 percent statewide. The lowest-priced bronze-level plans would increase, on average, by 20 percent, and the lowest-priced gold plans would increase by 16 percent, according to a department analysis obtained by the Tribune ... 'It's just more indication of what we've seen already, which is (that) the incredible uncertainty that is being injected into the health care system by the Trump administration is causing chaos,' said Stephani Becker, a senior policy specialist at the Sargent Shriver National Center on Poverty Law." Story here

STATE

- "Illinois' unpaid bill backlog hits a record $16 billion," by Reuters: "Illinois' pile of unpaid bills topped $16 billion for the first time as the state deals with the fallout of an unprecedented two straight fiscal years without complete budgets, the state comptroller's office reported on Tuesday. The bill backlog is growing despite the enactment of a fiscal 2018 spending plan and income tax increase in July that ended a budget impasse between Illinois' Republican governor and Democrats who control the legislature." Story here

- "Trump administration move could mean changes for Loyola sexual assault policy," by Loyola Phoenix's Christopher Hacker and Mary Norkol: "The Trump administration may change rules for how colleges handle sexual assault allegations involving students, raising concerns at Loyola that protections for victims could be rolled back. President Donald Trump's Secretary of Education, Betsy DeVos, recently criticized Obama-era policies that told schools that receive federal funding, including Loyola, how to handle allegations of sexual misconduct. She argued they 'failed' students by forcing schools to assume someone accused of sexual assault is guilty." Story here

- "One student shot, one arrested at high school in downstate Mattoon," by AP: "A teacher subdued a male student who fired shots and wounded another student in a central Illinois high school cafeteria on Wednesday morning, police said. Mattoon police Chief Jeff Branson and Mattoon School Superintendent Larry Lilly said the shooting happened at Mattoon High School about 11:30 a.m. Wednesday. The suspect, a male student, is in custody, police said, and the injured student is in stable condition at a local hospital." Story here

CHICAGO

- "New police training center advances; protesters want funds spent elsewhere," by DNAinfo's Heather Cherone: "Plans for a state-of-the-art $95 million training facility for Chicago police and fire recruits advanced Wednesday after winning the endorsement of a key city panel. While the Chicago Plan Commission unanimously approved the plan to buy the 30-acre site at 4301 W. Chicago Ave. in Garfield

Park for $9.6 million, a coalition of groups rallied outside Mayor Rahm Emanuel's fifth-floor City Hall office urging that the plan be shelved and the money spent on schools and community redevelopment efforts." Story here

- "'Nothing will ever be OK again': Police officer's nephew fatally shot on Far South Side porch," by Chicago Tribune's Elyssa Cherney and Madeline Buckley: "Issac Harper's twin sister cried softly as she stood in the street in her socks. 'Nothing will ever be OK again,' she said to a group of family members huddled outside a crime scene on the Far South Side late Tuesday. The woman then sat in a car as police went inside a two-story brick home to investigate her brother's fatal shooting on the back porch. She rocked back and forth and stared straight ahead. Harper, 21, was with his sister outside, smoking a cigarette, in the Longwood Manor neighborhood just before 9:40 p.m. when gunfire erupted, police said. The college student and Amazon employee was hit in the shoulder, leg and hip, according to police and relatives. He was pronounced dead on the scene, one of 11 people shot across the city on Tuesday." Story here

- "Kenneka Jenkins case highlights mistrust of police," by Chicago Tribune's John Keilman: "Video released by Rosemont police seemed to solve at least part of the Kenneka Jenkins mystery. The surveillance recordings depict Jenkins, 19, staggering alone through a kitchen of the Crowne Plaza Chicago O'Hare Hotel and around a corner where a walk-in freezer is located. Though the camera doesn't capture her entering the freezer, no one else appears in that part of the room until a hotel worker finds her body 21 hours later. Convincing proof Jenkins did not meet with foul play? Far from it, according to many engrossed by the case." Story here

- "Moving company says more people leaving Chicago than any other major city," by Illinois News Network: "The nation's biggest mover is corroborating Census data showing the exodus of residents from Chicago and across Illinois. Earlier this month, the U.S. Census released its report that said most Illinois' cities are shrinking in population, with the entire state estimated to have lost 58,456 people on net in 12 months ending in July. United Van Lines tracks how many people come and go from the nation's larger cities every summer. They found that more people moved from Chicago than any other metropolitan area." Story here

CHASING AMAZON

- "Rahm touts Chicago's 'Midwestern work ethic' in push for Amazon HQ," by DNAinfo's Heather Cherone: "Mayor Rahm Emanuel continued his intense push to persuade Amazon CEO Jeff Bezos to build the tech giant's second home in Chicago on Wednesday, using the opening of a new Downtown office to tout Chicagoans' 'Midwestern work ethic.' Chicagoans' 'incredible strength' would be an asset to the tech giant, which is looking to build a $5 billion second headquarters that would employ at least 50,000 people, Emanuel said." Story here

- "Rauner should be Team Chicago -- not St. Louis -- in Amazon race," by Crain's Chicago Business' Joe Cahill: "Whose side is Bruce Rauner on? Earlier this week, our governor said his administration is helping Missouri in its bid to bring Amazon's second headquarters to St. Louis. Noting the possible spillover benefits for nearby Illinois counties, Rauner said, 'We will be working in assistance with the St. Louis proposal.' Perhaps the statement was just an empty political gesture meant to placate downstate constituencies as Rauner's economic development team works to bring the online retail giant's new hub to Chicago. He hastened to add that his 'real focus' is on Chicago's bid." Story here

-- "Oak Brook to bid for Amazon headquarters at McDonald's site," by Pioneer Press' Chuck Fieldman: "Oak Brook officials are hopeful that the 2018 move of McDonald's corporate offices to Chicago provides the perfect fit for e-commerce giant Amazon's search for a 50,000-job second headquarters. Oak Brook is throwing its hat in the ring to be part of an official bid to Amazon officials looking to add

another headquarters outside of their Seattle site. 'I really think we have a good chance of getting this, or at least getting to talk with Amazon,' said Valentina Tomov, president and chief executive officer of the Greater Oak Brook Chamber of Commerce." Story here

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- "Puerto Rico entirely without power as Hurricane Maria hammers island with force not seen in 'modern history,'" by The Washington Post's Samantha Schmidt and Sandhya Somashekhar: Story here

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POLITICO

Lee, Kyong

From: Hoffman, John K.
Sent: Thursday, September 21, 2017 7:38 AM
To: Norwood, Felicia
Subject: Fw: [External] POLITICO Illinois Playbook: JB pounces on RAUNER's HB40 indecision — KWAME's all in for AG — STATE could lose $153B under ACA repeal

Director --

FYI, in case you haven't seen, Politico makes reference to the HB40 video from April.

John

From: Natasha Korecki
Sent: Thursday, September 21, 2017 6:23 AM
To: Hoffman, John K.
Subject: [External] POLITICO Illinois Playbook: JB pounces on RAUNER's HB40 indecision — KWAME's all in for AG — STATE could lose $153B under ACA repeal

09/21/2017 07:21 AM EDT

By Natasha Korecki (nkorecki@politico.com; @natashakorecki) and Kristen East (keast@politico.com; @kristenicoleast)

Good Thursday morning, Illinois.

THE BUZZ - Gov. Bruce Rauner's ongoing struggle with the politics of a controversial abortion bill hasn't gone unnoticed by potential opponents.

Today, J.B. Pritzker is seizing on Rauner's indecision with HB40 by releasing a new statewide TV ad where the billionaire Democrat declares if he's elected, HB40 will be the first bill he signs.

We have a first look at the ad, **"Stand Up"**: Watch

Earlier this month, Pritzker collected 4,000 postcards from throughout the state in support of HB40 and delivered them to Governor Rauner's office along with the bill's co-sponsors Sen. Heather Steans and Rep. Sara Feigenholtz. Video showing them delivering to Thompson Center here.

What's missing? Both of these videos discuss only one part of the proposed legislation, neglecting to mention that HB40 also calls for the expansion of public funding of abortions to Medicaid recipients and to state health plans. Both Pritzker's new TV ad and the Facebook video only talk about the language in the bill that aims to reverse a so-called "trigger law" that's on the books in Illinois.

As it happens, Rauner has said he support a bill only containing the "trigger law," language. It's the public funding expansion that he's rejected. Recall the video his administration released in April in which Dept. of Healthcare and Family Services' Felicia Norwood said: "Because expanding taxpayer funding of abortion is an extremely divisive issue, Gov. Rauner says he will veto House Bill 40 ... the administration does not support expanding taxpayer funding for elective procedures."

WORTH NOTING - We'll again point out that Democrats haven't sent him the bill. A procedural hold is still on that legislation, keeping it in the Senate. Personal PAC's Terry Cosgrove last week told us it won't be sent until Rauner vows to sign the bill as is. As we first reported Tuesday, Rauner now says he's undecided on the legislation, a change from his vow to veto it.

KWAME's IN - State Sen. Kwame Raoul made his candidacy for Illinois Attorney General official on Wednesday. "I think I have the strongest record than anyone I've heard mentioned," he said in an interview. He ticked off his work on criminal justice reform; a bill aimed at repeat gun offenders, his partnership with

Rauner as well as with Republican leaders in the House and Senate. Raoul said he was the point person to negotiate concealed carry legislation and adding background checks as well as legislation requiring reporting of lost and stolen weapons. "I think I have the best record to hit the ground running."

On AG's range of responsibilities, Raoul said he wouldn't shy away from any type of prosecution within the office's jurisdiction. He also defended Lisa Madigan against those who criticize her for not doing enough to take on public corruption. "It's unfair to criticize Lisa Madigan. You can only do what you're resourced to do. Sometimes federal prosecutors are better equipped than the Attorney General."

- "Raoul enters AG race, apologizes for 'Miss America' comment," by the State Journal-Register's Bernard Schoenburg: "State Sen. Kwame Raoul, D-Chicago, who says he will run for attorney general in 2018, on Wednesday apologized for how he referred to Republican candidate Erika Harold when discussing the office last week. 'I've seen the reaction to the comment that I made, and I don't blame anybody for being offended,' Raoul told The State Journal-Register. 'If I read them without the full context of our full conversation, I would have the same reaction. ... I take full responsibility for the bad characterization.' Raoul told the newspaper on Friday, after Democratic Attorney General Lisa Madigan announced she would not seek another term, that 'I think Lisa would have acquitted herself well against Miss America. I don't know what's behind the attorney general's decision ... but I doubt seriously it was any fear of Erika Harold.' Harold, of Urbana, was the 2003 Miss America, and is also a graduate of Harvard Law School, and now practices law." Story here

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HEALTH CARE

- "How Graham-Cassidy would play out in Illinois," by Crain's Chicago Business' Nona Tepper: "Federal health care funding to Illinois would be slashed by $153 billion, or 34 percent, from 2020 to 2036 if lawmakers approve the latest GOP proposal to repeal and replace the Affordable Care Act. That's the analysis by Washington-based consultancy Avalere Health as a proposal by Republican Sens. Lindsey Graham and Bill Cassidy progresses on Capitol Hill. The plan would cut federal funding to Illinois insurance programs by $8 billion, or 5 percent, from 2020 to 2026, and $18 billion, or 11 percent, from 2020 to 2027, according to Avalere ... 'I have expressed my concerns to members of Congress and members of the administration about the changes to the ACA and very significant negative impacts it could have on the people of Illinois,' Gov. Bruce Rauner said today at a news conference. Rauner said the proposed bill would have a 'big impact, negative impact' on Illinoisans who receive insurance through Obamacare." Story here

- "Illinois submits big Obamacare rate increases to the feds," by Chicago Tribune's Lisa Schencker: "Hundreds of thousands of Illinois consumers who buy health insurance on the state's Obamacare exchange will likely see average rates increase by 16 percent to 37 percent next year for the lowest-priced plans, according to a new analysis. The Illinois Department of Insurance submitted rates to the federal government Wednesday that would increase the average cost of the lowest-priced silver plans by 35 percent statewide. The lowest-priced bronze-level plans would increase, on average, by 20 percent, and the lowest-priced gold plans would increase by 16 percent, according to a department analysis obtained by the Tribune ... 'It's just more indication of what we've seen already, which is (that) the incredible uncertainty that is being injected into the health care system by the Trump administration is causing chaos,' said Stephani Becker, a senior policy specialist at the Sargent Shriver National Center on Poverty Law." Story here

STATE

- "Illinois' unpaid bill backlog hits a record $16 billion," by Reuters: "Illinois' pile of unpaid bills topped $16 billion for the first time as the state deals with the fallout of an unprecedented two straight fiscal years without complete budgets, the state comptroller's office reported on Tuesday. The bill backlog is growing despite the enactment of a fiscal 2018 spending plan and income tax increase in July that ended a budget impasse between Illinois' Republican governor and Democrats who control the legislature." Story here

- "Trump administration move could mean changes for Loyola sexual assault policy," by Loyola Phoenix's Christopher Hacker and Mary Norkol: "The Trump administration may change rules for how colleges handle

sexual assault allegations involving students, raising concerns at Loyola that protections for victims could be rolled back. President Donald Trump's Secretary of Education, Betsy DeVos, recently criticized Obama-era policies that told schools that receive federal funding, including Loyola, how to handle allegations of sexual misconduct. She argued they 'failed' students by forcing schools to assume someone accused of sexual assault is guilty." Story here

- "One student shot, one arrested at high school in downstate Mattoon," by AP: "A teacher subdued a male student who fired shots and wounded another student in a central Illinois high school cafeteria on Wednesday morning, police said. Mattoon police Chief Jeff Branson and Mattoon School Superintendent Larry Lilly said the shooting happened at Mattoon High School about 11:30 a.m. Wednesday. The suspect, a male student, is in custody, police said, and the injured student is in stable condition at a local hospital." Story here

CHICAGO

- "New police training center advances; protesters want funds spent elsewhere," by DNAinfo's Heather Cherone: "Plans for a state-of-the-art $95 million training facility for Chicago police and fire recruits advanced Wednesday after winning the endorsement of a key city panel. While the Chicago Plan Commission unanimously approved the plan to buy the 30-acre site at 4301 W. Chicago Ave. in Garfield Park for $9.6 million, a coalition of groups rallied outside Mayor Rahm Emanuel's fifth-floor City Hall office urging that the plan be shelved and the money spent on schools and community redevelopment efforts." Story here

- "'Nothing will ever be OK again': Police officer's nephew fatally shot on Far South Side porch," by Chicago Tribune's Elyssa Cherney and Madeline Buckley: "Issac Harper's twin sister cried softly as she stood in the street in her socks. 'Nothing will ever be OK again,' she said to a group of family members huddled outside a crime scene on the Far South Side late Tuesday. The woman then sat in a car as police went inside a two-story brick home to investigate her brother's fatal shooting on the back porch. She rocked back and forth and stared straight ahead. Harper, 21, was with his sister outside, smoking a cigarette, in the Longwood Manor neighborhood just before 9:40 p.m. when gunfire erupted, police said. The college student and Amazon employee was hit in the shoulder, leg and hip, according to police and relatives. He was pronounced dead on the scene, one of 11 people shot across the city on Tuesday." Story here

- "Kenneka Jenkins case highlights mistrust of police," by Chicago Tribune's John Keilman: "Video released by Rosemont police seemed to solve at least part of the Kenneka Jenkins mystery. The surveillance recordings depict Jenkins, 19, staggering alone through a kitchen of the Crowne Plaza Chicago O'Hare Hotel and around a corner where a walk-in freezer is located. Though the camera doesn't capture her entering the freezer, no one else appears in that part of the room until a hotel worker finds her body 21 hours later. Convincing proof Jenkins did not meet with foul play? Far from it, according to many engrossed by the case." Story here

- "Moving company says more people leaving Chicago than any other major city," by Illinois News Network: "The nation's biggest mover is corroborating Census data showing the exodus of residents from Chicago and across Illinois. Earlier this month, the U.S. Census released its report that said most Illinois' cities are shrinking in population, with the entire state estimated to have lost 58,456 people on net in 12 months ending in July. United Van Lines tracks how many people come and go from the nation's larger cities every summer. They found that more people moved from Chicago than any other metropolitan area." Story here

CHASING AMAZON

- "Rahm touts Chicago's 'Midwestern work ethic' in push for Amazon HQ," by DNAinfo's Heather Cherone: "Mayor Rahm Emanuel continued his intense push to persuade Amazon CEO Jeff Bezos to build the tech giant's second home in Chicago on Wednesday, using the opening of a new Downtown office to tout Chicagoans' 'Midwestern work ethic.' Chicagoans' 'incredible strength' would be an asset to the tech giant, which is looking to build a $5 billion second headquarters that would employ at least 50,000 people, Emanuel said." Story here

- "Rauner should be Team Chicago -- not St. Louis -- in Amazon race," by Crain's Chicago Business' Joe Cahill: "Whose side is Bruce Rauner on? Earlier this week, our governor said his administration is helping Missouri in its bid to bring Amazon's second headquarters to St. Louis. Noting the possible spillover benefits for nearby

Illinois counties, Rauner said, 'We will be working in assistance with the St. Louis proposal.' Perhaps the statement was just an empty political gesture meant to placate downstate constituencies as Rauner's economic development team works to bring the online retail giant's new hub to Chicago. He hastened to add that his 'real focus' is on Chicago's bid." Story here

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Lee, Kyong

From: Besler, Patrick <PBesler@hrs.ilga.gov>
Sent: Tuesday, April 25, 2017 3:50 PM
To: McGady, Shawn
Subject: [External] RE: Hb40

Is this information accurate?

http://familiesusa.org/product/federal-poverty-guidelines

From: McGady, Shawn [mailto:Shawn.McGady@illinois.gov]
Sent: Tuesday, April 25, 2017 2:45 PM
To: Besler, Patrick
Subject: RE: Hb40

Yes

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Sent: Tuesday, April 25, 2017 2:45 PM
To: McGady, Shawn
Subject: [External] RE: Hb40

Thanks, so under Hb40 someone in any of those populations can receive a medicaid funded abortion?

From: McGady, Shawn [mailto:Shawn.McGady@illinois.gov]
Sent: Tuesday, April 25, 2017 2:40 PM
To: Besler, Patrick
Subject: RE: Hb40

Below are our eligibility groups.

All Kids Assist
Eligibility - Children up to 19 with family income at or below 147% of the Federal Poverty Limit (FPL) ($3,014 per month for family of four (4))

All Kids Share
Eligibility - Children up to 19 with family income above 147% and at or below 157% FPL (between $3,015 and $3,219 a month for a family of four (4)).

All Kids Premium Level 1
Eligibility - Children up to 19 with family income above 157% and at or below 209% FPL (between $3,220 and $4,285 a month for a family of four (4)).

All Kids Premium Level 2
Eligibility - Children up to 19 with family income above 209% and at or below 318% FPL (between $4,286 and $6,519 per month for a family of four (4)).

Moms and Babies

Eligibility - Pregnant women and their babies up to age one (1) with a family income at or below 213% FPL (at or below a month for a family of three (3) plus the unborn baby). Babies under one (1) are eligible at any income level if Medicaid covered their mother at the time of birth.

FamilyCare Assist
Eligibility - Parents and caretaker relatives raising dependent minor children with an income at or below 138% FPL ($2,829 per month for a family of four (4)) for adults.

ACA Adults
Eligibility - Adults age 19-64 without minor children in the home who do not receive Medicare and have income up to 138% FPL (monthly income up to $1,387 for an individual or $1,868 for a couple).

Aid to Aged Blind and Disabled (AABD/Seniors and Persons with Disability) Medical
Eligibility - Persons who are 65 and older, who are blind, or who are disabled, with monthly income up to 100% FPL ($1,005 for a single person and $1,353 for a couple) and no more than $2,000 of non-exempt resources for one person and $3,000 for a couple.

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Hey Shawn, was just asked the following question. What income level would one have to be at to receive a Medicaid funded abortion under this bill. is it 200% FPL?

I am not too familiar with the bill so correct me if there is a different threshold in it, but our Medicaid income threshold is 138% . Also what is the monetary value of 138% FPL?

With that 200% FPL they may have been talking about like a family? Let me know thanks.

Patrick D. Besler
House Republican Staff
217-782-5528
PBesler@hrs.ilga.gov

House Republican Staff

Lee, Kyong

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Shawn do you have a monetary value associated with the group below?

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Patrick D. Besler
House Republican Staff
217-782-5528
PBesler@hrs.ilga.gov

House Republican Staff

Lee, Kyong

From: Besler, Patrick <PBesler@hrs.ilga.gov>
Sent: Tuesday, April 25, 2017 2:46 PM
To: McGady, Shawn
Subject: [External] RE: Hb40

Thanks.

From: McGady, Shawn [mailto:Shawn.McGady@illinois.gov]
Sent: Tuesday, April 25, 2017 2:45 PM
To: Besler, Patrick
Subject: RE: Hb40

Yes

From: Besler, Patrick [mailto:PBesler@hrs.ilga.gov]
Sent: Tuesday, April 25, 2017 2:45 PM
To: McGady, Shawn
Subject: [External] RE: Hb40

Thanks, so under Hb40 someone in any of those populations can receive a medicaid funded abortion?

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Eligibility - Children up to 19 with family income above 147% and at or below 157% FPL (between $3,015 and $3,219 a month for a family of four (4)).

All Kids Premium Level 1
Eligibility - Children up to 19 with family income above 157% and at or below 209% FPL (between $3,220 and $4,285 a month for a family of four (4)).

All Kids Premium Level 2
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Moms and Babies

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FamilyCare Assist
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ACA Adults
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Lee, Kyong

From: Kelm, Dave <DKelm@hrs.ilga.gov>
Sent: Thursday, April 20, 2017 11:06 AM
To: McGady, Shawn
Subject: [External] HB40

Shawn:

Do you guys care at all about HB40?

Thx-dk

David A. Kelm
Senior Legal Counsel
House Republican Leader James B. Durkin
Illinois Statehouse Room 220
Springfield, IL 62701
DKelm@hrs.ilga.gov
Tel: 217/782-0670
Cell: 217/836-2082
Fax: 217/524-7748
House Republican Staff

Lee, Kyong

From: Norwood, Felicia
Sent: Wednesday, April 19, 2017 5:44 PM
To: Hoffman, John K.
Cc: Marchiori, Ray; Dellamorte, Gina
Subject: RE: HB 40 interviews

Thanks

Felicia F. Norwood
Director
Illinois Department of Healthcare and Family Services Chicago Office: 312-793-4792 Springfield Office: 217-782-7755

-----Original Message-----
From: Hoffman, John K.
Sent: Wednesday, April 19, 2017 5:39 PM
To: Norwood, Felicia
Cc: Marchiori, Ray; Dellamorte, Gina
Subject: RE: HB 40 interviews

Director --

Flannery's story just ran. He used a clip from you saying you disagree that the Governor has been wrong on women's health issues and noting the two bills he did sign. The focus of the story was mainly about Personal PAC criticizing his threatened veto. The cardinal's statement of praise was also included. Overall, I think it was a balanced report.

I'll send a link to the story if it's made available later.

John

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From: Norwood, Felicia
Sent: Wednesday, April 19, 2017 1:32 PM
To: Hoffman, John K.
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Subject: RE: HB 40 interviews

Let's just do it by phone.

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Illinois Department of Healthcare and Family Services Chicago Office: 312-793-4792 Springfield Office: 217-782-7755

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From: Hoffman, John K.
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To: Norwood, Felicia
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Subject: RE: HB 40 interviews

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From: Norwood, Felicia
Sent: Wednesday, April 19, 2017 1:21 PM
To: Hoffman, John K.
Cc: Marchiori, Ray
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John

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From: Kelly, Catherine
Sent: Wednesday, April 19, 2017 12:53 PM
To: Burnett, Sara
Subject: HB 40

Hi, Sara:
Believe some others are weighing in, as well, but I wanted to make sure you had this background. Director Norwood of HFS is also available to talk about current policy in Illinois. John Hoffman from HFS can be reached at 312.793.4971 to coordinate.

Please let me know.

Best,
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Background on HB 40

· Under current Illinois law, abortions are already covered under Medicaid in situations including:

o Saving the life of the mother

o Protecting the health of the mother

o Rape or incest

· Illinois already goes above and beyond federal law by covering abortions to protect the health of the mother.

o The Hyde Amendment (federal) only allows federal/public money to be used in the to save the life of the mother, or in the case of rape or incest. Current Illinois law exceeds federal guidelines and goes a step farther in allowing abortion in the case to protect the health of the mother.

· While the majority of states have followed the federal government's lead in restricting abortions, Illinois is not one of them.

o Approximately seventeen states, including Illinois, allow taxpayer funds to pay for abortion beyond the federal guidelines (typically to protect the health of the mother).

· HB 40 will do nothing to change the current protections for abortion in Illinois.

o If HB 40 does not pass or is vetoed, the status quo will remain. All abortions currently covered will continue to be covered.

· Governor Rauner is taking the same position as Governors Ryan and Edgar.

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From: Hoffman, John K.
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To: Norwood, Felicia
Cc: Marchiori, Ray; Dellamorte, Gina
Subject: RE: HB 40 interviews

Correction, Director: Mike Flannery is with FOX CHICAGO 32, not Channel 2. Gina made the catch. (I've been around too long, I think.)

Sorry about the confusion.

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From: Norwood, Felicia
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Lee, Kyong

From: Hoffman, John K.
Sent: Wednesday, April 19, 2017 1:45 PM
To: Norwood, Felicia
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Subject: RE: HB 40 interviews

Okay, 2:30 by phone?

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I spoke with Brad Hahn and Ray. The Governor's Office is letting reporters know you are available to talk if they are interested. They're directing them through me. I'll let you know if and when requests come in.

John

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From: Kelly, Catherine
Sent: Wednesday, April 19, 2017 12:53 PM
To: Burnett, Sara
Subject: HB 40

Hi, Sara:
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Please let me know.

Best,
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Background on HB 40

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o Rape or incest

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· HB40 expands taxpayer funding for abortion to include purely elective procedures. This moves us beyond the position of 47 other states.

Lee, Kyong

From: Norwood, Felicia
Sent: Wednesday, April 19, 2017 1:32 PM
To: Hoffman, John K.
Cc: Marchiori, Ray; Dellamorte, Gina
Subject: RE: HB 40 interviews

Let's just do it by phone.

Felicia F. Norwood
Director
Illinois Department of Healthcare and Family Services Chicago Office: 312-793-4792 Springfield Office: 217-782-7755

-----Original Message-----
From: Hoffman, John K.
Sent: Wednesday, April 19, 2017 1:31 PM
To: Norwood, Felicia
Cc: Marchiori, Ray; Dellamorte, Gina
Subject: RE: HB 40 interviews

Mike Flannery, Channel 2, would like to come to the office for an interview, ideally between 2 and 2:30. Or we can do it by phone, which could be a little bit later. Please advise.

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From: Norwood, Felicia
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To: Hoffman, John K.
Cc: Marchiori, Ray
Subject: RE: HB 40 interviews

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in error, please notify the sender immediately by return e-mail and destroy this communication and all copies thereof, including all attachments. Receipt by an unintended recipient does not waive attorney-client privilege, attorney work product privilege, or any other exemption from disclosure.

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Lee, Kyong

From: McGady, Shawn
Sent: Friday, March 03, 2017 8:45 PM
To: 'Sinner, Justin'
Subject: RE: HB40

I will see what I can do.

From: Sinner, Justin [mailto:JSinner@sgop.ilga.gov]
Sent: Friday, March 03, 2017 4:37 PM
To: McGady, Shawn
Subject: [External] HB40

Shawn,

Senator Bivins has asked for a breakdown of the HB 40 fiscal impact. Can you please provide information regarding the calculation?

> HB40 Fiscal Impact: The estimated annual cost for abortion services resulting from House Bill 40 is approximately $1.8 million, which would be 100% GRF funded. There may be other budgetary impacts that are not quantifiable.

Thanks.

Justin Sinner
Senate Republican Staff
B-Section, Stratton Building
217-782-0797
email: jsinner@sgop.ilga.gov

Please note that my e-mail address is changing. My new e-mail address will be my name as it appears now @sgop.ilga.gov

Lee, Kyong

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Lee, Kyong

From: Kelm, Dave <DKelm@hrs.ilga.gov>
Sent: Friday, February 17, 2017 10:00 AM
To: McGady, Shawn
Subject: [External] RE: HB40

Shawn:

I see on your Fiscal Note for HB 40 that there is the possibility of a $1.3M cost. Do you guys have any projections of the hit that could be possible from the Hyde amendment relating to federal funding?

Thx-dk

David A. Kelm
Senior Legal Counsel
House Republican Leader James B. Durkin
Illinois Statehouse Room 220
Springfield, IL 62701
DKelm@hrs.ilga.gov
Tel: 217/782-0670
Cell: 217/836-2082
Fax: 217/524-7748
House Republican Staff

Lee, Kyong

From: Vespa, Michael
Sent: Thursday, February 16, 2017 11:39 AM
To: McGady, Shawn
Cc: Carr, Jodi C.
Subject: Jennifer

Would like to talk to you about HB40

Lee, Kyong

From: Norwood, Felicia
Sent: Wednesday, February 15, 2017 9:14 AM
To: Bassi, Gregory; McGady, Shawn
Subject: : From Rep Feigenholtz

Let's discuss.

Felicia F. Norwood
Director

Begin forwarded message:

> **From:** Felicia Norwood <ffnorwood@me.com>
> **Date:** February 15, 2017 at 9:12:09 AM CST
> **To:** Felicia Norwood <Felicia.Norwood@illinois.gov>
> **Subject: [External] Fwd: From Rep Feigenholtz**
>
> Begin forwarded message:
>
> > **From:** Sara Feigenholtz <staterep12@gmail.com>
> > **Date:** February 15, 2017 at 8:49:01 AM CST
> > **To:** Felicia Norwood <ffnorwood@me.com>
> > **Subject: From Rep Feigenholtz**
> >
> > Dear Director,
> >
> > I have requested a fiscal note from your agency for HB40.
> >
> > The Medicaid portion of HB40 is identical to HB 4013 from the 99th general assembly.
> > The corrected fiscal note on HB4013 was
> > Zero.
> >
> > I would appreciate a response to this request today if possible.
> >
> > Thank you.
> >
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> >
> > Sara Feigenholtz
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>
> should be the same

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Lee, Kyong

From: McGady, Shawn
Sent: Thursday, February 09, 2017 1:53 PM
To: Besler, Patrick
Subject: RE: [External] Hb40 ASAP

Yes. thanks

-----Original Message-----
From: Besler, Patrick [mailto:PBesler@hrs.ilga.gov]
Sent: Thursday, February 09, 2017 1:53 PM
To: McGady, Shawn
Subject: RE: [External] Hb40 ASAP

This is the right one for Mitchell right?

House Sponsors
Rep. Bill Mitchell

Last Action

Date Chamber Action
2/9/2017 House Filed with the Clerk by Rep. Bill Mitchell

Statutes Amended In Order of Appearance

755 ILCS 5/18-3 from Ch. 110 1/2, par. 18-3

Synopsis As Introduced
Amends the Probate Act of 1975. Provides that a specified notice to creditors shall be delivered to the Illinois Department of Healthcare and Family Services, at the Bureau of Collections at the Chicago office of the Department, if the decedent was 55 years of age or older or resided in a nursing facility or other medical institution. Provides that a copy of the petition to admit the will to probate or for letters of administration and the decedent's social security number and date of birth shall be attached to the notice delivered to the Department.

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From: McGady, Shawn [mailto:Shawn.McGady@illinois.gov]
Sent: Thursday, February 09, 2017 1:41 PM
To: Besler, Patrick
Subject: RE: [External] Hb40 ASAP

When we get something I will let you know. Thanks!

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From: Besler, Patrick [mailto:PBesler@hrs.ilga.gov]
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I don't have anything yet.

Sent from my iPhone

> On Feb 9, 2017, at 1:17 PM, Besler, Patrick <PBesler@hrs.ilga.gov> wrote:
>
> Do you have a fiscal impact?
>
> Sent from my iPhone
>
> This electronic mail transmission may contain confidential or privileged information.
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Sent from my iPhone

Lee, Kyong

From: Griffith, Donovan
Sent: Thursday, February 09, 2017 11:09 AM
To: Butler, Wendy; McGady, Shawn
Cc: Fulkerson, Zack; Taylor, Pam
Subject: RE: Final Members

Alright, I'll talk with him today.

Thank you.

From: Butler, Wendy
Sent: Thursday, February 09, 2017 11:04 AM
To: Griffith, Donovan; McGady, Shawn
Cc: Fulkerson, Zack; Taylor, Pam
Subject: RE: Final Members

Pam asked him twice in the same conversation and he said no twice.

Wendy Butler, CMS
Director of Governmental Affairs
217/524-1409 (direct line)
217/785-1941 (main office)
217/685-9947 (cell)
wendy.butler@illinois.gov

From: Griffith, Donovan
Sent: Thursday, February 09, 2017 10:57 AM
To: Butler, Wendy; McGady, Shawn
Cc: Fulkerson, Zack; Taylor, Pam
Subject: RE: Final Members

FYI, I am hearing a different story from LaShawn than what you have him listed as.

From: Butler, Wendy
Sent: Thursday, February 09, 2017 10:10 AM
To: Griffith, Donovan; McGady, Shawn
Cc: Fulkerson, Zack; Taylor, Pam
Subject: RE: Final Members

The highlighted members were ours and we are following up this morning.

- K. Burke
- Conyears-Ervin
- Crespo
- D'Amico
- Ford - NO
- Kifowit
- Manly
- Mayfield

- McAsey-EXCUSED and not here this week
- Stuart
- Thapedi
- Walsh
- Yingling

Wendy Butler, CMS
Director of Governmental Affairs
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217/785-1941 (main office)
217/685-9947 (cell)
wendy.butler@illinois.gov

From: Griffith, Donovan
Sent: Thursday, February 09, 2017 8:49 AM
To: McGady, Shawn; Butler, Wendy
Subject: Final Members

This is who we need to shore up on HB40:

- K. Burke
- Conyears-Ervin
- Crespo
- D'Amico
- Ford
- Kifowit
- Manly
- Mayfield
- McAsey
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If some of these individuals are not on your original list please discuss with one another on who will talk to who.

Thanks,

Donovan

Donovan Griffith
Senior House Liaison
Office of the Governor, Bruce Rauner
100 W Randolph St, Chicago, IL
C: 312-720-0709

Lee, Kyong

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Lee, Kyong

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We did – no firm answer. He said something to the effect of checking with Leader Currie and asked if we were going to share our results with her.

Wendy Butler, CMS
Director of Governmental Affairs
217/524-1409 (direct line)
217/785-1941 (main office)
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wendy.butler@illinois.gov

From: McGady, Shawn
Sent: Thursday, February 09, 2017 10:55 AM
To: Butler, Wendy
Subject: RE: Final Members

Hi Wendy,

Didn't you guys speak to Thapedi already? I though he gave you guys some strange answers.

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Cc: Fulkerson, Zack; Taylor, Pam
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To: Griffith, Donovan; McGady, Shawn
Cc: Fulkerson, Zack; Taylor, Pam
Subject: RE: Final Members

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C: 312-720-0709

Lee, Kyong

From: Fulkerson, Zack
Sent: Thursday, February 09, 2017 10:54 AM
To: Butler, Wendy
Cc: Griffith, Donovan; McGady, Shawn; Taylor, Pam
Subject: Re: Final Members

Just spoke with Hurley. She is a "yes."

Sent from my iPhone

On Feb 9, 2017, at 10:10 AM, Butler, Wendy <Wendy.Butler@Illinois.gov> wrote:

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- Conyears-Ervin
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wendy.butler@illinois.gov

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To: McGady, Shawn; Butler, Wendy
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Donovan

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Senior House Liaison
Office of the Governor, Bruce Rauner
100 W Randolph St, Chicago, IL
C: 312-720-0709

Lee, Kyong

From: Fulkerson, Zack
Sent: Thursday, February 09, 2017 10:37 AM
To: Butler, Wendy
Cc: Griffith, Donovan; McGady, Shawn; Taylor, Pam
Subject: Re: Final Members

And just now with Yingling. He is still undecided.

Sent from my iPhone

> On Feb 9, 2017, at 10:10 AM, Butler, Wendy <Wendy.Butler@Illinois.gov> wrote:
>
> The highlighted members were ours and we are following up this morning.
>
>
>
> · K. Burke
>
> · Conyears-Ervin
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> wendy.butler@illinois.gov<mailto:wendy.butler@illinois.gov>
>
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> Sent: Thursday, February 09, 2017 8:49 AM
> To: McGady, Shawn; Butler, Wendy
> Subject: Final Members
>
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> Thanks,
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> Donovan
>
>
> [cid:image003.jpg@01D282BC.B040E070]<https://www.illinois.gov/Pages/de
> fault.aspx>Donovan Griffith Senior House Liaison Office of the
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> <image001.png>
> <image003.jpg>

Lee, Kyong

From: Carr, Jodi C.
Sent: Thursday, February 09, 2017 10:29 AM
To: McGady, Shawn
Subject: RE: Final Members

She highlighted: K. Burke, Conyears-Ervin, Crespo, D'Amico, Ford (NO), Kifowit, McAsey (Excused) Yingling

Not highlighted: Manly, Mayfield, Stuart, Thapedi Walsh

Jodi Carr Babcock
Healthcare and Family Services
Office of the Director/Legislative Affairs
217-557-3254

From: McGady, Shawn
Sent: Thursday, February 09, 2017 10:27 AM
To: Carr, Jodi C.
Subject: Fwd: Final Members

Can you tell me who she highlighted and who she did not.

Sent from my iPhone

Begin forwarded message:

> **From:** "Butler, Wendy" <Wendy.Butler@Illinois.gov>
> **To:** "Griffith, Donovan" <Donovan.Griffith@illinois.gov>, "McGady, Shawn" <Shawn.McGady@illinois.gov>
> **Cc:** "Fulkerson, Zack" <Zack.Fulkerson@illinois.gov>, "Taylor, Pam" <Pam.Taylor@illinois.gov>
> **Subject: RE: Final Members**
>
> The highlighted members were ours and we are following up this morning.
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> - K. Burke
> - Conyears-Ervin
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Wendy Butler, CMS
Director of Governmental Affairs
217/524-1409 (direct line)
217/785-1941 (main office)
217/685-9947 (cell)
wendy.butler@illinois.gov

From: Griffith, Donovan
Sent: Thursday, February 09, 2017 8:49 AM
To: McGady, Shawn; Butler, Wendy
Subject: Final Members

This is who we need to shore up on HB40:

- K. Burke
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If some of these individuals are not on your original list please discuss with one another on who will talk to who.

Thanks,

Donovan

Donovan Griffith
Senior House Liaison
Office of the Governor, Bruce Rauner
100 W Randolph St, Chicago, IL
C: 312-720-0709

Lee, Kyong

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Subject: Fwd: Final Members

Can you tell me who she highlighted and who she did not.

Sent from my iPhone

Begin forwarded message:

> **From:** "Butler, Wendy" <Wendy.Butler@Illinois.gov>
> **To:** "Griffith, Donovan" <Donovan.Griffith@illinois.gov>, "McGady, Shawn" <Shawn.McGady@illinois.gov>
> **Cc:** "Fulkerson, Zack" <Zack.Fulkerson@illinois.gov>, "Taylor, Pam" <Pam.Taylor@illinois.gov>
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Lee, Kyong

From: Fulkerson, Zack
Sent: Thursday, February 09, 2017 10:17 AM
To: Butler, Wendy
Cc: Griffith, Donovan; McGady, Shawn; Taylor, Pam
Subject: Re: Final Members

Just talked to Crespo. He said he is "inclined to say yes"

Sent from my iPhone

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> <image001.png>
> <image003.jpg>

Lee, Kyong

From: Butler, Wendy
Sent: Thursday, February 09, 2017 10:11 AM
To: McGady, Shawn
Subject: RE: Final Members

Don't worry about it. I sent another email highlighting the ones we are working on from his latest list and 2 of them we've already gotten responses. Copied you.

Wendy Butler, CMS
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-----Original Message-----
From: McGady, Shawn
Sent: Thursday, February 09, 2017 10:10 AM
To: Butler, Wendy
Subject: Re: Final Members

I am in Stratton for a few more minutes and than I have a meeting at 11-12:30. Can meet real quick now or after 12:30.

Sent from my iPhone

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>
>
>
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> <image001.png>
> <image003.jpg>

Lee, Kyong

From: Butler, Wendy
Sent: Thursday, February 09, 2017 10:07 AM
To: McGady, Shawn
Subject: RE: Final Members

Do you want to do a quick call?

From: Griffith, Donovan
Sent: Thursday, February 09, 2017 8:49 AM
To: McGady, Shawn; Butler, Wendy
Subject: Final Members

This is who we need to shore up on HB40:

- K. Burke
- Conyears-Ervin
- Crespo
- D'Amico
- Ford
- Kifowit
- Manly
- Mayfield
- McAsey
- Stuart
- Thapedi
- Walsh
- Yingling

If some of these individuals are not on your original list please discuss with one another on who will talk to who.

Thanks,

Donovan

Donovan Griffith
Senior House Liaison
Office of the Governor, Bruce Rauner
100 W Randolph St, Chicago, IL
C: 312-720-0709

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Lee, Kyong

From: McGady, Shawn
Sent: Thursday, February 09, 2017 9:04 AM
To: Griffith, Donovan; Butler, Wendy
Subject: RE: Final Members

Below are notes from the members on the HFS list. Stuart probably fell through the cracks because she replaced a Republican. HFS will try and talk to her.

Wendy-please let me know if we can help you with any members on your list.

Thanks!

From: Griffith, Donovan
Sent: Thursday, February 09, 2017 8:49 AM
To: McGady, Shawn; Butler, Wendy
Subject: Final Members

This is who we need to shore up on HB40:

- K. Burke
- Conyears-Ervin
- Crespo
- D'Amico- YES
- Ford
- Kifowit
- Manly- is undecided right now. She says she's generally supportive of "choice", but hasn't read the bill nor heard from Sara.
- Mayfield-YES
- McAsey
- Stuart
- Thapedi
- Walsh
- Yingling

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Thanks,

Donovan

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Lee, Kyong

From: Griffith, Donovan
Sent: Thursday, February 09, 2017 8:49 AM
To: McGady, Shawn; Butler, Wendy
Subject: Final Members

This is who we need to shore up on HB40:

- K. Burke
- Conyears-Ervin
- Crespo
- D'Amico
- Ford
- Kifowit
- Manly
- Mayfield
- McAsey
- Stuart
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Lee, Kyong

From: Besler, Patrick <PBesler@hrs.ilga.gov>
Sent: Wednesday, February 08, 2017 4:17 PM
To: McGady, Shawn
Subject: RE: [External] Hb40

Thanks Shawn, also Rep. Mitchell reached out again wondering about money we spend on heroin. Do you have anything yet?

-----Original Message-----
From: McGady, Shawn [mailto:Shawn.McGady@illinois.gov]
Sent: Wednesday, February 08, 2017 3:51 PM
To: Besler, Patrick
Subject: Re: [External] Hb40

No. we have no position

Sent from my iPhone

> On Feb 8, 2017, at 3:42 PM, Besler, Patrick <PBesler@hrs.ilga.gov> wrote:
>
> Are you guys still opposed? Patti is wondering.
>
> Sent from my iPhone
>
> This electronic mail transmission may contain confidential or privileged information.
> If you believe that you have received this message in error, please notify the sender by reply transmission and delete the message without copying or disclosing it.

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Lee, Kyong

From: McGady, Shawn
Sent: Wednesday, February 08, 2017 3:51 PM
To: Besler, Patrick
Subject: Re: [External] Hb40

No. we have no position

Sent from my iPhone

> On Feb 8, 2017, at 3:42 PM, Besler, Patrick <PBesler@hrs.ilga.gov> wrote:
>
> Are you guys still opposed? Patti is wondering.
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> Sent from my iPhone
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> If you believe that you have received this message in error, please notify the sender by reply transmission and delete the message without copying or disclosing it.

Lee, Kyong

From: Besler, Patrick <PBesler@hrs.ilga.gov>
Sent: Wednesday, February 08, 2017 3:43 PM
To: McGady, Shawn
Subject: [External] Hb40

Are you guys still opposed? Patti is wondering.

Sent from my iPhone

Lee, Kyong

From: McGady, Shawn
Sent: Friday, February 03, 2017 2:58 PM
To: Griffith, Donovan
Cc: Butler, Wendy
Subject: HB40

Andrade is also “yes”
Left messages at: Stratton, Greenwood Manley, Martwick, Mayfield, Riley, Wallace, Halpin

Lee, Kyong

From: McGady, Shawn
Sent: Friday, February 03, 2017 2:56 PM
To: Butler, Wendy
Cc: Griffith, Donovan
Subject: Re: HB40

These are al yes.

Mah

Chapa LaVia

Lou Lang (now co-sponsor)

Arroyo (now-co-sponsor)

Tabares

Sent from my iPhone

On Feb 3, 2017, at 2:34 PM, Butler, Wendy <Wendy.Butler@Illinois.gov> wrote:

C. Mitchell – Y
L. Fine – Y
M. Moylan – Y
W. Guzzardi – Y
Kifowit – undecided
K. Burke – undecided
Conyers-Ervin – undecided
Wendy Butler, CMS
Director of Governmental Affairs
217/524-1409 (direct line)
217/785-1941 (main office)
217/685-9947 (cell)
wendy.butler@illinois.gov

From: Griffith, Donovan
Sent: Friday, February 03, 2017 2:34 PM
To: McGady, Shawn; Butler, Wendy
Subject: HB40
Could you both send me your updated names on the HB40 roll call so I can update our master list?
Thanks
Donovan Griffith
Senior House Liaison
Office of the Governor, Bruce Rauner
100 W Randolph St, Chicago, IL
C: 312.720.0709

Lee, Kyong

From: Villagrana, Hector
Sent: Friday, February 03, 2017 2:43 PM
To: McGady, Shawn
Subject: RE: HB40

Andrade is also "yes"

Left messages at: Stratton, Greenwood Manley, Martwick, Mayfield, Riley, Wallace, Halpin

---

From: McGady, Shawn
Sent: Friday, February 03, 2017 2:41 PM
To: Villagrana, Hector
Subject: Re: HB40

Sure

Sent from my iPhone

On Feb 3, 2017, at 2:40 PM, Villagrana, Hector <Hector.Villagrana@illinois.gov> wrote:

> Sorry, those are all yeses. Haven't gotten any other positions at all. Left several messages. Do you need those?
>
> ---
>
> **From:** McGady, Shawn
> **Sent:** Friday, February 03, 2017 2:39 PM
> **To:** Villagrana, Hector
> **Subject:** Re: HB40
>
> Do you have positions?
>
> Sent from my iPhone
>
> On Feb 3, 2017, at 2:37 PM, Villagrana, Hector <Hector.Villagrana@illinois.gov> wrote:
>
> > To the list you sent me I've added:
> > Mah
> > Chapa LaVia
> > Lou Lang (now co-sponsor)
> > Arroyo (now-co-sponsor)
> > Tabares
> >
> > ---
> >
> > **From:** McGady, Shawn
> > **Sent:** Friday, February 03, 2017 2:36 PM
> > **To:** Villagrana, Hector
> > **Subject:** Fwd: HB40
> >
> > Can you please send me what you have?
> >
> > Sent from my iPhone

Begin forwarded message:

From: "Griffith, Donovan" <Donovan.Griffith@illinois.gov>
To: "McGady, Shawn" <Shawn.McGady@illinois.gov>, "Butler, Wendy" <Wendy.Butler@Illinois.gov>
Subject: HB40

Could you both send me your updated names on the HB40 roll call so I can update our master list?

Thanks

Donovan Griffith
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Lee, Kyong

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Sent: Friday, February 03, 2017 2:41 PM
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Subject: Re: HB40

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Sent from my iPhone

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> > Sent from my iPhone
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> > > **To:** "McGady, Shawn" <Shawn.McGady@illinois.gov>, "Butler, Wendy" <Wendy.Butler@Illinois.gov>
> > > **Subject: HB40**
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> > > **Donovan Griffith**

Senior House Liaison
Office of the Governor, Bruce Rauner
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Lee, Kyong

From: Villagrana, Hector
Sent: Friday, February 03, 2017 2:40 PM
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Sorry, those are all yeses. Haven't gotten any other positions at all. Left several messages. Do you need those?

From: McGady, Shawn
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To: Villagrana, Hector
Subject: Re: HB40

Do you have positions?

Sent from my iPhone

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> > **Subject: HB40**
> >
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> > Thanks
> >
> > **Donovan Griffith**
> > Senior House Liaison

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Lee, Kyong

From: McGady, Shawn
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To: Villagrana, Hector
Subject: Re: HB40

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>
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>
> > **From:** "Griffith, Donovan" <Donovan.Griffith@illinois.gov>
> > **To:** "McGady, Shawn" <Shawn.McGady@illinois.gov>, "Butler, Wendy" <Wendy.Butler@Illinois.gov>
> > **Subject: HB40**
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Lee, Kyong

From: Villagrana, Hector
Sent: Friday, February 03, 2017 2:38 PM
To: McGady, Shawn
Subject: RE: HB40

To the list you sent me I've added:
Mah
Chapa LaVia
Lou Lang (now co-sponsor)
Arroyo (now-co-sponsor)
Tabares

From: McGady, Shawn
Sent: Friday, February 03, 2017 2:36 PM
To: Villagrana, Hector
Subject: Fwd: HB40

Can you please send me what you have?

Sent from my iPhone

Begin forwarded message:

> **From:** "Griffith, Donovan" <Donovan.Griffith@illinois.gov>
> **To:** "McGady, Shawn" <Shawn.McGady@illinois.gov>, "Butler, Wendy" <Wendy.Butler@Illinois.gov>
> **Subject: HB40**
>
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> Thanks

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Lee, Kyong

From: McGady, Shawn
Sent: Friday, February 03, 2017 2:37 PM
To: Villagrana, Hector
Subject: Fwd: HB40

FYI

Sent from my iPhone

Begin forwarded message:

> **From:** "Butler, Wendy" <Wendy.Butler@Illinois.gov>
> **To:** "Griffith, Donovan" <Donovan.Griffith@illinois.gov>, "McGady, Shawn" <Shawn.McGady@illinois.gov>
> **Subject: RE: HB40**
>
> C. Mitchell – Y
> L. Fine – Y
> M. Moylan – Y
> W. Guzzardi – Y
> Kifowit – undecided
> K. Burke – undecided
> Conyers-Ervin – undecided
> Wendy Butler, CMS
> Director of Governmental Affairs
> 217/524-1409 (direct line)
> 217/785-1941 (main office)
> 217/685-9947 (cell)
> wendy.butler@illinois.gov
>
> **From:** Griffith, Donovan
> **Sent:** Friday, February 03, 2017 2:34 PM
> **To:** McGady, Shawn; Butler, Wendy
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Sent: Friday, February 03, 2017 2:35 PM
To: Griffith, Donovan; McGady, Shawn
Subject: RE: HB40

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M. Moylan – Y
W. Guzzardi – Y

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