Table of Contents

State/Territory Name: Illinois

State Plan Amendment (SPA) #:14-0021

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

April 2, 2015

Felicia F. Norwood, 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 14-0021

Dear Ms. Norwood:

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

Transmittal #14-0021 - Approves Illinois' request to implement a Savings and Quality Based Pay-for-Performance incentive payments among the following Coordinating Entities: Care Coordination Entities for Persons with Disabilities, Care Coordination Entities for Children with Special Needs, Accountable Care Entities, and Medical Home Network.

--Effective Date: January 1, 2014

As you continue to implement this payment model we ask you to provide to CMS the results of the quality measures for this payment methodology and any other reviews of access to care for beneficiaries impacted by this SPA to ensure that there are no access and/or quality of care issues.

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/
Alan Freund
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Theresa Eagleson, HFS
Robert Mendonsa, HFS
Mary Doran, HFS
Teresa Hursey, HFS
Sara Barger, 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: **14-0021**

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: **January 1, 2014**

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 **2014** **$ 4.1 Million**
b. FFY **2015** **$ 16.4 Million**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, Pages 31, 31A, 31B, ~~and~~ 32 ,30, 30A, 30B, 33, 33A, 33B, 34, 35, 36, 36A, 37, 38, 39, 39A, 40, 41, 41A, 41B, 42, 43, and 44.
Pen and ink authorized on 3/31/15. cs.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, Pages 31 ~~and 32~~ New Page, New Page, 32, 30, New Page, New, Page, 33, New Page, New Page, 34, 35, 36, New Page, 37, 38, 39, New Page, 40, New Page, 41A, 41B, 42, 43, and 44.
Pen and ink authorized on 3/31/15. cs.

10. SUBJECT OF AMENDMENT:
Care Coordination Entities – Savings and Quality Based Pay-for-Performance Incentive Payment

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: 3/31/14

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: 03/31/14

18. DATE APPROVED: 04/02/15

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01/01/15

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Alan Freund

22. TITLE: Acting Associate Regional Administrator

23. REMARKS:

Citation	Condition or Requirement

IV. PCCM – Care Coordination Entities, Accountable Care Entities and Medical Home Network

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 health plans (Managed Care Organizations (MCOs), Managed Care Community Networks (MCCNs) and Coordinating Entities: Accountable Care Entities (ACEs) ~~managed care entities (managed care organizations (MCOs, Primary Care Case Managers (PCCM)~~ and Care Coordination Entities (CCEs)) 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 health plans ~~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 (Coordinating Entities: Care Coordination Entities for Seniors and Persons with Disabilities and Care Coordination Entities for Children with Special Needs (CCEs); Accountable Care Entities (ACEs); and Medical Home Network (MHN) ~~**Care Coordination Entity CCE**~~) ~~including capitated PCCMs that qualify as PAHPs.~~

~~☐ iii. Both.~~

Individuals eligible for services provided by Coordinating Entities may, depending on the populations served by each available health plan, choose among available health plans operating in their contracting area. Health plans may include MCOs, MCCNs, ACEs, CCEs, and MHN.

Citation	Condition or Requirement

a. 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. As further detailed in Section D.1., CCEs may serve Seniors and Persons with Disabilities, Children with Special Needs, or ACA adults. 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 services, mental health and substance abuse services, inpatient and outpatient hospital services, rehabilitation services and social services. ~~and long-term care services.~~ When applicable to the Enrollee's needs and the CCE's scope of coordinated services, care coordination by a CCE must include ensuring the provision of or arranging for long-term services. CCEs that serve Children with Special Needs must also coordinate pediatric dental services and referrals for Early Intervention services~~; and social services~~.

b. An ACE is an organization comprised of and governed by its participating providers, with a legally responsible lead entity, that receives a care coordination payment to coordinate the care of its Enrollees, and is accountable for the quality, cost, and overall care of its Enrollees. The ACE demonstrates an integrated delivery system, shares clinical information in a timely manner, and designs and implements a model of care and financial management structure that promotes provider accountability, quality improvement, and improved health outcomes. As further detailed in section D1, ACEs serve the Family Health Population and ACA Adults.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
	c. Medical Home Network (MHN) is an integrated delivery network that receives a care coordination payment to coordinate the care of its Enrollees and virtually links hospitals and primary care sites, known as medical homes to facilitate communication and ensure care continuity between participating institutions through real-time activity alerts and access to pertinent information at the point of care. MHN serves the PCCM eligible population as specified in approved SPA 06-12.

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.~~

☐ iii. Both.

42 *CFR* 438.50(b)(2)
42 *CFR* 438.50(b)(3)

2. The payment method to the contracting entity will be:

☑ i. Fee-for-service.
Under the Coordinating Entities' ~~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 Coordinating Entities ~~CCE's~~ will receive a monthly PMPM for individuals enrolled within the Coordinating Entity ~~CCE~~. The PMPMs will be based on the population for which the Coordinating Entity ~~CCE~~ is coordinating ~~cooordianting~~ care. The Department ~~will negotiate PMPM rates with each CCE and~~ will provide these rates in each Coordinating Entity ~~CCE~~ contract.

☑ iv. A bonus/incentive payment. Depending on the Coordinating Entity, there are two types of incentive payments; a withhold incentive payment for MHN described in (a) below and a pool payment described in (b) below.

~~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~~

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

a. For MHN, the Department will withhold a percentage of the monthly Case Management Fees. MHN can earn the withheld amounts as incentive payments by meeting or exceeding quality measure targets. The quality measures in effect on January1, 2014 and annual targets associated with the withhold incentive payment for MHN are provided on the Department's website at http://www2.illinois.gov/hfs/PublicInvolvement/cc/ACE/Pages/default.aspx.

b. Coordinating Entities that serve at least 1,000 Enrollees in a given year will be eligible to receive a Savings and Quality Based Pay-for-Performance Incentive Pool Payment (incentive pool payment) on annual basis beginning in the calendar year after implementation of the first Coordinating Entity. The incentive payment pool will compare risk-adjusted Per Member Per Month (PMPM) costs for each Coordinating Entity to similarly risk-adjusted PMPM capitation rates paid to the Managed Care Organizations (MCOs) who cover the same population for the same year in a similar geographic region.

On an annual basis, if the Coordinating Entity PMPM is less than the PMPM capitation rate for the comparable MCO program, the difference will be multiplied by the enrolled member months for the particular Coordinating Entity to calculate the total amount of the incentive pool payments. The maximum amount of incentive pool payments a Coordinating Entity may receive per year is 50 percent of the total difference.

Coordinating Entities must demonstrate a lower PMPM than the PMPM capitation rate paid to MCOs and meet a quality metric threshold in order to receive any incentive pool payments. Coordinating Entities that demonstrate a lower PMPM than the PMPM capitation rate paid to MCOs and meet a quality metric threshold will receive an incentive pool payment of 10 percent of the calculated annual difference. Coordinating Entities may earn additional incentive pool payments of up to 40 percent of the calculated difference by meeting Quality Measure Targets.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
	There will be four Quality Measure targets and Coordinating Entities will have the ability to earn incentive pool payments equal to 10 percent of the annual difference per Quality Measure Target. Given the unique nature of each Coordinating Entity due to Enrollee needs and enrollment sizes, the Department will vary Quality Measures used for incentive pool payments. The Quality Measures in effect as of January 1, 2014 associated with the incentive pool payments for each Coordinating Entity are provided on the Department's website at http://www2.illinois.gov/hfs/PublicInvolvement/cc/ACE/Pages/default.aspx. PMPMs will include all health care, supplemental, and administrative costs, and, for Coordinating Entities, care coordination fees. Coordinating Entity PMPMs will be set for each calendar year to align with MCO PMPM capitation rates and will be calculated at the beginning of the third quarter after the end of each measurement year, to allow for claims incurred during the measurement year to be submitted and adjudicated for payment. Coordinating Entity costs for each measurement year will be calculated for all Enrollees by summarizing the fee-for-service claims and supplemental payments for each Coordinating Entity's population including care coordination fees paid to the Coordinating Entity and the result expressed as a risk-adjusted PMPM rate, which will be the Measurement Year PMPM. The Measurement Year PMPM will include member months for all Enrollees, regardless of length of enrollment with the Coordinating Entity. For any Enrollee for whom paid claims in a contract year exceed $80,000, 80 percent of the costs that exceed $80,000 will be excluded from the calculation of actual costs for the Coordinating Entity. Costs in excess of the $80,000 per person limit will be totaled, and a pooling charge will be applied to the Coordinating Entity PMPM to allow for comparison to the MCO PMPM capitation rates whose calculation had no such limit applied. Costs are calculated by applying Medicaid rates to covered services. In all cases, costs for blood factor will be removed from the measurement of actual costs for the Coordinating Entity's PMPM and the MCO rates will be adjusted accordingly.

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

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

[If applicable to this State plan, place a check mark to affirm the State has met all of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).]

☑ i. Incentive payments to the PCCM or Coordinating Entity ~~CCE~~ will not exceed 5% of the total FFS payments for all Medicaid ~~those~~ services provided to Enrollees ~~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 Coordinating Entities ~~CCEs~~.

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

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

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
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 Coordinating Entity ~~CCE~~ programs during both the development of the program and on-going as the Department proceeds with the implementation of the Coordinating Entity ~~CCE~~ programs. Participants in the process has included other state agencies, and community and provider organizations, such as but not limited to: • 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 including providers participating in the Coordination Entities networks; • 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. In order to implement the Coordinating Entities, the Department held several committee meetings with community and provider entities to determine interest in the programs and to develop a solicitation to secure Coordinating Entities. Several meeting dates and materials used for discussion can be found on the Department's web site at the following link for meeting dates – October 13, 2011, November 15, 2011, April 20, 2012, and July 2012: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx The State hosted a public webinar on August 28, 2013 after posting the ACE solicitation to describe the ACE program and solicit feedback on the solicitation. The State hosted a public webinar on June 30th, 2014 describing the rollout of the mandatory managed care program during which the Department answered questions from the public. Furthermore, the Department posted a public notice for ACEs in various newspapers beginning on 6/26/14.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
1932(a)(1)(A)	5. The State plan program will ☐ will not ☑ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ☑/ voluntary ☑ enrollment will be implemented in the following county/area(s): i. County/counties (mandatory). Cook, Macon, Logan, Dewitt, Piatt, Mercer, Rock Island, Boone, Champaign, Christian, Clinton, DuPage, Ford, Henry, Kane, Lake, Kankakee, Knox, Madison, McHenry, McLean, Menard, Peoria, St. Clair, Sangamon, Stark, Tazewell, Vermilion, Will and Winnebego counties. ii. County/counties (voluntary). ~~Shelby, Moultrie, Lee, Ogle, Putnam, Whiteside, Bureau, LaSalle, Carroll, Madison~~, Adams, Brown, Bureau, Carroll, Cass, Clark, Coles, Crawford, Cumberland, DeKalb, Douglas, Edgar, Effingham, Fulton, Grundy, Hancock, Henderson, Iroquois, Jasper, Kendall, LaSalle, Lee, Livingston, Macoupin, Marshall, Mason, McDonough, Montgomery, Morgan, Moultrie, Ogle, Pike, Putnam, Richland, Schuyler, Scott, Shelby, Stephenson, Warren, Whiteside and Woodford counties and any other county where a Coordinating Entity receives approval from the Department to ~~chooses to~~ operate as a Coordinating Entity. iii. Area/areas (voluntary ~~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.~~ Some Coordinating Entities had enrollments prior to July 1, 2014 when the State implemented mandatory managed care expansion for the Family Health Plan and ACA Adult populations. Some enrollments occurred in the mandatory managed care counties listed in B.5.i.

Citation	Condition or Requirement
	C. State assurances and compliance with the statute and regulations. If applicable to the State plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 *CFR* 438.50(c)(1)	☐ 1. The State assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 *CFR* 438.50(c)(2) 1902(a)(23)(A)	☑ 2. The State assures that all the applicable requirements of section 1905(t) of the Act for PCCM (Coordinating Entity ~~CCE~~) and PCCM (Coordinating Entity ~~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 Coordinating Entities ~~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 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.

Citation	Condition or Requirement

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. and not listed in subsections D.2., E., F., and G,. as exempt from mandatory enrollment into a Coordinating Entity, will be enrolled in a Coordinating Entity. Populations served by each Coordinating Entity include:

i. CCEs for Seniors and Persons with Disabilities

a. Individuals who are 65 years of age or older and eligible for Medicaid.

b. Individuals who are over 18 years of age and under 65 years of age, who meet the definition of blind or disabled under Section 1614(a) of the Social Security Act (42 U.S.C. 1382), and whose Medicaid eligibility is based on meeting that definition.

c. ACA Adults: Individuals eligible for HFS Medical Programs through the Affordable Care Act (ACA) as of January 1, 2014 and pursuant to 305 ILCS 5/5-2(18).

ii. CCEs for Children with Special Needs

Children's with Special Needs: Individuals eligible for CCE services as identified by the Department through the use of the 3M™ Clinical Risk Grouping software as Status 6.1 and above, or through another process, if adopted by the Department, subject to all other eligibility and enrollment requirements set forth in the contracts.

iii. Accountable Care Entities

a. Family Health Plan Population: Individuals whose eligibility has been determined on the basis of being a child, a parent or other caretaker relative eligible for Covered Services under Title XIX or Title XXI, or a pregnant woman.

b. ACA Adults: Individuals eligible for HFS Medical Programs through the Affordable Care Act (ACA) as of January 1, 2014 and pursuant to 305 ILCS 5/5-2(18).

vi. Medical Home Network (MHN):

PCCM Eligible Populations: MHN may serve individuals eligible for HFS Medical Programs, except PCCM excluded populations identified in SPA #06-12.

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 19 and under 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.~~

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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 (Coordinating Entity ~~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 any Coordinating Entity available in their county ~~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 Coordinating Entity ~~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) ~~I~~42 *CFR* 438.50(d)(3)(i)	☑ iii. Children, under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI. No earlier than November 1, 2014, recipients who are eligible under this subsection D.2.iii may elect to voluntarily enroll in an ACE or a CCE that serves Children with Special Needs. If the recipient actively chooses to voluntarily enroll in an ACE or 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 the ACE or CCE in accordance with the policies of the program, including the ability to change their PCP one time per month.
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. No earlier than November 1, 2014, recipients who are eligible under this subsection D.2.iv may elect to voluntarily enroll in an ACE or a CCE that serves Children with Special Needs. If the recipient actively chooses to voluntarily enroll in an ACE or CCE serving Children with Special Needs, 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 the ACE or CCE serving Children with Special Needs 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)(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

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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.

1. The following individuals are excluded from enrollment in any Coordinating Entity:

- ~~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.~~

  i. Individuals that are dually eligible for both Medicare and Medicaid.

- ii. Individuals who are eligible only after a "spend-down" of income or assets.
- iii. Children of those individuals whose care is subsidized by the Department of Children and Family Services (E.4.iii and iv above).
- iv. Individuals for whom some or all of their care is the responsibility of the Department of Corrections or the Department of Juvenile Justice.
- v. Inmates of a public institution.
- ~~Individuals under 21 years of age who receive Supplemental Security Income.~~
- vi. Individuals enrolled in a presumptive eligibility program.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

- vii. 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.~~

- viii. Populations already managed:

  a. High-level third-party liability/private insurance.

  b. 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.~~

  c. Individuals already enrolled in an MCO.

2. The Family Health Plan population is excluded from enrollment into a CCE serving Seniors and Persons with Disabilities.

3. Individuals in the Aged, Blind or Disabled category of assistance are excluded from enrollment in an ACE, managed under Chapters III, V, and VI of this Attachment.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

42 *CFR* 438.50

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

~~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.ii~~i~~.

H. Enrollment process.

1932(a)(4)

1. Definitions 42 *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.

   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 current provider/client relationships under the Primary Case Management Program or other MCOs and 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 Coordinating Entity ~~CCE~~ Networks will be assigned clients as described below. The Coordinating Entity ~~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.

Citation	Condition or Requirement

iii. The equitable distribution of Medicaid recipients among qualified MCOs and PCCMs or Coordinating Entities ~~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 in a mandatory county who does not voluntarily select a managed care plan (which includes a Coordinating Entity ~~CCE~~) and a PCP will be auto-assigned to a manage care plan and PCP if a choice is not made within 60 days from the date of the initial enrollment issued by the Illinois Client Enrollment Services ~~Broker~~ (ICES~~B~~).

1932(a)(4)
42 *CFR* 438.50

3. As part of the State's discussion on the default enrollment process, include the following information:

i. The State will ☑ will not ☐ use a lock-in for managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be 60 days.

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

During the enrollment process, potential enrollees will be sent an initial enrollment packet and a second enrollment letter. The second enrollment letter will specify the health plan and provider to whom the potential enrollee will be assigned if no choice is made. If no choice is made and a client is enrolled through auto-assignment, within five days after enrollment the Coordinating Entity will send a welcome packet to the enrollee that 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 how to request a PCP change.

Citation	Condition or Requirement

iv. Describe the State's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *[Examples: State-generated correspondence, HMO enrollment packets, etc.]*

During the enrollment process, potential enrollees will receive an information guide from Illinois Client Enrollment Services. This guide will provide information regarding disenrollment rights, including without cause during the first 90 days of enrollment. In addition, welcome packets issued to each Coordinating Entities member will include information regarding disenrollment rights, including without cause during the first 90 days of enrollment.

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 at a minimum:

a. Current health plan and provider assignment

b. Existing provider-client relationships based on paid claims data.

c. The geographic location of the client and the PCP.

d. 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, Illinois Client Enrollment Services will report to the Department potential enrollees who have voluntarily chosen a health plan and PCP, potential enrollees who are enrolled by auto-assignment, and enrollees who request to change from one health 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**

[Material Removed]

~~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 client is enrolled into a Plan and to a PCP through auto-assignment. Within five days of receiving confirmation from the Department that an individual has enrolled with a Plan, the Plan will send a welcome packet to the enrollee confirming that they are enrolled with the Plan and giving the enrollee basic information, such as, how to get needed care, when a referral is needed from their PCP, the benefits of preventive and primary care and information 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 in their initial enrollment packet (Day 1). This 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. In addition, the CEB program web site includes information on the~~

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	**Condition or Requirement**

[Material Removed]

~~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.~~

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 Coordinating Entity ~~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 (Coordinating Entity ~~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 Coordinating Entities ~~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.

☑ The State assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 *CFR* 438.56(c).

Citation	Condition or Requirement

4. Describe any additional circumstances of "cause" for disenrollment (if any).

An Enrollee may request, orally or in writing, to disenroll from Coordinating Entity ~~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 Coordinating Entity ~~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 & Coordinating Entity ~~CCE~~).**

Coordinating Entities are responsible for coordination of all Medicaid services. Providers will continue to bill the Department for Medicaid services via fee-for-service.

- ~~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.