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State/Territory Name: Illinois

State Plan Amendment (SPA) #13-014

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

December 27, 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 13-014

Dear Ms. Hamos:

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

Transmittal #13-014 - Approves Illinois' request to implement an alternative model of healthcare delivery through Care Coordination Entities (CCEs).

--Effective Date: September 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,

[redacted] Actin

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: 13-014
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: September 1, 2013

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 $41,000
b. FFY 2014 $2.75 Million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1g-F, Pages 30 through 44

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
New Pages

10. SUBJECT OF AMENDMENT:
Care Coordination Entities

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: 09-27-2013

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:

18. DATE APPROVED: December 27, 2013

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: September 1, 2013

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

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 State of Illinois enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organizations (MCOs, Primary Care Case Managers (PCCM) and Care Coordination Entities (CCE)) with care coordination services in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the *Social Security Act* (the Act). Under this authority, a State can amend its Medicaid State plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 *CFR* 431.50), freedom of choice (42 *CFR* 431.51) or comparability (42 *CFR* 440.230). This authority may *not* be used to mandate enrollment in prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii-vii below)

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 (**Care Coordination Entity - CCE**) including capitated PCCMs that qualify as PAHPs.

☐ iii. Both.

CCE's are a collaboration of providers and community agencies, governed by a lead entity that receives a care coordination payment in order to provide care coordination services for its Enrollees. A CCE shall have a network of providers and community partners who shall deliver coordinated quality care across provider and community settings to Enrollees. The Enrollee shall be at the center of the CCE's coordinated care network and delivery system. The CCE shall coordinate care across the spectrum of the healthcare system with a particular emphasis on managing transitions between levels of care, and coordination between services for physical health, mental health and substance abuse. Care coordination by a CCE must include ensuring the provision of or arranging for a majority of care around the Enrollee's needs; a medical home with a Primary Care Provider (PCP), specialist services, diagnostic and treatment

Citation	Condition or Requirement

services, mental health and substance abuse services, inpatient and outpatient hospital services, rehabilitation and long-term care services; and social services.

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.
Under the CCE's Provider Network, medical services shall be reimbursed by the Department in accordance with its Fee-for-service reimbursement schedule.

☐ ii. Capitation.

☑ iii. A case management fee.
The CCE's will receive a monthly PMPM for individuals enrolled within the CCE. The PMPM will be based on the popualtion the CCE is cooordianting care. The Department will negotiate PMPM rates with each CCE and will provide these rates in each CCE contract.

☑ iv. A bonus/incentive payment.
CCE's shall be eligible to receive an incentive payment for coordination services defined by the Department that show improvement in care of their enrollees.

a. CCE program quality measures will be determined by the Department and shall be measures that are established by HEDIS or are Department defined measurements.

b. All CCE program quality measures will be described on the Department's website.

c. Beginning with the initial measurement year, which is the calendar year following initial enrollment, the Department shall withhold a percentage of the CCE's monthly Case Management Fees. The CCE can earn the withheld amounts as incentive payments by meeting or exceeding quality measure targets determined by the Department. For the measures the target goal will be set at a percent above or below the baseline determined by the Department for each quality measure equal to 10% of the difference between the baseline score and 100% depending on whether the target represents an increase or decrease from the baseline. The initial baseline year is the calendar year prior to initial enrollment and the initial measurement year is the calendar year following initial enrollment. All measurement years will be calendar years. In subsequent measurement years, the previous year's performance will be the baseline for that measurement year unless the previous year's

Citation	Condition or Requirement

performance was below the initial baseline, in which case the initial baseline remains the baseline.

☐ v. A supplemental payment.

☑ vi. Other. *[Please provide a description below.]*

The contract will include a shared savings program as defined by the Department and as approved by CMS. The Department is currently working with CMS to establish the CCE shared savings program. The shared savings program shall not be implemented until the methodology receives CMS approval.

1905(t)
42 *CFR* 440.168

3. For States that pay a PCCM or CCE on a fee-for-service basis,incentive payments are permitted as an enhancement to the PCCM or CCE's case management fee, if certain conditions are met.

42 *CFR* 438.6(c)(5)(iii)(iv)

[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 or CCE will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM or CCE 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 or CCEs.

☑ vi. Incentives will not be conditioned on intergovernmental transfer agreements.

☐ vii. Not applicable to this 1932 State plan amendment.

42 *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 has held numerous meetings with physicians, provider associations and advocates to discuss and review input regarding the CCE program during both the development of the program and on-going as the Department proceeds with the implementation of the CCE program. Participants in the process has included other state agencies, and community and provider organizations, such as but not limited to:

Citation	Condition or Requirement

- State agencies: Division of Mental Health, Division of Developmental Disabilities and the Department on Aging;
- Provider associations, such as the Illinois Hospital Association, Illinois Association of Rehabilitation Facilities, Illinois Primary Health Care Association;
- Individual providers;
- Client advocates, such as Centers for Independent Living, IARF, Area Agencies on Aging; and
- Local health departments.

The State is committed to continue to have meetings with representatives from the above listed entities throughout implementation and on an on-going basis. These meetings will be through ad-hoc requests and regularly scheduled steering committee or stakeholder meetings.

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).

   Cook, Macon, Logan, Dewitt, Piatt, Mercer, Rock Island

   ii. County/counties (voluntary).

   Shelby, Moultrie, Lee, Ogle, Putnam, Whiteside, Bureau, LaSalle, Carroll, Madison

   iii. Area/areas (mandatory)

   Beginning on October 1, 2013, mandatory enrollment will be implemented in Macon, DeWitt, Piatt, Logan, Mercer and Rock Island counties. Cook County mandatory enrollment will begin on February 1, 2014.

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.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
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 PCCM (CCE) and PCCM (CCE) 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.
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* 438 for MCOs and PCCM and CCEs 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 for payments under any risk contracts will be met.
1932(a)(1)(A) 42 *CFR* 447.362 42 *CFR* 438.50(c)(6)	☑ 7. The State assures that all applicable requirements of 42 *CFR* 447.362 for 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. The following individuals residing in the counties listed in subsection B.5.i.:

Citation	Condition or Requirement

- Persons age 19 and older who are aged, blind or disabled and meet more restrictive eligibility criteria than those under SSI and as described in 42 CFR sections 435.121, 435.122, 435.130, 435.133, 435.134.
- Certain institutionalized individuals who were eligible in December 1973 as described in 42 CFR 435.131.
- Persons age 19 or older who would be eligible if institutionalized except they receive home and community based services under a waiver as described in 42 CFR 435.217.
- Qualified Severely Impaired Blind and Disabled Individuals older than age 65 as described in 1902(a)(10)(A)(i)(II) and 1905(q) of the Social Security Act.
- Disabled widows and widowers as described in section 1634 of the Act.
- Persons age 19 and older who qualify for the AABD expansion as described in 42 CFR sections 435.320, 435.322 and 435.324.
- Persons age 19 and older who qualify for Health Benefits for Workers with Disabilities under the Ticket to Work-Work Improvement Act (TWWIIA) as described in 1902(a)(10)(A)(II).

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.

Recipients who are eligible for Medicare may elect to voluntarily enroll in a CCE to receive the benefit of care coordination, such as managing transitions between levels of care, and coordination between services for physical health, mental health and substance abuse. If the recipient actively chooses to voluntarily enroll in CCE, the recipient will maintain the same benefits and have the same co-pays they currently have with their medical card. If the recipient voluntarily enrolls they will participate in CCE in accordance with the policies of the program, including the ability to change their PCP one time per month.

Citation	Condition or Requirement
1932(a)(2)(C) 42CFR 438(d)(2)	☑ ii. Indians who are members of federally recognized Tribes except when the MCO or PCCM (CCE) 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*. If the recipient actively chooses to voluntarily enroll in CCE, the recipient will maintain the same benefits and have the same co-pays they currently have with their medical card. If the recipient voluntarily enrolls they will participate in CCE in accordance with the policies of the program, including the ability to change their PCP one time per month.
1932(a)(2)(A)(i) l42 *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)(iii)	☐ iv. Children, under the age of 19 years, who are eligible under 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. Identification of Mandatory Exempt Group

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.]* Children identified as either receiving services from, or participating in, a particular program will be identified through the use of paid claims data.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
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. ☐ 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.
1932(a)(2)	4. Describe how the State identifies the following groups of children who are exempt 42 *CFR* 438.50(d) from mandatory enrollment: *[Examples: Eligibility database, self-identification.]* 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

Citation	Condition or Requirement
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 and self-identification. ii. Indians who are members of federally recognized Tribes except when the MCO or PCCM or CCE 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. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment.** • Individuals under 21 years of age whose categorical basis for eligibility is blindness or disability. • 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, for the cost of their residential care program. • Individuals who are eligible only after a "spend-down" of income or assets. • Children of those individuals whose care is subsidized by the Department of Children and Family Services (E.4.iii and iv above). • Individuals for whom some or all of their care is the responsibility of the Department of Corrections or the Department of Juvenile Justice. • Inmates of a public institution. • Individuals under 21 years of age who receive Supplemental Security Income. • Individuals enrolled in a presumptive eligibility program.

Citation	Condition or Requirement

- Individuals enrolled in the following limited benefits programs:
  - Illinois Healthy Women.
  - All Kids Rebate.
  - Family Care Rebate.
  - Illinois Cares Rx (formerly SeniorCare/Circuit Breaker).
  - Emergency medical assistance only under the provisions of section 1903(v)(2) of the *Social Security Act*
  - State Renal Dialysis.
  - State Hemophilia.

- Populations already managed:
  - High-level third-party liability/private insurance
  - Individuals under 21 years of age with special needs, who are not excluded pursuant to E.2 above, whose care is managed by the Division of Specialized Care for Children of the University of Illinois at Chicago or directly by the department.
  - Participants in the Program for All-Inclusive Care for the Elderly.

42 *CFR* 438.50 **G. List all other eligible groups who will be permitted to enroll on a voluntary basis.**

Indians who are members of Federally recognized Tribes except when the MCO or PCCM or CCE 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.

Recipients who are also eligible for Medicare.

Eligible recipients who reside in the voluntary counties provided in Section B.5.iii

H. Enrollment process.

1932(a)(4) 1. Definitions42 *CFR* 438.50

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.

Citation	Condition or Requirement

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-client relationships will be considered based on historical claims data.

ii. The relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

Providers who enroll in the CCE Networks will be assigned clients as described below. The CCE's shall work to enroll Medicaid enrolled providers with a specific emphasis on enrollment of primary care providers enrolled in the Department's Primary Care Case Management program, in which most of the recipients are participating.

iii. The equitable distribution of Medicaid recipients among qualified MCOs and PCCMs or CCEs 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.]*

A Potential Enrollee <u>in a mandatory county</u> who does not select a managed care plan <u>(which includes a CCE)</u> and a PCP will be auto-assigned to a manage care <u>plan if a choice is not made within 60 days from the date of the initial enrollment issued by</u>~~, which shall include a CCE, by~~ the Illinois Client Enrollment Broker (ICEB).

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.

Citation	**Condition or Requirement**

iii. Describe the State's process for notifying Medicaid recipients of their auto-assignment. *[Example: State generated correspondence.]*

During the 60 day enrollment process (as defined in 3.ii above), potential enrollees will be sent an initial enrollment packet (Day 1), a reminder letter (Day 14) and a second enrollment letter (Day 30). In addition, the ICEB will attempt to contact the potential enrollee by phone a minimum of 2 times during the 60 day enrollment period. Each enrollment letter (initial and second) notifies the potential enrollee of the date that they must make a choice and that if no choice is made by that date, the potential enrollee with be auto-assigned to a Plan and PCP. The second enrollment letter (Day 30) will also specify the managed care plan and provider to whom the potential enrollee will be assigned if no choice is made. If no choice is made by the potential enrollee during the 60 day enrollment period, the ~~and a~~ client is enrolled into a Plan and to a PCP through auto-assignment.~~, w~~Within five days of receiving confirmation from the Department that an individual has enrolled with a Plan, the Plan ~~after enrollment the CCE~~ will send a welcome packet to the enrollee confirming that they are enrolled with the Plan and giving the enrollee ~~includes all~~ basic information, ~~including a summary of important topics,~~ such as, how to get needed care, when a referral is needed from their PCP, the benefits of preventive and primary care and information ~~about~~ on how to request a PCP change.

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 60 day enrollment process (as defined in 3.ii and iii above), potential enrollees will receive an information guide from the I~~llinois C~~lient E~~nrollment B~~roker in their initial enrollment packet (Day 1). This ~~information guide~~ packet will provide information regarding disenrollment rights, including the right to change Plans during the first 90 days of enrollment. The ICEB Customer Service Representatives will also educate the client on the 90 day period when assisting the client to enroll. ~~without cause during the first 90 days of enrollment.~~ In addition, the CEB program web site includes information on the

Citation	Condition or Requirement

90 day period, as well as additional information on when an enrollee can change Plans.

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 default assignment algorithm will take into consideration:

- Current managed care plan and provider assignment
- Existing provider-client relationships based on paid claims data.
- The geographic location of the client and the PCP.
- Special needs of the client, if known.
- Panel capacity limits set by the HFS and limits set by the provider.

vii. 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 weekly basis the Illinois Client Enrollment Broker will report to the Department Potential Enrollees who have voluntarily chosen a managed care plan and PCP, Potential Enrollees who are enrolled by auto-assignment, and Enrollees who request to change from one managed care plan to another during enrollment change periods. In addition, the Department will produce ad-hoc reports as necessary.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

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 or CCE 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 (CCE) 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 CCEs.

☐ 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.

☑ 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 two 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 12 months.

3. Place a check mark to affirm State compliance.

Citation	Condition or Requirement

☑ 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).

An Enrollee may request, orally or in writing, to disenroll from CCE at any time for any of the following reasons: (i) the Enrollee moves out of the Contracting Area; and (ii) other reasons, including, but not limited to, poor quality of care, lack of access to Covered Services, lack of access to Providers experienced in dealing with the Enrollee's health care needs, or, if automatically re-enrolled and such loss of coverage causes the Enrollee to miss the Open Enrollment period. Changes for cause at other times will be allowed, upon approval of the State, for the reasons permitted in accordance with 42 *CFR* 438.56(c).
Enrollees may change their PCPs every 30 days.

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 and CCE programs operated under section 1932(a)(1)(A)(i) State plan amendments.

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM &CCE).

- Services provided to newborns up to 91 days after birth.
- Family planning, obstetrical and gynecological services

- Immunizations.
- Emergency room services.
- Transportation services.
- Pharmaceuticals.
- Dental services.
- Vision services.
- Therapies.
- Mental health and substance abuse services.
- Outpatient ancillary services.
- Services to treat sexually transmitted diseases.

Citation	Condition or Requirement

- Services to treat tuberculosis.
- Services provided pursuant to the *Individuals with Disabilities Education Act*.
- Lead screening and epidemiological services.
- Services provided by:
  - School-based/-linked clinics to individuals under 21 years of age.
  - Certified local public health departments.
  - Mobile vans, with department approval.
  - Homeless sites operated by a federally qualified health center or rural health clinic.

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.]*

N/A

☑ 4. The selective contracting provision is not applicable to this State plan.