Table of Contents

State/Territory Name: Illinois

State Plan Amendment (SPA) #: 14-0038

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

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

March 23, 2017

Felicia Norwood, Director
Illinois Department of Healthcare and Family Services
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Attn: Teresa Hursey

Dear Ms. Norwood:

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

Transmittal #14-0038 – Managed Care Delivery System for Family Health Plan and Affordable Care Act Adults – Effective Date: July 1, 2014

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

Sincerely,

/s/

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

Enclosure

cc: Sara Barger, HFS
Kimberley Cox, HFS
Mary Doran, 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
14-0038

2. STATE:
ILLINOIS

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

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

4. PROPOSED EFFECTIVE DATE:
July 1, 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*

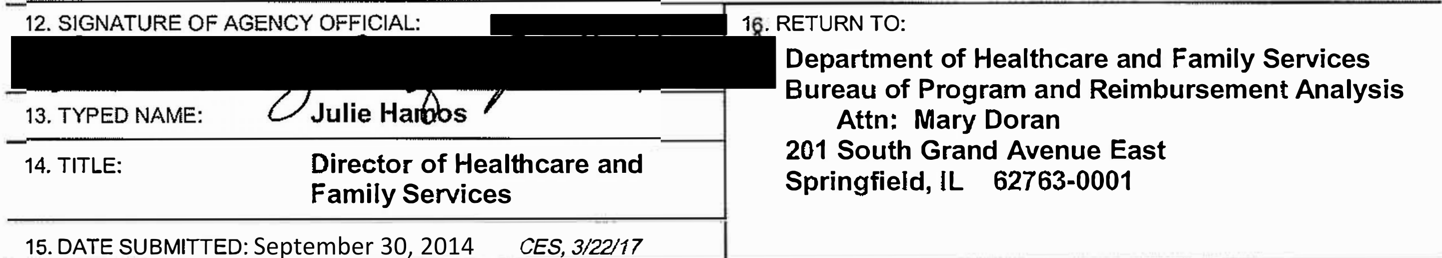
7. FEDERAL BUDGET IMPACT
a. FFY 2014
b. FFY 2015

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, Pages 1,2,3,5A,9,10,16,25,45,59 thru 72

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, Pages 3,9,10,16,25 and 45

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:

13. TYPED NAME: **Julie Hamos**

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

15. DATE SUBMITTED: September 30, 2014 *CES, 3/22/17*

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: September 30, 2014

18. DATE APPROVED: March 23, 2017

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME Alan Freund

22. TITLE: Acting Associate Regional Administrator

23. REMARKS:

FORM CMS-179 (07/92) *Instructions on Back*

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

I. Care Coordination

A. The State of Illinois enrolls Medicaid beneficiaries on a mandatory basis into various types of coordinated care. The choice of coordinated care entity depends on the county in which the client resides and their eligibility qualifications (See II. B, of this Attachment). The types of coordinating care entities and programs are as follows:

1. Primary Care Case Management-Primary Care Providers (Subsection II of this Attachment)
   - i. Fee for service
   - ii. Case Management Fee
   - iii. Mandatory for certain counties and populations
2. Integrated Care Program-MCOs (Subsection III of this Attachment)
   - i. Capitated
   - ii. Bonus/Incentive payment
   - iii. Mandatory for certain counties and populations
3. Primary Care Case Management – 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) (Subsection IV of this Attachment)
   - i. Fee for service
   - ii. Case Management Fee
   - iii. Bonus/Incentive payment
   - iv. Mandatory for certain counties and populations
4. Medicare and Medicaid Alignment Initiative (Subsection V of this Attachment)
   - i. Capitated
   - ii. Bonus/Incentive payment
   - iii. Voluntary
5. Managed Care Entity- Family Health Plan and Affordable Care Act Adults (Subsection VI of this Attachment).
   - i. Capitated
   - ii. Bonus/Incentive payment
   - iii. Mandatory for certain counties and populations.

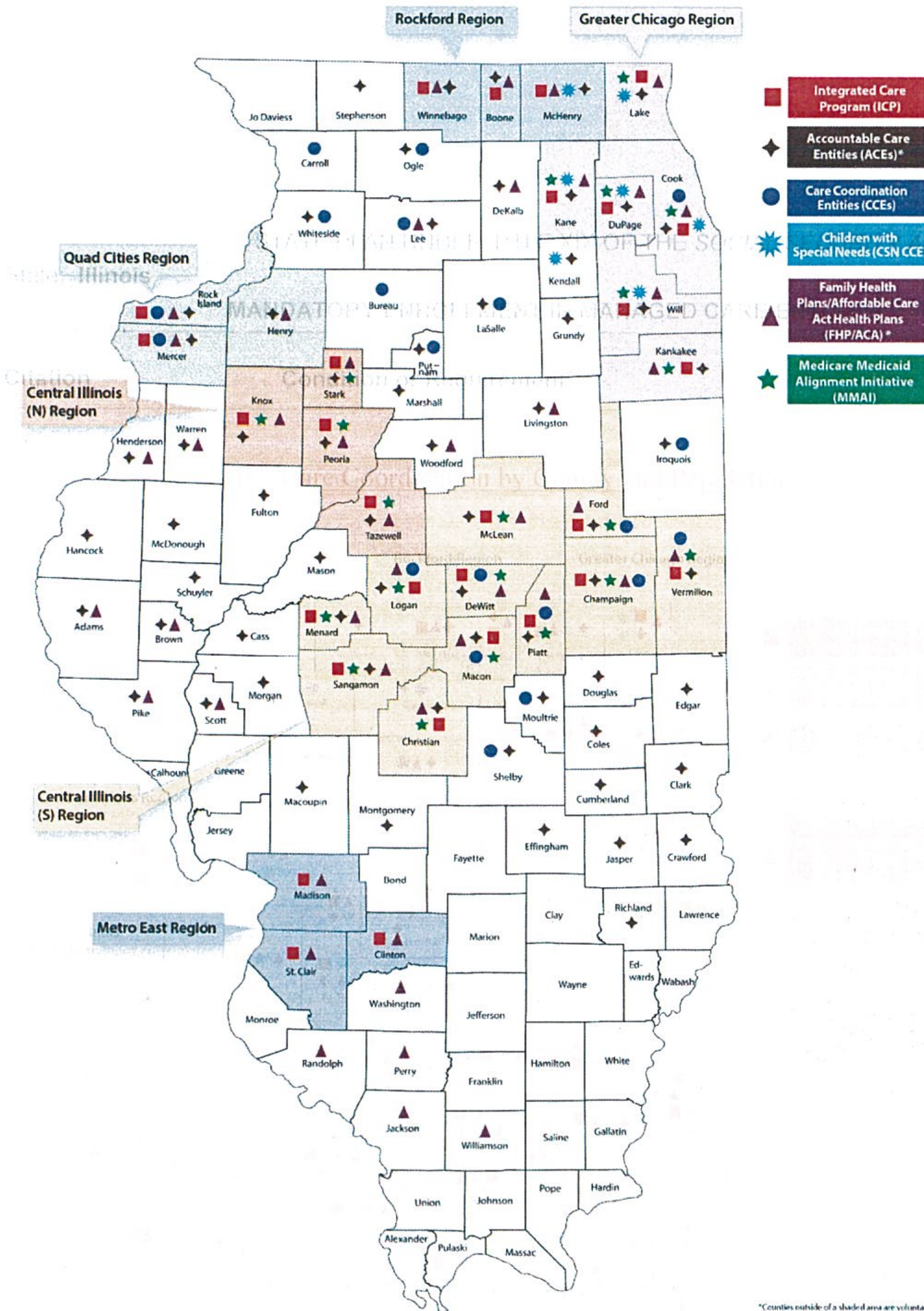
STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	**Condition or Requirement**

B. Care Coordination by County and Population



STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
	II. Primary Care Case Management (PCCM) – Primary Care Providers (PCP)
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 organization (MCOs) and/or primary care case managers (PCCMs)) 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 (including capitated PCCMs that qualify as PAHPs). ☐ iii. Both.
42 *CFR* 438.50(b)(2) 42 *CFR* 438.50(b)(3)	2. The payment method to the contracting entity will be: ☑ i. Fee-for-service. ☐ ii. Capitation. ☑ iii. A case management fee. Primary care providers (PCPs), enrolled to provide the primary care case management (PCCM), shall be paid the following monthly care management fees: a. $2.00 for children under 21 years of age. b. $3.00 for non-disabled non-elderly adults. c. $4.00 for disabled or elderly adults. PCPs shall include physicians as defined in 89 *Ill. Adm. Code* 140.410, federally qualified health centers as defined in 89 *Ill. Adm. Code* 140.461(d), rural health clinics as defined in 89 *Ill. Adm. Code* 140.461(c), school-based/-linked clinics as defined in 89 *Ill. Adm. Code* 140.410(g), certified local health departments 77 *Ill. Adm. Code* 600,

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	**Condition or Requirement**

Beginning July1, 2014, a mandatory PCCM-PCP program will remain as follows:

- Effective July 1, 2014 only in the following counties: Adams, Alexander, Bond, Brown, Bureau, Calhoun, Carroll, Cass, Clark, Clay, Edwards, Effingham, Fayette, Franklin, Fulton, Gallatin, Greene, Grundy, Hamilton, Hancock, Hardin, Henderson, Iroquois, Jackson, Jasper, Jefferson, Jersey, Jo Davies, Johnson, Kendall, LaSalle, Lawrence, Lee, Livingston, Macoupin, Marion, Marshall, Mason, Massac, McDonough, Monroe, Montgomery, Morgan, Moultrie, Ogle, Perry, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Saline, Schuyler, Scott, Shelby, Stephenson, Union, Wabash, Warren, Washington, Wayne, White, Whiteside, Williamson, and Woodford counties.
- Effective July 1, 2014, for all remaining counties a transition period will begin and mandatory enrollment in this program will end when mandatory enrollment in other care coordination enrollment in this attachment has been completed for that county and population.

iv. Area/areas (voluntary).
~~Beginning August 2, 2006, a voluntary PCCM program will be implemented statewide.~~

Citation | **Condition or Requirement**

ii. Indians who are members of federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the *Indian Self Determination Act*; or an urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the *Indian Health Care Improvement Act*.

Recipient database and self-identification.

42 *CFR* 438.50

F. 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.
- ~~Participants in a home- and community-based waiver program.~~
- 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.
  - Those managed under Subsections III thru VI of this Attachment.

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 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*.

H. Enrollment process.

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

1. Definitions
   i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through State records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.
   ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

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

2. State process for enrollment by default
   Describe how the State's default enrollment process will preserve:
   i. The existing provider-recipient relationship (as defined in H.1.i). Existing provider-client relationships will be considered based on historical claims data.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
	III. Managed Care Organization (MCO) - Integrated Care Program
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 organization (MCOs) through the Integrated Care program, which, unlike the ~~PPCM~~ PCCM program, is a full-risk capitated program, 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 _X__ i. MCO ____ ii. PCCM (including capitated PCCMs that qualify as PAHPs) ____ iii. Both
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	2. The payment method to the contracting entity will be: ____ i. fee for service; _X__ ii. capitation; ____ iii. a case management fee; _X__ iv. a bonus/incentive payment; ____ v. a supplemental payment, or ____ vi. other. (Please provide a description below).
	Contractors may earn payments based on performance for specified quality metrics. To fund the incentive pool, each month the Department shall withhold a portion of the contractual Capitation rate. The withheld amount will be one percent (1%) in the first measurement year, one and a half percent (1.5%) in the second measurement year and two percent (2%) in the third measurement year.

Citation	**Condition or Requirement**
07/13	A Potential Enrollee who does not select an MCO will be auto-assigned to an MCO or Other Care Coordination Entity by the ICEB. During the first twelve (12) month period of an expansion in a geographical area the contract, the auto-assignment will equalize enrollment in the participating MCOs so that each MCO has approximately the same number of enrollees. The ICEB will equalize the auto-assignment by distributing the enrollment of those that do not make an active choice between the available health two plans, taking into considerations existing provider patient relationships, provider capacity and geographical access. During the second year, auto-assignment will occur systematically and randomly by algorithm with the same considerations, ~~but each MCO will receive approximately fifty percent (50%) of all auto-assignments~~, as capacity allows. During the second year there will not be an effort to equalize enrollment between the plans. The Department will re-evaluate and modify, as necessary, the auto-assignment algorithm and may provide that auto-assignment will also be based on Contractor's performance on quality measures. The Department shall provide written notice of any modification of the auto-assignment algorithm at least sixty (60) days before the implementation of the modification.
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 _X_ / 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, reminder letters and a second enrollment letter. The second enrollment letter will specify the 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 MCO 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, a benefits summary, and information about the complaint, grievance and appeal processes.
07/13	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.)*

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

V. MCO- Medicare Medicaid Alignment Initiative (MMAI)

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The Centers for Medicare & Medicaid Services (CMS) and State of Illinois will establish a Federal-State partnership to implement the Medicare-Medicaid Alignment Initiative (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid Enrollees). The Federal-State partnership will include a Three-way Contract with Demonstration Plans that will provide integrated benefits to Medicare-Medicaid Enrollees in the targeted geographic areas. The Demonstration will begin on February 1, 2014 and will continue until December 31, 2017. The initiative is testing an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid Enrollees, enhance quality of care, and reduce costs for both the State and the Federal government. The Demonstration will be voluntary with passive enrollment of those Medicare-Medicaid Enrollees that do not select a health plan. Participants can opt out of the demonstration at any time. Passive enrollment will be in compliance with the requirements of 42 CFR 438.50 (f), "enrollment by default" - for recipients who do not choose an MCO during their enrollment period, the State must have a default enrollment process for assigning those recipients to contracting MCOs.

B~~C~~. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

☑ i. MCO
☐ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
☐ iii. Both

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

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

☐ i. fee for service;
☑ ii. capitation;
☐ iii. a case management fee;
☑ iv. a bonus/incentive payment;
☐ v. a supplemental payment; or
☐ vi. other. (Please provide a description below).

Bonus/Incentive Payment- Quality Withhold:
Both CMS and the Department will withhold a percentage of their respective components of the Capitation Rate, with the exception of the Part D Component amounts. The quality withhold will be 1% of the capitation in the first year of the demonstration. This amount will

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN HEALTH PLANS

Citation	Condition or Requirement
	VI. Managed Care Entity- Family Health Plan and Affordable Care Act Adults
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), Accountable Care Entities (ACEs) 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 health plans 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)
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 *CFR* 438.50(b)(1)	**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.]* 1. The State will contract with an: ☑ i. MCO ☐ ii. PCCM ☐ iii. Both.
42 *CFR* 438.50(b)(2) 42 *CFR* 438.50(b)(3)	2. The payment method to the contracting entity will be: ☐ i. Fee-for-service. ☑ ii. Capitation. ☐ iii. A case management fee. ☑ iv. A bonus/incentive payment. The Department will establish an incentive pool from which MCOs may earn payments based on its performance with respect to specified quality metrics. To fund the pool, each month the Department shall withhold a portion of the contractual capitation rate.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN HEALTH PLANS

Citation	Condition or Requirement

The withheld amount will be one percent (1%) in the first measurement year, one and a half percent (1.5%) in the second measurement year and two percent (2%) in the third measurement year. Subsequent increases in withheld amounts will be negotiated and agreed to by the Department and the MCOs. An equal portion of the incentive pool will be allocated to each quality metric. If the MCO reaches the target goal on a quality metric, the MCO will earn the percentage of the incentive pool assigned to that quality metric. Withholds of MCO's capitation payment for the purposes of funding the incentive pool shall commence with January capitation payment of the first measurement year. For purposes of measuring quality metrics, 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 performance was below the initial baseline, in which case the initial baseline remains the baseline.

Quality metrics, baselines and goals will be negotiated and established through countersigned letters prior to the beginning of each measurement year and can be found on the Department's website at http://www2.illinois.gov/hfs/PublicInvolvement/cc/icp/Pages/default.aspx.

☐ v. A supplemental payment.
☐ vi. Other. *[Please provide a description below.]*

1905(t)
42 *CFR* 440.168

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

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 MCO will not exceed 5% of the total capitation payments provided to Enrollees 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.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN HEALTH PLANS

Citation	Condition or Requirement
	☑ v. Incentives will be made available to both public and private MCOs.
	☑ 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 development and implementation of its mandatory managed care program. Participants in the process has included other state agencies, and community and provider organizations, such as but not limited to:

- State agencies, such as the Division of Mental Health;
- Provider associations, such as the Illinois Hospital Association, Illinois Primary Health Care Association;
- Individual providers;
- Client advocates; 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.

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 the implementation of this state plan amendment in various newspapers.

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):

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN HEALTH PLANS

Citation	Condition or Requirement
	i. County/counties (mandatory). Cook, Lake, Kane, DuPage, Will, Kankakee, Winnebago, Boone, McHenry, Rock Island, Henry, Mercer, Knox, Stark, Peoria, Tazewell, McLean, Ford, Champaign, Vermilion, Piatt, DeWitt, Macon, Logan, Menard, Sangamon, Christian, Madison, St. Clair, and Clinton counties.
	ii. County/counties (voluntary). DeKalb, Lee, Livingston, Woodford Warren, Henderson, Brown, Adams, Pike, Scott, Washington, Randolph, Perry, Jackson, and Williamson counties; and any other county where an MCO may choose to operate.
	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 Entities) and PCCM (Coordinating Entities) 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 health plans 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 will be met.

Citation	Condition or Requirement
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.

D. Eligible groups.

1932(a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.

   Individuals residing in the counties listed in subsection B.5.i, not listed in subsections D.2, E, F, and G as exempt from mandatory enrollment into a health plan, and one of the following categories of assistance:

   - 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.
   - 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).

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.

1932(a)(2)(C)
42CFR 438(d)(2)

☑ ii. Indians who are members of federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the *Indian Self Determination*

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN HEALTH PLANS

Citation	**Condition or Requirement**
	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 health plan available in their county, 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 a health plan in accordance with the policies of the program.
1932(a)(2)(A)(i) 42 *CFR* 438.50(d)(3)(i)	☑ iii. Children, under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
	If the recipient actively chooses to voluntarily enroll in a health plan, 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 health plan in accordance with the policies of the program.
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 a health plan. If the recipient actively chooses to voluntarily enroll in a health plan, 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 health plan in accordance with the policies of the program.
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.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN HEALTH PLANS

Citation	Condition or Requirement
	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.
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.

Citation	**Condition or Requirement**
	iv. Children under 19 years of age who are receiving foster care or adoption assistance. Recipient database and self- identification
1932(a)(2) 42 *CFR* 438.50(d)	5. Describe the State's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the State plan if they are not initially identified as exempt. *[Example: Self-identification.]* Not Applicable
1932(a)(2) 42 *CFR* 438.50(d)	6. Describe how the State identifies the following groups who are exempt from mandatory enrollment into managed care: *[Examples: Usage of aid codes in the eligibility system, self-identification.]* i. Recipients who are also eligible for Medicare. Recipient database 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: a. Individuals in the Aged, Blind, or Disabled category of assistance. b. Individuals that are dually eligible for both Medicare and Medicaid.

Citation	Condition or Requirement
	c. Individuals who are eligible only after a "spend-down" of income or assets.
	d. 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.
	e. Inmates of a public institution.
	f. Individuals enrolled in a presumptive eligibility program.
	g. Individuals enrolled in limited benefits programs.
	h. Populations already managed:
	i. High-level third-party liability/private insurance
	ii. 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.
	iii. Individuals already enrolled under Subsection III thru V of this Attachment.
42 *CFR* 438.50	**G. List all other eligible groups who will be permitted to enroll on a voluntary basis.**
	Eligible recipients who reside in the voluntary counties provided in Section B.5.ii.
	H. Enrollment process.
1932(a)(4) 42 *CFR* 438.50	1. Definitions
	a. 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.
	b. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN HEALTH PLANS

Citation	**Condition or Requirement**
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 relationship under the Primary Care Case Management Program or other MCOs and historical data. ii. The relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). The FHP/ACA program contractors have targeted all Medicaid enrolled providers to join their plans, with specific emphasis on enrollment of primary care providers enrolled in the Department's Primary Care Case Management program, in which most of the beneficiaries are participating.. iii. The equitable distribution of Medicaid recipients among qualified MCOs and PCCMs or Coordinating Entities 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 who does not select a health plan and a PCP will be auto-assigned to a health plan, which may include a Coordinating Entity, by the Illinois Client Enrollment Services (ICES).
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 PCP 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

Citation **Condition or Requirement**

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.

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

During the enrollment process, potential enrollees will receive an information guide from the Illinois Client Enrollment Services. This information guide will provide information regarding disenrollment rights, 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:

- Current health 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 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.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: Illinois

MANDATORY ENROLLMENT IN HEALTH PLANS

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 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) 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.

☑ 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.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN HEALTH PLANS

Citation	Condition or Requirement
	3. Place a check mark to affirm State compliance. ☑ The State assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 *CFR* 438.56(c). 4. Describe any additional circumstances of "cause" for disenrollment (if any) An Enrollee may request, orally or in writing, to disenroll from a Coordinating Entity 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).
1932(a)(5) 42 *CFR* 438.50 42 *CFR* 438.10	**K. Information requirements for beneficiaries.** *[Place a check mark to affirm State compliance.]* ☑ 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 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).** • Services that are provided in a State Facility operated as a psychiatric hospital as a result of a forensic commitment; • Services that are provided through a Local Education Agency (LEA); • Services that are experimental or investigational in nature; • Medical and surgical services that are provided solely for cosmetic purposes; • Diagnostic and therapeutic procedures related to infertility or sterility; • Early intervention services, including case management, provided pursuant to the Early Intervention Service System Act; and • Services funded through the Juvenile Rehabilitation Services Medicaid Matching Fund.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN HEALTH PLANS

Citation	Condition or Requirement
1932 (a)(1)(A)(ii)	**M. Selective contracting under a 1932 State plan option**

[To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.]

1. The State will ☐ will not ☑ intentionally limit the number of entities it contracts under a 1932 State plan option.

☐ 2. The State assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 State plan option. *[Example: A limited number of providers and/or enrollees.]*

   N/A

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

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 0938-0933. The time required to complete this information collection is estimated to average 10 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

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