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State/Territory Name: IL

State Plan Amendment (SPA) #: 13-0013-MM4

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages
4) Additional Attachments that are part of the state plan

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

March 28, 2014

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 IL-13-0013-MM4

Dear Ms. Hamos:

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

Transmittal #IL-13-0013-MM4 -Single State Agency
-Effective Date: October 1, 2013

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
Pat Curtis, HFS
Jacquetta Ellinger, HFS

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Illinois**

Transmittal Number:

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

IL-13-0013

Proposed Effective Date

10/01/2013 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 431.10, 42 CFR 431.11, 42 CFR 431.12, 42 CFR 431.50

Federal Budget Impact

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

Subject of Amendment

Single State Agency (A1-A3)

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

  The Governor has authorized the director of Healthcare and Family Services to act as his designee to review, approve and submit State Plan amendments under Title XIX of the Social Security Act. The director has reviewed this submission and has no comments.

Signature of State Agency Official

Submitted By:	**Jamie Ursch**
Last Revision Date:	**Mar 27, 2014**
Submit Date:	**Dec 30, 2013**

DATE RECEIVED
12/30/2013

DATE APPROVED:
3/28/14

PLAN APPROVED - ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL:
10/1/2013

SIGNATURE OF REGIONAL OFFICIAL:

TYPED NAME
Verlon Johnson

TITLE:
Associate Regional Administrator

Medicaid Administration

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

State Plan Administration Designation and Authority	A1

42 CFR 431.10

Designation and Authority

State Name: Illinois

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency: Illinois Department of Healthcare and Family Services (HFS)

Type of Agency:

- ○ Title IV-A Agency
- ◉ Health
- ○ Human Resources
- ○ Other

Type of Agency

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

20 ILCS 2205/2205-5, 305 ILCS 5/2-12(3) & (4), 305 ILCS 5/5-1 et seq

The single state agency supervises the administration of the state plan by local political subdivisions.

○ Yes ◉ No

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

○ Yes ◉ No

☒ Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

◉ Yes ○ No

Enter the following information for each waiver:

Remove

Date waiver granted (MM/DD/YY):

The type of responsibility delegated is (check all that apply):

☐ Determining eligibility

☒ Conducting fair hearings

☐ Other

Name of state agency to which responsibility is delegated:

Illinois Department of Human Services (DHS)

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

The Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS), as the parties to this waiver, acknowledge that HFS delegates the authority to DHS to make final Medicaid decisions on behalf of HFS for appeals filed by Medicaid applicants or recipients adversely affected by an eligibility determination made by a DHS employee or functional eligibility or service level determination made by a DHS employee or its designee and heard by a DHS hearing officer. These administrative decisions consist of the following hearings brought by applicants and recipients adversely affected by:

1) determinations of Medicaid eligibility made by DHS Division of Family and Community Services staff;
2) determinations made by DHS Division of Rehabilitation Services staff or its designee with regard to the Persons with Physical Disabilities, Persons with HIV or AIDS, and Persons with Brain Injuries Waivers; and
3) determinations made by DHS Division of Mental Health and Division of Alcoholism and Substance Abuse staff or its designee with regard to the Mental Health and Alcohol and Substance Abuse programs.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

Department of Human Services (DHS) has acknowledged and agreed in writing that it conducts Medicaid eligibility and service level determinations in accordance with policies and procedures established by HFS and acts as a neutral and impartial decision-maker on behalf of the Illinois single state Medicaid agency in adjudicating Medicaid appeal fair hearings and that it complies with all federal and state laws, regulations and policies governing the Medicaid program. HFS and DHS have entered into an Intergovernmental Agreement related to Medicaid Fair Hearings that minimally includes the following provisions:

1) identifying the relationships and respective responsibilities of the parties, including the respective responsibilities to effectuate the fair hearing rules in 42 C.F.R. 431 subpart E;
2) quality control and oversight by HFS as the single Medicaid agency, including regular reporting by DHS to

3) assurances that DHS complies with all federal and state law, regulations and policies, including those pertaining to eligibility criteria applied by the HFS under 42 C.F.R. 435, prohibitions against conflicts of interest and improper incentives; and safeguarding confidentiality.

In addition, DHS acknowledges and agrees that it gives appropriate deference as defined by law to the single state Medicaid agency's interpretation of all federal and state Medicaid laws, rules and regulations, and policy manuals. DHS acknowledges that it:

1) conducts de novo reviews in Medicaid appeal hearings as set forth below;
2) cooperates with any and all federal or state audits and monitoring;
3) assists HFS in the tracking and reporting of Medicaid appeal decisions as required by law; and
4) complies with each of the following conditions of this waiver:

a) DHS ensures that every applicant and recipient is informed, in writing, of the fair hearing process, how to contact DHS Bureau of Hearings, and how to obtain information about fair hearings from that agency.

b) In all Medicaid appeal hearings, DHS shall dismiss appeals when the conditions described in 42 C.F.R. 431.223 are present, and when the appeal request is:

i) not signed by the Medicaid recipient or his or her authorized representative or
ii) submitted outside the time permitted by the applicable state regulations.

c) Except where agreed to by the parties to the appeal or when the recipient requests delays due to good cause, DHS agrees to schedule, hear and issue decisions in its Medicaid appeal hearings within the time period set forth in federal and state regulations.

d) Both parties shall allow all parties' witnesses to appear and testify by telephone at hearings within the parameters established by state law, regulations, and policy.

e) When a continuance is necessary, DHS shall only grant requests within the parameters of state law and regulations, and shall ensure that hearings are not unreasonably delayed.

f) DHS shall issue decisions that are based on the evidence introduced before the record is deemed closed by the hearing officer and the applicable provision(s) of federal or state laws, rules and regulations, or policy manuals supporting the decision.

g) HFS retains oversight of the State Medicaid Plan and any waiver authority duly granted by the Secretary of the U.S. Department of Health and Human Services. As the single state Medicaid agency, HFS has established a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by DHS. This monitoring process minimally includes:

i) the issuance of reports by DHS to HFS, at least on a quarterly basis, including information regarding the number, status, and disposition of Medicaid appeals;

ii) continued sharing of a hearings database containing information on all Medicaid appeals allowing HFS to monitor progress of such cases;

iii) periodic inter-agency meetings between DHS and HFS to discuss progress and any issues related to the administration of delegated appeals; and,

iv) authority of HFS staff conduct random reviews of case files and final administrative decisions to ensure compliance with applicable state and federal law, regulation and policy.

Add

☐ The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

☒ The Medicaid agency

☒ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

Medicaid Administration

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- ☒ The Medicaid agency
- ☒ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☐ The Federal agency administering the SSI program

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- ☒ Medicaid agency
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☐ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

○ Yes ◉ No

State Plan Administration
Organization and Administration — A2

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

STATE OF ILLINOIS MEDICAID ADMINISTRATION

The Illinois Department of Healthcare and Family Services (HFS or Department), as the successor agency to the Illinois Department of Public Aid, is Illinois' single state agency responsible for administering the state Medicaid plan. The Governor appoints the HFS Director and the HFS Inspector General.

HFS's program responsibilities include Medicaid, the Title XXI Children's Health Insurance Program (CHIP) and Illinois' Child Support Services program under Title IV-A.

As the single state Medicaid agency, HFS has delegated specific functions to State entities that assist the Department with the administration of the State Medicaid Program. Roles and responsibilities are identified in Interagency Agreements and executed by the State entities.

In addition to state departments, HFS works with local public health departments, the Cook County Health & Hospitals System, state universities, local school districts' special education programs and any other governmental entity providing medical or behavioral health services to Medicaid clients to assure those services meet federal requirements and to claim federal reimbursement for them.

HFS is responsible for all functions necessary to provide quality health coverage to eligible groups of individuals, comply with state and federal law and regulation concerning Medicaid, and secure federal reimbursement for the Medicaid program expenditures. Those functions include managing the Medicaid state plan to assure any services provided by a different agency are authorized for

reimbursement as well as providing technical assistance in the design and implementation of services provided by those agencies. HFS facilitates the coordination of the service delivery system and quality oversight as well as being accountable for quality oversight of the entire program. The Department conducts all federal Medicaid reporting and reimbursement claims. Any state or local governmental entity participating in the Illinois Medicaid program must enter into an intergovernmental agreement with HFS to detail the responsibilities and obligations of each.

Medicaid and CHIP administrative responsibilities lie primarily with the Division of Medical Programs, the Division of Finance, and the Office of Inspector General. The Office of Information Systems, Office of Legislative Affairs, Office of Planning, Office of Outreach Services, Division of Personnel and Labor Relations and Office of General Counsel provide support services for administration of Illinois' Medicaid program. Each of these organizational units is subdivided further into bureaus or offices as described below.

HFS, under its Bureau of All Kids and Bureau of Medical Eligibility and Special Programs, makes determinations of Medicaid eligibility for applications processed in its central casework units. Since HFS and DHS share a single eligibility system, either agency can process Medicaid determinations. However, HFS caseworkers process only applications from individuals seeking solely medical benefits. These applications may result in enrollment into the new groups under 1902(a)(10)(A)(i)(VIII) and (IX) of the Social Security Act (ACA adults and former foster children) or existing groups of children, parents and other caretaker relatives, pregnant women, persons with breast or cervical cancer under 1902(a)(10)(A)(ii)(XVIII) of the Act, workers with disabilities (Medicaid Buy-In under Ticket to Work and Work Incentives Improvement Act under section 1902(a)(10)(A)(ii)(XV) of the Act) and limited reproductive health benefits under the Illinois Healthy Women waiver.

In addition to making Medicaid eligibility determinations, HFS:

1) with assistance from the University of Illinois at Chicago, Division of Specialized Care for Children (DSCC), makes determinations of functional eligibility for applicants to and recipients enrolled in the 1915(c) waiver, Children that are Medically Fragile/Technology Dependent;

2) makes determinations of medical necessity for medical services and items for recipients enrolled in the Medicaid program, including, but not limited to, prior approval of medical equipment, prescription drugs, and transportation;

3) through its Bureau of Long Term Care, directly administers the Supportive Living Program;

4) establishes policy and provides oversight and monitoring of the Illinois Department on Aging's administration of the 1915(c) waiver for Persons who are Elderly, and

5) establishes policy and provides oversight and monitoring of DHS administration of the following 1915(c) waivers: Persons with Physical Disabilities, Persons with HIV or AIDS, Persons with Brain Injuries, Adults with Developmental Disabilities, Support for Children and Young Adults with Developmental Disabilities, and Residential Support for Children and Young Adults with Developmental Disabilities.

Division of Medical Programs

The Division of Medical Programs (DMP) contains the core of Illinois' Medicaid programs. DMP is led by a Division Administrator who reports to the Director and serves as director of Illinois' Medicaid program and CHIP. The division's senior management team consists of the HFS Medical Director, five Deputy Administrators, and the Medicaid/Medicare Coordinator. The Deputy Administrators are each responsible for one or more of the division's 14 bureaus. Each Deputy's bureaus' responsibilities are described below.

Deputy Administrator for Integrated Care

Bureau of Professional and Ancillary Services (BPAS)

The Bureau of Professional and Ancillary Services administers pharmacy and dental benefits. This includes processing prior authorization requests for certain medications, including Preferred Drug List and non-preferred drugs. BPAS uses the expertise of physicians and pharmacists in monitoring drug utilization patterns of patients and prescribing patterns of practitioners. Staff coordinate all aspects of the HFS preferred drug list including communications with manufacturers, financial review, clinical review, negotiations and contracting. BPAS is also responsible for oversight of the Maximum Allowable Cost (MAC) drug-pricing program. The bureau oversees the contracted fiscal intermediary for dental coverage. Staff also perform quality assurance functions, including annual client and provider satisfaction surveys, and facilitates a peer review committee. BPAS is responsible for dental provider recruitment and training activities, client education and Early and Periodic Screening Diagnosis and Treatment outreach activities.

Bureau of Hospital and Provider Support (BHPS)
The Bureau of Hospital and Provider Support is responsible for a variety of activities within the Division of Medical Programs including provider support, billing instruction and resolution, and provider education for hospital and hospice service providers. The bureau handles a variety of specialized payment and inter-governmental transfer arrangements, prepares quarterly static hospital payments and initiates the related inter-fund transfers. BHPS assists providers in the use of the Department's Medical Electronic Data interchange (MEDI) system to verify client eligibility as well as offers providers a means to submit electronic claims to the Department via direct data entry free of charge. BHPS oversees reimbursement and billing related activities for hospice, renal dialysis centers, ambulatory surgical treatment centers, and hospital services. The bureau maintains the enrolled provider database, is responsible for collecting provider assessments from hospitals, nursing facilities and intermediate care facilities for the developmentally disabled and maintains accounts receivable for outstanding debts owed to the Department related to medical expenditures.

Bureau of Managed Care (BMC)
The Bureau of Managed Care administers the Department's mandatory and voluntary managed care programs, the statewide Primary Care Case Management (PCCM) program and related programs such as the Illinois Client Enrollment Broker and the External Quality Review Organization. As the Department moves toward more a fully integrated care coordination model that meet the state goals under the Medicaid reform law, P.A. 96-1501, and Accountable Care Act initiatives, BMC is overseeing the implementation of additional care coordination programs that will provide medical care to most Medicaid clients in Illinois. Current and future care coordination entities include Managed Care Organizations (MCOs), Managed Care Community Networks (MCCNs), Care Coordination Entities (CCEs) for seniors and adults with disabilities and children with complex medical needs, and hospital based Accountable Care Entities (ACEs). BMC monitors the policy, operational and systematic aspects of these care coordination programs including oversight of all contracts and review of all deliverable from each contractor for each program. Through these care coordination programs, BMC ensures that clients receive education about the importance of a medical home, their health plan, and their health care choices, and that they are enrolled in a "best fit" medical home.

Deputy Administrator for Operations

Bureau of Technical Support (BTS)
The Bureau of Technical Support serves as liaison to information systems staff concerning computer information needs, including the development, implementation and operation of the technical aspects of all medical program functions; serves as a link to other state agencies, organizations outside government, as well as federal agencies, in the development and implementation of technical information, data exchanges and technologies involving the Medicaid Management Information System (MMIS); administers the Recipient Eligibility Verification (REV) system and coordinates the Medical Electronic Data Interchange (MEDI) project; performs maintenance and security functions of data bases for Medical information and ensures that daily spending for medical services follows the Department's spending plan.

Bureau of Claims Processing (BCP)
The Bureau of Claims Processing is responsible for timely and accurate adjudication of 7.8 million medical claims submitted each month by providers. A major goal is to improve processing and efficiency. The bureau's processing encompasses error correction, utilization review, pricing, returned checks, adjustments, special processing of claims for newborns, abortions, hysterectomies, sterilizations, claims for individuals with Medicare/Medicaid coverage, and retrieving copies of claims/vouchers for research and investigative purposes. Once billings have been adjudicated, the bureau sends invoice schedules to the Comptroller for payment to the provider. A variety of reports are generated on a daily, weekly, and monthly basis providing the status of processing and payments.

Bureau of Medical Administration Support (BMAS)
The Bureau of Medical Administrative Support is responsible for a wide variety of administrative functions supporting the DMP including personnel management, proper handling of state contracts, initiating voucher processing and coordinating print requests. BMA also operates the Health Benefits Hotline, receiving and responding to a wide variety of calls from clients and the general public. Calls largely concern eligibility, the application process, replacement of medical cards, assistance in finding providers and questions regarding covered medical benefits. The Health Benefits Hotline also accepts calls from medical providers seeking to verify participants' eligibility for services. BMAS also operates the Pharmacy Hotline responding to inquiries regarding pharmacy benefits and billing procedures. Pharmacy Hotline staff also process prior approval requests, refill-too-soon requests, and other system edit override requests.

Deputy Administrator for Long Term Care and Mental Health

Bureau of Quality Management (BQM)
The Bureau of Quality Management is responsible for programs and projects concerning maternal and child health (MCH) including reproductive and maternal health outcomes. The bureau has administered Illinois Healthy Women, Illinois' Section 1115 Family Planning Waiver program, and performs quality reporting under the Children's Health Insurance Program Reauthorization Act of 2008 data. The bureau's MCH quality assurance and improvement initiatives are focused on determining cost-effectiveness for statewide implementation. The staff is responsible for all MCH-related procurement processes, and the development and management of MCH-related contracts. BQM also is responsible for the quality oversight of the 1915(c) Home and Community-Based Services (HCBS) waiver programs. Other bureau functions include serving in a liaison capacity for sister-agencies that operate other Medicaid programs, including: Department of Human Services (DHS) Early Intervention, oversight of the federally-mandated Quality Improvement Organization (QIO), coordination and business administration of the Medicaid Electronic Health Records Provider Incentive Program (EHR/PIP), and monitoring and determination of compliance with pay-for-performance (bonus) measures associated with the Primary Care Case Management (PCCM)/Illinois Health Connect (IHC) program (also see discussion under BMC). BQM will become the focal point for HFS quality monitoring, compliance and improvement processes across all medical programs and services.

Bureau of Long Term Care (BLTC)
The Bureau of Long Term Care has direct responsibility for establishing policy for nursing facilities and supportive living facilities (SLFs). The bureau is responsible for enrolling and dis-enrolling long term care facilities which includes nursing facilities, intermediate care facilities for the developmentally disabled (ICFs/DD), SLFs, and Specialized Mental Health Rehabilitation Facilities (SMHRFs); conducting field staff reviews to monitor and evaluate the accuracy of nursing home MDS assessments to ensure rate accuracy; certifying and monitoring SLFs; interagency coordination and policy development of Community-based Behavioral Health Services including Screening Assessment and Support Services (SASS) Program, Crisis and Referral Entry Service (CARES), and the Illinois DocAssist initiative; efforts to rebalance long-term care services; developing and implementing new initiatives relating to long term care; and resolving reimbursement problems.

Bureau of Long Term Services Transformation (BLTST)
The Bureau of Long Term services Transformation has lead responsibility for coordinating the rebalancing of Medicaid long term supports and services to community settings in Illinois. To accomplish this work, the bureau works closely with DHS and DoA, the other state agencies operating Home and Community-Based Services waiver programs, in developing new waivers and waiver amendments, providing technical assistance and monitoring HCBS waiver activities. The bureau also facilitates activities of the state's Money Follows the Person grant; implementation of Olmstead lawsuit settlements; and implementation of the state's Balancing Incentive Program.

Deputy Administrator for Eligibility

Bureau of All Kids (BAK)
The Bureau of All Kids has lead responsibility for processing applications and determining eligibility for health coverage submitted through Illinois Integrated Eligibility System. BAK also determines presumptive eligibility enrollment for children and pregnant women, manages enrollment for reproductive health care under the Illinois Healthy Women waiver, and processes applications from people referred through the Illinois Breast and Cervical Cancer Prevention Program who need treatment for breast or cervical cancer. The bureau provides customer service for clients enrolled in Illinois Healthy Women, treatment for Breast or Cervical Cancer, All Kids Share and All Kids Premium, incarcerated pregnant women and hospitalized incarcerated inmates to process eligibility renewals and assist in making coverage changes.

Bureau of Eligibility Integrity (BEI)
The Bureau of Eligibility Integrity is charged with the overall goal of maintaining the integrity of eligibility determinations and manages medical eligibility rules for the Integrated Eligibility System (IES) rules engine, including developing and maintaining the eligibility performance reporting system and reports generated from the system. BEI is responsible for assuring that IES produces decisions that fully support state and federal policy concerning eligibility for Medicaid, CHIP and state only health coverage programs. The bureau develops and maintains ongoing and ad hoc analyses and reports to evaluate both system accuracy and

performance of casework processing units. The bureau also evaluates business processes to achieve efficient use of limited resources, timely customer service and accurate eligibility processing.

Bureau of Medical Eligibility and Special Programs (BMESP)
The Bureau of Medical Eligibility and Special Programs is responsible for developing and writing medical eligibility policy releases, position papers, and administrative rules. This includes the review of proposed and adopted changes in federal and state laws and regulations, which may impact eligibility for medical benefits under the Illinois Public Aid Code, the Illinois Children's Health Insurance Program Act, the Illinois Covering All Kids Health insurance Act, federal Titles XIX (Medicaid) and XXI (State Children's Health Insurance Program) of the Social Security Act and related programs. The bureau is also responsible for maintaining Medicaid and CHIP State Plan sections pertaining to eligibility and acts as liaison with federal officials regarding eligibility issues. BMESP also manages the Health Benefits for Workers with Disabilities, Illinois' Medicaid Buy-In under the Ticket to Work and Work Incentives Improvement Act and serves as the central processing unit for Medicaid Pay-In Spend-down.

Deputy Administrator for Care Coordination Rates and Finance

Bureau of Rate Development and Analysis (BRDA)
The Bureau of Rate Development and Analysis is responsible for setting provider rates for existing and new providers and ensuring that those rates, whether fee for service or static lump sum payments, are consistent with the state plan. These responsibilities include administering the federal Disproportionate Share (DSH) program by setting DSH rates annually and overseeing the federally mandated DSH audit. BRDA conducts the hospital and nursing facility upper payment limit calculations and physician average commercial rate demonstrations. Staff responsibilities are concentrated in data analysis, requiring expertise in data mining from the Department's medical data warehouse for inclusion in state and federal reporting. BRDA also gathers and supplies the data needed by actuarial consultants for the development of actuarially sound managed care rates.

Bureau of Program and Policy Coordination (BPPC)
The Bureau of Program and Policy Coordination provides analytic, financial monitoring, policy oversight and technical support services for the Illinois Medicaid program. Working with other state agencies, units of local government and local education agencies, BPPC is responsible for coordinating, developing and implementing policies and methodologies to increase, monitor and maintain federal funding to the state. Staff coordinates technical development and support of data collection and reporting computer systems required by the federal government (e.g., Medicaid Statistical Information System, Transformed Medicaid Statistical Information System, State Enrollment Database System and Long Term Care (MDS/OASIS data collection system help desk). BPPC serves as the lead in coordinating the review of proposed and adopted changes in federal and state laws and regulations that may impact provider reimbursement or medical coverage under Illinois' Medicaid program. Staff coordinates, develops and submits Medicaid state plan materials, other than those associated with eligibility, necessary to secure federal matching funds and manages projects to promulgate state rule changes. In addition, BPPC is responsible for coordinating, developing and maintaining provider communications (e.g., policy notices, provider handbooks, fee schedules) related to reimbursement and medical coverage.

Division of Finance (DoF)

The Division of Finance develops the Department's budget and secures necessary appropriation authority, provides ongoing fiscal management through formulation and monitoring of spending and headcount allocations for the Department's bureaus, obtains maximum federal reimbursement for Medical Programs and Child Support spending and provides fiscal and other analyses as needed for decision makers or in response to requests. DoF contains five bureaus, all of which participate in administration of the Illinois Medicaid program.

Bureau of Budget and Cash Management (BBCM)
The Bureau of Budget and Case Management is responsible for the development, submission and negotiation of the Department's budget request. The bureau is entrusted with the allocation and management of the financial resources the Department receives. This includes funding for personal services and other operations' costs such as contractual, travel, commodities, printing, equipment and telecommunications services. The unit develops budget requests and monitors spending through the year. BBCM also bills and collects rebates from pharmaceutical manufacturers for the Department's purchases of their prescription drugs. The bureau also develops liability estimates and spending projections for Illinois' Medicaid program.

Bureau of Collections (BOC)
The Bureau of Collections (BOC) is responsible for federally mandated Medicaid recovery and cost avoidance projects. The bureau identifies, verifies, and maintains participants' third party health insurance information and purchases available health insurance for participants with high-cost medical conditions. The bureau recovers funds owed to HFS by health insurers and medical providers. BOC is responsible for coordination of benefits to assure Illinois Medicaid is the payer of last resort. BOC also recovers medical and financial (cash) assistance expended on behalf of participants from the estates of deceased participants, recovery of medical or cash assistance from liens placed on participant's real property and all manner of recovery actions.

Bureau of Fiscal Operations (BFO)
The Bureau of Fiscal Operations handles the Department's accounting functions. BFO processes contracts, obligations and vouchers, as well as payroll, and with the exception of medical payments and child support payments. BFO also handles all cash receipts and reporting, and administers the Department's Programmatic Administration and Accounting System (PAAS).

Bureau of Health Finance (BHF)
The Bureau of Health Finance receives over 1,500 annual cost reports submitted by nursing homes, Supportive Living Facilities (SLFs), hospitals, Federally Qualified Health Centers, Rural Health Clinics and facilities for the developmentally disabled (ICF-DD). Financial audits are performed as necessary on the cost reports when Medicaid rates are re-based. BHF staff performs solvency and financial analysis of quarterly reports from managed care organizations and contractors. BHF also performs cash flow analysis and financial evaluation on facilities experiencing operating or cash flow problems. In addition to the Department's programs, BHF performs audits as necessary for the Department of Human Services (DHS) Division of Rehabilitation Services; ICF-DD facility audits for DHS Division of Disability Services; and hospital audits and cost settlements for the University of Illinois at Chicago Division of Specialized Care for Children. Other bureau functions relate to SLFs, disproportionate share hospitals, state institutions and Civil Monetary Penalty Act financial analysis for the federal Centers for Medicare and Medicaid Services and the Illinois Department of Public Health.

Bureau of Federal Finance (BFF)
The Bureau f Federal Finance is responsible for claiming federal financial participation (FFP) under Title XIX and Title XXI from the U.S. Department of Health and Human Services and drawing those dollars into the State Treasury. The bureau serves as liaison with the Centers for Medicare & Medicaid Services and the Administration of Children and Families - Office of Child Support Enforcement in matters of federal reimbursement, FFP integrity and quarterly financial-compliance audits.

Office of Inspector General (OIG)

The mission of the Office of Inspector General is to prevent, detect, and eliminate fraud, waste, abuse, mismanagement and misconduct in programs administered by the Department. The Inspector General is appointed by the Governor and confirmed by the Senate for a four-year term. The office's budget is contained within that of HFS.

The Inspector General has mandated general oversight responsibilities over the Department's integrity functions, which include, but are not limited to, investigating misconduct by employees, vendors, contractors, and medical providers, auditing medical providers to ensure that appropriate payments are made for services rendered, performing quality of care reviews, monitoring quality assurance programs, conducting quality control measurements, investigating fraud or intentional program violations by recipients, initiating actions related to violations or sanctions and contract violations. The OIG is organized in the seven units described below.

Office of Counsel to the Inspector General (OCIG)
OCIG attorneys represent the Department in recovery actions, actions seeking the termination, suspension or denial of a provider's Program eligibility, and state income tax delinquency cases. OCIG also handles joint hearings with the Department of Public Health (DPH) in instances when DPH is seeking to decertify a long term care facility. OCIG is also responsible for the oversight and enforcement of all HFS-OIG Sanctions. In addition to enforcing Illinois Program Sanctions, OCIG staff review Exclusion Databases to identify providers, suppliers, and professionals who have been excluded from other state or federal healthcare programs. In instances where an eligible provider is identified, OCIG takes action to terminate or exclude the provider from participation in Illinois.

Bureau of Fraud Science Technology (BFST)
The Bureau of Fraud Science Technology uses advanced Statistical Predictive Modeling technology to analyze, detect and prevent

fraud and abuse of Medicaid by providers and recipients. BFST selects and conducts monthly analyses of providers whose claim patterns deviate significantly from peer group norms or established parameters in combination with DNA and the Surveillance Utilization and Review System. These analyses include contacting recipients to verify receipt of services. BFST also manages the Recipient Restriction Program to identify recipients who use Medicaid Services inappropriately and, with the recommendation of the OIG's medical consultant(s), locks them into a single physician and/or pharmacy to control utilization. Bureau staff develops and maintains the OIG Dynamic Network Analysis Predictive Modeling System and advanced sampling techniques to utilize model-risk scores. BFST uses fraud detection routines to prevent and detect health care fraud, abuse, overpayments and billing errors. OIG uses results to identify fraud referrals, establish desk reviews, target field audit and review efforts and establish self-audit reviews. Staff also identifies program integrity solutions, including prepayment claims processing system edits and policy and operational innovations. BFST processes data requests for law enforcement agencies including the ISP, FBI, Illinois Attorney General, U.S. Department of Justice and other states' inspectors general.

Bureau of Investigations (BOI)
BOI investigates the eligibility of recipients in categorical assistance programs involving cash, Supplemental Nutrition Assistance Program (SNAP) and the legacy programs now administered by IDHS. It also investigates improper use of Medicaid privileges, investigates SNAP trafficking fraud, performs SNAP disqualifications, investigates HMO marketing and childcare fraud, as welll as managing the Fraud Prevention Investigations program. BOI also works closely with the Bureau of Managed Care (BMC) to monitor the marketing practices of HMOs and other managed care entities. BOI also manages general fraud prevention investigations and HFS's Long Term Care Asset Discovery Investigations designed to prevent ineligible persons from receiving long term care benefits due to diverting or not disclosing assets.

Bureau of Medicaid Integrity (BMI)
BMI performs post-payment compliance audits, provider quality of care reviews, medical eligibility reviews of recipients, and client satisfaction surveys. The OIG collects the overpayment in full or establishes a credit against future claims received from the provider. In some cases, termination of the provider from participation in the Medicaid Program is pursued. The bureau conducts quality of care reviews of physicians enrolled in the Medicaid Program by sampling patient records and subsequent peer review as appropriate. Actions against providers with serious quality of care deficiencies can include: requests for corrective action, requests for continuing medical education, suspension or termination from the Medicaid Program. BMI also administers federally mandated Medicaid Eligibility Quality Control and the eligibility portion of Payment Error Rate Measurement.

Bureau of Internal Affairs (BoIA)
The Bureau of Internal Affairs investigates HFS employee misconduct of employees and contractors in a confidential manner and engages in diligent efforts to identify fraudulent staff activity and security weaknesses. The bureau prepares investigative reports and shares the findings with the agency's division administrators. The bureau also follows investigations to determine if appropriate actions have been taken, and coordinates investigations of employees and contractors with state or federal authorities.

Administrative Services Unit (ASU)
The Administrative Services Unit provides administrative support for the office including payroll, personnel, collections, procurement, special budgetary statistical information and research for investigations. The unit monitors and submits information to the Provider Participation Unit of any action taken by the Department against Medicaid providers and works closely with the Office of Counsel to the Inspector General to ensure that appropriate staff is notified of provider terminations, suspensions, debarments and reinstatements. The Unit is responsible for investigative research resulting from fraud and abuse referrals and for cross matching information on fugitive felons from the Illinois State Police and the Cook County Sheriff with recipient lists. ASU also collects overpayments and court-ordered restitution from providers as a result of an audit or peer review and tracks delinquent accounts for referral for follow-up.

Fraud and Abuse Executive (FAE)
The Fraud and Abuse Executive coordinates federal and state law enforcement activities related to the Illinois Medicaid Program. The FAE coordinates policy issues and clarifications, identifies key Medicaid and Department of Human Services' personnel to provide testimony at criminal and civil proceedings and facilitates the disposition of global settlement agreements generated by the National Association of Attorney Generals, the U.S. Departments of Health and Human Services and Justice. FAE is the liaison with the Illinois State Police Medicaid Fraud Control Unit and participates in each of three regional task force meetings along with Illinois State Police and Attorney General Medicaid Fraud Control Unit personnel. Also attending task force meetings are the Federal Bureau of Investigation, U.S. Health and Human Services, Postal Inspectors, U.S. Attorney Office personnel, as welll as various other State and Federal representatives. FAE implements payment withholds in cases of suspected fraud or willful

misrepresentation to the Medicaid Program and Illinois state law in the event of program-related felony indictments.

Office of General Counsel, Bureau of Administrative Hearings

HFS, Office of General Counsel, Bureau of Administrative Hearings (BAH) is generally responsible for conducting fair hearings and making final agency decisions for appeals filed by Medicaid applicants or recipients adversely affected by an eligibility determination made by an HFS employee or functional eligibility or service level determination made by an HFS employee or designee. These appeals are heard by an HFS hearing officer. Specifically, HFS will conduct hearings and make final agency decisions brought by applicants or recipients adversely affected by:

1) eligibility determinations made by HFS' central unit casework staff ;
2) determinations made by DHS DDD staff or its designee, including functional eligibility and service level determinations related to the following 1915(c) waivers: a) Adults with Developmental Disabilities, b) Children and Young Adults with Developmental Disabilities, and c) Residential Supports for Children and Young Adults with Developmental Disabilities;
3) functional eligibility and service level determinations made by DSCC staff or its designee, related to the 1915(c) waiver for Children that are Medically Fragile/Technology Dependent;
4) determinations made by HFS staff or its designee related to approval of medical items and services, including, but not limited to, prior approval for medical equipment, pharmacy, and transportation;
5) eligibility and involuntary discharge actions affecting recipients of the Supportive Living Program waiver; and,
6) functional eligibility and service level determinations made by the Department on Aging or its designee related to the 1915 (c) waiver for Persons who are Elderly.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

The Illinois Constitution establishes that the state Executive Branch includes a Governor, Lieutenant Governor, Attorney General, Secretary of State, Comptroller and Treasurer. The Illinois Civil Administrative Code creates the departments of state government reporting to the Governor. Under state statutory authority, Illinois' major health and human service departments all provide services of one kind or another to Illinoisans enrolled in Medicaid.

The Department of Healthcare and Family Services (HFS) is the single state Medicaid agency in Illinois. As the single state Medicaid agency, HFS has delegated specific functions to State entities that assist the Department with the administration of the State Medicaid Program. Roles and responsibilities are identified in Interagency Agreements and executed by the State entities.

The Department of Human Services (DHS) administers Temporary Assistance for Needy Families (TANF) and the Supplemental Nutritional Assistance Program (SNAP) and is responsible for community health services, programs for the developmentally disabled and physically disabled as well as having designation as the state's mental health authority.

HFS and DHS staff all use the same data systems and data bases for determining eligibility. DHS staff conduct all activities related to making determinations and redeterminations of eligibility for any individual requesting or receiving Medicaid, including individuals whose eligibility is determined using a MAGI-based income methodology: infants and children under age 19, parents and other caretaker relatives, pregnant women and the newly eligible adults under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act; former foster care adults under section 1902(a)(10)(A)(i)(IX) of the Act as well as the non-MAGI populations who are aged, blind or have a disability; and individuals requesting or receiving assistance through the Medicare Savings Programs and/or who are residing in an institution. At this time, DHS does not conduct activity related to making determinations and redeterminations of eligibility for individuals who are diagnosed with a need for treatment for breast or cervical cancer under section 1902(a)(10)(A)(ii)(XVIII) of the Act, workers with disabilities (Medicaid Buy-In under Ticket to Work and Work Incentives Improvement Act under section 1902(a)(10)(A)(ii)(XV) of the Act) or reproductive health benefits under the Illinois Healthy Women waiver.

HFS staff conduct all activities related to making determinations and redeterminations of eligibility for individuals whose eligibility

is determined using a MAGI-based income methodology: infants and children under age 19, parents and other caretaker relatives, pregnant women and the newly eligible adults under section 1902(a)(10)(A)(i)(VIII) of the Act; and former foster care adults under section 1902(a)(10)(A)(i)(IX) of the Act. Additionally, HFS conducts all activities related to making determinations and redeterminations of eligibility for individuals who are diagnosed with a need for treatment for breast or cervical cancer under section 1902(a)(10)(A)(ii)(XVIII) of the Act, workers with disabilities (Medicaid Buy-In under Ticket to Work and Work Incentives Improvement Act under section 1902(a)(10)(A)(ii)(XV) of the Act) and limited reproductive health benefits under the Illinois Healthy Women waiver. Eligibility determination responsibilities may be shifted between the agencies from time to time based on staffing and workload.

HFS retains authority for all Medicaid policy and procedures, including all determinations of eligibility, for Medicaid. HFS controls the rules programmed into the data system processing Medicaid eligibility and is responsible for all policy and procedural guidance followed by DHS staff in processing determinations of Medicaid eligibility. Casework staff conducting eligibility determinations and redeterminations are employed under the state's Personnel Code into the same series of job titles used by HFS and must meet the same qualifications as HFS staff.

Illinois' Medicaid eligibility process is fully integrated with that of SNAP and TANF eligibility determinations. For that reason, DHS, through its Division of Family and Community Services, makes most, although not all, determinations of eligibility for Medicaid for the groups covered under the Illinois State Medicaid plan or any federally granted waiver authority at the discretion of HFS.

In addition to Medicaid eligibility determinations, DHS:

1) through its Division of Developmental Disabilities or its designee, makes determinations of functional eligibility and service level determinations for applicants to and recipients enrolled in the following 1915 (c) waivers:
   a. Adults with Developmental Disabilities,
   b. Supports for Children and Young Adults with Developmental Disabilities, and
   c. Residential Support for Children and Young Adults with Developmental Disabilities;
2) through its Division of Rehabilitation Services (DRS), makes determinations of functional eligibility and service level determinations for applicants to and recipients enrolled in the following 1915(c) waivers:
   a. Persons with Physical Disabilities,
   b. Persons with HIV or AIDS, and
   c. Persons with Brain Injuries;
3) through its Division of Mental Health (DMH) and Division of Alcoholism and Substance Abuse (DASA) or its designee, makes service level determinations for applicants to and recipients of the Mental Health and Alcohol and Substance Abuse programs.

The Department on Aging administers Illinois' programs for residents aged 60 and older including administering the 1915(c) waiver for Persons who are Elderly.

The Department of Children and Family Services administers Illinois' child welfare program and cooperates in establishing Medicaid eligibility for children who are wards of the state.

The Department of Public Health administers a wide variety of programs designed to protect and improve the health of Illinoisans through regulatory activity, including health care facility licensure and certification, and health promotion.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

- (•) Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ( ) An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ( ) The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Casework staff working for DHS are hired under the state's Personnel Code into the same series of job titles used by HFS. DHS staff conduct all activities related to determining eligibility for Medicaid.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ○ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

○ Yes ○ No

State Plan Administration Assurances — A3

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

- ☑ The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- ☑ All requirements of 42 CFR 431.10 are met.
- ☑ There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.
- ☑ The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

- ☑ There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

- ☐ There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

☐ When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

☑ The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

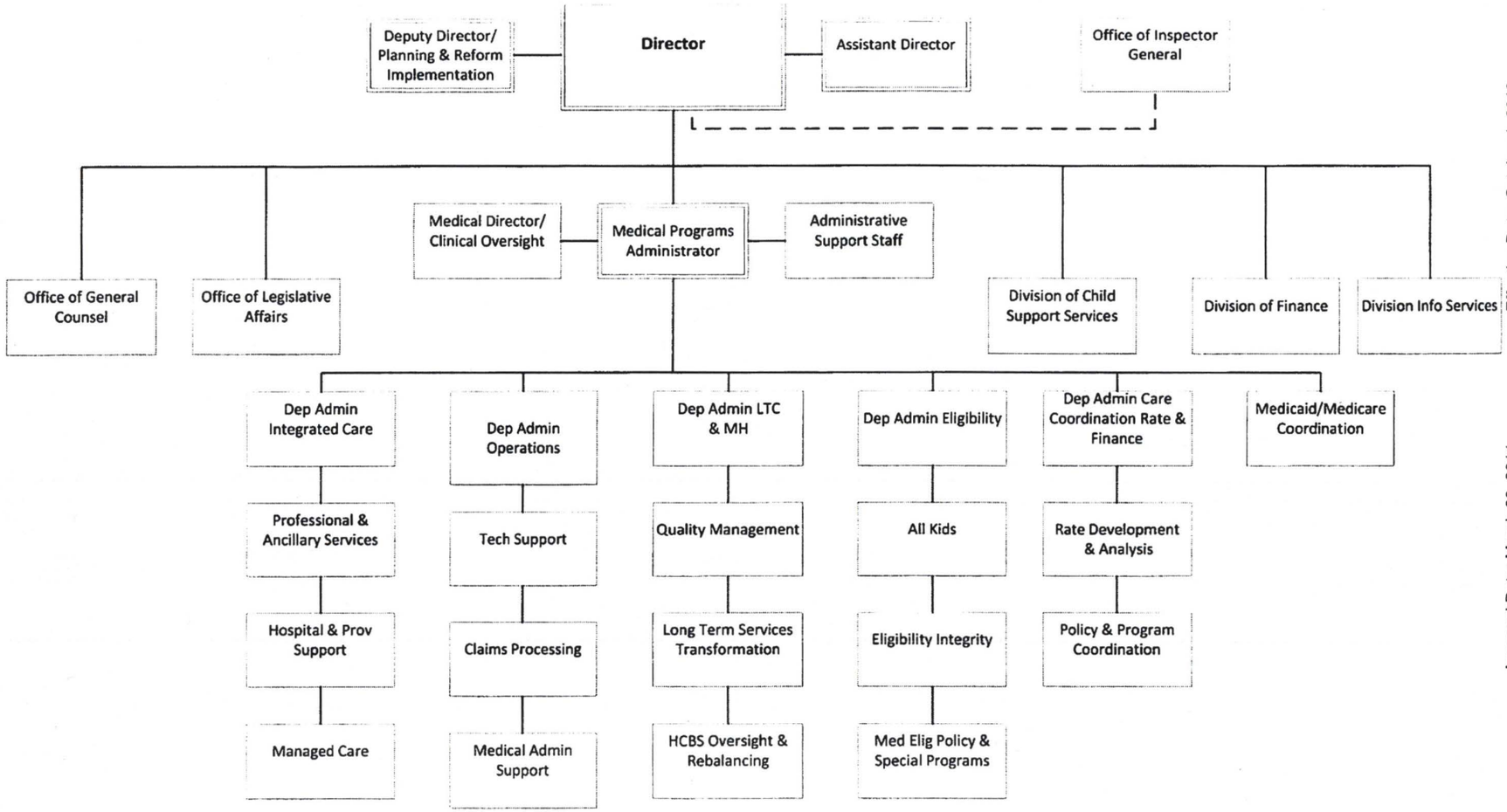
Citation		Condition or Requirement
1902(a)(73)	1.4	Tribal Consultation Requirements

_X_ The State seeks advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian *Self-Determination and Education Assistance Act*, or Urban Indian Organizations under the *Indian Health Care Improvement Act*.

There is a single qualifying entity in Illinois, the American Indian Health Service of Chicago (AIHSC). The State met with a representative of the AIHSC to establish a process for notification of all proposed changes to the Illinois Medicaid program, including the process for seeking their comment and input. Prior to submittal of this amendment, the State provided a summary of the agreed processes to the AIHSC for their approval.

For changes that may directly impact their organization of the provision of services to Native Americans, the State will provide email notification of the proposed changes. The notifications will describe the purpose of the program changes, the anticipated impact on the AIHSC or Native American enrollees, and provide information regarding the process for submitting official written comments and questions. The notification will also include advanced drafts of the changes. The email notifications will provide at least a two week time period for review and comment. This time frame will periodically be reviewed with the AIHSC to determine if it is sufficient.

For changes that the State determines do not directly impact the AIHSC, the State will still provide an email notification. The email will notify the AIHSC that a direct impact is not anticipated, but a review of the proposals and comments would still be welcomed.


Deputy Director/ Planning & Reform Implementation
Director
Assistant Director
Office of Inspector General
Office of General Counsel
Office of Legislative Affairs
Medical Director/ Clinical Oversight
Medical Programs Administrator
Administrative Support Staff
Division of Child Support Services
Division of Finance
Division Info Services
Dep Admin Integrated Care
Dep Admin Operations
Dep Admin LTC & MH
Dep Admin Eligibility
Dep Admin Care Coordination Rate & Finance
Medicaid/Medicare Coordination
Professional & Ancillary Services
Tech Support
Quality Management
All Kids
Rate Development & Analysis
Hospital & Prov Support
Claims Processing
Long Term Services Transformation
Eligibility Integrity
Policy & Program Coordination
Managed Care
Medical Admin Support
HCBS Oversight & Rebalancing
Med Elig Policy & Special Programs

OFFICE OF THE ATTORNEY GENERAL
STATE OF ILLINOIS

Lisa Madigan
ATTORNEY GENERAL

State Plan Under Title XIX of the Social Security Act
State of Illinois
Attorney General Certification

I certify that:

The Illinois Department of Healthcare and Family Services is the single State agency with the legal authority to:

1. administer the state Medicaid plan; and

2. make rules and regulations that it follows in administering the plan.

The legal authority under which the agency administers the plan is 20 ILCS 2205/2205-5; 305 ILCS 5/2-12(3), (4); and 305 ILCS 5/5-1 et seq.

The agency has the legal authority to make rules and regulations under 305 ILCS 5/12-13.

9.25.13
DATE

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MEDICAID ADMINISTRATION	
TRANSMITTAL NUMBER: IL-13-0013-MM4	**STATE:** Illinois
Notwithstanding the statement in A1 and the checked assurance on A3, the single state agency has not entered into an agreement with the Illinois Department of Human Services to conduct Medicaid eligibility determinations or fair hearings to date, but will enter into an agreement as soon as possible.	

SUPERSEDING PAGES OF STATE PLAN MATERIAL		
TRANSMITTAL NUMBER: IL-13-0013-MM4	**STATE:** ILLINOIS	
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	**COMPLETE PAGES SUPERSEDED:**	**PARTIAL PAGES SUPERSEDED:**
A1 – A3	Section 1 (Pages 1-8) Attachment 1.1A Attachment 1.2A Attachment 1.2B Attachment 1.2C Attachment 1.2D	Section 1.4 (page 9)(State Medical Care Advisory Committee only. Tribal consultation will remain in the state plan.)
A1-A2	Notwithstanding any other provisions of the Medicaid State Plan, the agencies designated in A1 and A2 will determine eligibility for coverage to the extent specified in A1 and A2.	