Table of Contents

State/Territory Name: IL

State Plan Amendment (SPA) #: 12-023

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Regional Operations Group

November 5, 2019

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

Attn: Douglas Elwell

Dear Ms. Eagleson:

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

Transmittal #12-023	-Changes Co-Payments -Effective Date: July 1, 2012 -Approval Date: November 1, 2019

If you have any questions, please have a member of your staff contact Courtenay Savage at 312-353-3721 or via email at Courtenay.Savage@cms.hhs.gov.

Sincerely,

/s/
Ruth A. Hughes
Deputy Director
Center for Medicaid and CHIP Services
Regional Operations Group

Enclosure

cc: Sara Barger, HFS
Mary Doran, HFS
Jane Eckert, HFS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Regional Operations Group

November 5, 2019

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

Attn: Douglas Elwell

Dear Ms. Eagleson:

This letter is being sent as a companion to the Centers for Medicare and Medicaid Services' (CMS) approval of State Plan Amendment (SPA) TN #12-023, which the state submitted on September 28, 2012 to increase cost sharing in the state plan.

During the review of this SPA, CMS concluded that the state was not in compliance with the requirements of sections 1916A(a)(2)(B), (b)(1)(B)(ii) and (b)(2)(A) of the Social Security Act (the Act), as implemented at 42 CFR §447.56(f). These statutory and regulatory requirements limit the total amount of premiums and cost sharing to a five percent aggregate cap. The aggregate cap is based on the beneficiary's family income used to determine eligibility (or, in the case of a family with multiple beneficiaries, all beneficiaries in the household).

During the review of the SPA, the state was unable to describe and implement a tracking mechanism that met the regulatory requirements. Therefore, the state elected to submit SPA TN #19-0015 to eliminate all cost sharing effective September 1, 2019 and is being approved concurrently with SPA TN #12-023.

If you have any questions, please have a member of your staff contact Courtenay Savage at 312-353-3721 or via email at Courtenay.Savage@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Deputy Director
Center for Medicaid and CHIP Services
Regional Operations Group

Enclosure

cc: Sara Barger, HFS
Mary Doran, HFS
Jane Eckert, 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: **12-023**

2. STATE: **ILLINOIS**

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

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

4. PROPOSED EFFECTIVE DATE: **July 1, 2012**

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 1902 of the *Social Security Act*

7. FEDERAL BUDGET IMPACT
a. FFY **2012** **($ 4.5 million)**
b. FFY **2013** **($ 17.9 million)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.18-A, Pages 1 & 2 (new)
Attachment 4.18-C, Pages 1 & 2 (new)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.18-A, Page 1
Attachment 4.18-C, Page 1

10. SUBJECT OF AMENDMENT:
Co-Payments

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:
[redacted]

13. TYPED NAME: **Julie Hamos**

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

15. DATE SUBMITTED 9/28/12

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 28, 2012

18. DATE APPROVED: November 1, 2019

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2012

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Ruth A. Hughes

22. TITLE: Deputy Director

23. REMARKS:

FORM CMS-179 (07/92)

Instructions on Back

CO-PAYMENTS

A. Hospitals

07/12 1. Effective for dates of service July 1, 2012, a co-payment is required for all inpatient days with the exception of those classes of individuals identified in Section B.3. of this attachment.~~days of care provided children (individuals through age 17), long-term care facility residents and pregnant women, including those post-partum women who have given birth within the last sixty days.~~

2. The co-payment is a deduction from the hospital per diem.

07/12 3. The co-payment amount is determined as follows:

~~$325 per day or more~~	~~$3.00 per day~~
~~Above $275 but less than $325 per day~~	~~$2.00 per day~~
~~$275 per day or less~~	~~No co-payment~~

Inpatient hospital services: a daily copayment amount as defined in federal regulations at 42 CFR 447.50 et seq., which, for dates of service beginning July 1, 2012 through March 31, 2013, is $3.65. Beginning April 1, 2013, the copayment amount is $3.90. Copayments for hospital admissions will not exceed a total amount of $75.00.

Non-emergency services rendered in an emergency room: a copayment amount as defined in federal regulations at 42 CFR 447.50 et seq., which, for dates of service beginning July 1, 2012 through March 31, 2013, is $3.65. Beginning April 1, 2013, the copayment amount is $3.90.

4. The co-payment amounts are automatically deducted from the Department's per diem payment to the hospital.

5. No provider may deny care or services on account of an individual's inability to pay a co-payment. (This requirement, however, does not extinguish the liability for payment of the co-payment.)

07/03 6. The exclusions for children and long-term care residents are enforced by MMIS edits using patient age and resident's information. Those exclusions are enforced based upon indicators entered into the Department's computer system. Indicators exist for pregnancy, hospice selection and long term care residency upon admission to the Long Term Care facility. Family planning services are uniquely identified by procedure code and drug therapeutic class code.

7. The hospital is required to identify days of care for pregnant women in coding ~~the *UB* 92~~.

~~07/12~~ ~~8. A nominal co-payment amount as described in Section A.3. of this attachment may be imposed for non-emergency services provided in an emergency room.~~

B. Non-institutional providers

1. The provider is responsible for collecting the co-payment from the patient. The co-payment amount owed by the patient is automatically deducted from the department's payment, regardless of the provider's ability to collect from the patient.

07/12 2. Effective for dates of service July 1, 2012, a co-payment will be assessed to participants ~~for each fee-for-service visit~~ based on the following rate:

a. A $2.00 co-payment for each over the counter and generic drug billed to the Department. ~~fee-for-service office visit to a chiropractor, podiatrist, optometrist, or physician.~~

b. For dates of service beginning July 1, 2012 through March 31, 2013, a $3.65 ~~$3.00~~ co-payment for each brand name drug billed to the Department. Beginning April 1, 2013, the copayment amount is $3.90.

c. For dates of service beginning July 1, 2012 through March 31, 2013, a $3.65 a $3.65 co-payment for each office visit and encounter visit billed to the Department. Beginning April 1, 2013, the copayment amount is $3.90.~~No co-payment for generic legend drugs.~~

Except, no co-payment will be assessed for emergency services, as defined in 42 *CFR* 447.53(b)(4), or for pharmacy products that are so identified in the Department's point of sale system for pharmacies and listed in notices to providers, available to the public on the Department's Internet website.

07/12 3. Co-payments will not apply to:

a. persons residing in hospitals, nursing facilities, intermediate care facilities for the mentally retarded;~~,~~

b. pregnant women (including a postpartum period of 60 days) ;~~,~~

c. children under 19 years of age;~~,~~

d. all non institutionalized individuals whose care is subsidized by the Department of Children and Family Services or the Department of Corrections;~~,~~, ~~and~~

e. hospice patients; and~~.~~

f. ~~In addition, co-payments will not apply to~~ residents of a State-certified, State-licensed, or State-contracted residential care program where residents, as a condition of receiving care in that program, are required to pay all of their income, except an authorized protected amount for personal use, to the cost of their residential care program. For the purpose of this subsection, the protected amount shall be no greater than the protected amount authorized for personal use by the Department.

07/12 4. Co-payments will not be assessed for services paid by Medicare, family planning services, certain medications, cancer chemotherapy, radiation therapy and~~,~~ renal dialysis treatment ~~and over the counter drugs~~.

5. Except for those services and drugs excluded, the Department will automatically deduct the appropriate co-payment from the provider.

6. No provider may deny services to an eligible individual due to the individual's inability to pay the co- payment. However, this does not remove the individual's liability for the co-payment. The patient will self-declare inability to pay at the time of service.

CO-PAYMENTS

A. Hospitals

07/12 1. Effective for dates of service July 1, 2012, a co-payment is required for all inpatient days with the exception of those classes of individuals identified in Section B.3. of this attachment.~~days of care provided children (individuals through age 17), long-term care facility residents and pregnant women, including those post-partum women who have given birth within the last sixty days.~~

2. The co-payment is a deduction from the hospital per diem.

07/12 3. The co-payment amount is as follows:

~~$325 per day or more~~	~~$3.00 per day~~
~~Above $275 but less than $325 per day~~	~~$2.00 per day~~
~~$275 per day or less~~	~~No co-payment~~

Inpatient hospital services: a daily copayment amount as defined in federal regulations at 42 CFR 447.50 et seq., which, for dates of service beginning July 1, 2012 through March 31, 2013, is $3.65. Beginning April 1, 2013, the copayment amount is $3.90. Copayments for hospital admissions will not exceed a total amount of $75.00.

Non-emergency services rendered in an emergency room: a copayment amount as defined in federal regulations at 42 CFR 447.50 et seq., which, for dates of service beginning July 1, 2012 through March 31, 2013, is $3.65. Beginning April 1, 2013, the copayment amount is $3.90.

4. The co-payment amounts are automatically deducted from the Department's per diem payment to the hospital.

5. No provider may deny care or services on account of an individual's inability to pay a co-payment. (This requirement, however, does not extinguish the liability for payment of the co-payment.)

07/03 6. The exclusions for children and long-term care residents are enforced by MMIS edits using patient age and resident's information. Those exclusions are enforced based upon indicators entered into the Department's computer system. Indicators exist for pregnancy, hospice selection and long term care residency upon admission to the Long Term Care facility. Family planning services are uniquely identified by procedure code and drug therapeutic class code.

7. The hospital is required to identify days of care for pregnant women in coding ~~the *UB 92*~~.

~~07/12~~ ~~8. A nominal co-payment amount as described in Section A.3. of this attachment may be imposed for non-emergency services provided in an emergency room.~~

B. Non-institutional providers

1. The provider is responsible for collecting the co-payment from the patient. The co-payment amount owed by the patient is automatically deducted from the department's payment, regardless of the provider's ability to collect from the patient.

CO-PAYMENTS

07/12 2. Effective for dates of service July 1, 2012 through August 31, 2019, a co-payment will be assessed to participants ~~for each fee-for-service visit~~ based on the following rate:

a. A $2.00 co-payment for each over the counter and generic drug billed to the Department. ~~fee-for-service office visit to a chiropractor, podiatrist, optometrist, or physician.~~

b. For dates of service beginning July 1, 2012 through March 31, 2013, a $3.65 ~~$3.00~~ co-payment for each brand name drug billed to the Department. Beginning April 1, 2013, the copayment amount is $3.90.

c. For dates of service beginning July 1, 2012 through March 31, 2013, a $3.65 co-payment for each office visit and encounter visit billed to the Department. Beginning April 1, 2013, the copayment amount is $3.90.~~No co-payment for generic legend drugs.~~

Except, no co-payment will be assessed for emergency services, as defined in 42 *CFR* 447.53(b)(4), or for pharmacy products that are so identified in the Department's point of sale system for pharmacies and listed in notices to providers, available to the public on the Department's Internet website.

07/12 3. Co-payments will not apply to:

a. persons residing in hospitals, nursing facilities, intermediate care facilities for the mentally retarded;~~,~~

b. pregnant women (including a postpartum period of 60 days) ;~~,~~

c. children under 19 years of age;~~,~~

d. all non institutionalized individuals whose care is subsidized by the Department of Children and Family Services or the Department of Corrections;~~,~~, ~~and~~

e. hospice patients; and~~.~~

f. ~~In addition, co-payments will not apply to~~ residents of a State-certified, State-licensed, or State-contracted residential care program where residents, as a condition of receiving care in that program, are required to pay all of their income, except an authorized protected amount for personal use, to the cost of their residential care program. For the purpose of this subsection, the protected amount shall be no greater than the protected amount authorized for personal use by the Department.

07/12 4. Co-payments will not be assessed for services paid by Medicare, family planning services, certain medications, cancer chemotherapy, radiation therapy and~~,~~ renal dialysis treatment ~~and over the counter drugs~~.

5. Except for those services and drugs excluded, the Department will automatically deduct the appropriate co-payment from the provider.

6. No provider may deny services to an eligible individual due to the individual's inability to pay the co- payment. However, this does not remove the individual's liability for the co-payment. The patient will self-declare inability to pay at the time of service.