Table of Contents

State/Territory Name: IL

State Plan Amendment (SPA) #: 18-0001

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

October 4, 2018

Patricia Bellock, 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. Bellock:

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

Transmittal #18-0001 – Consolidation and Expansion of Managed Care
– Effective Date: January 1, 2018
– Approval Date: October 3, 2018

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

Sincerely,

/s/

Ruth A. Hughes
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: 18-0001

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, 2018

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 2018 $ 0
b. FFY 2019 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, Pages 1 through 20 21 (and)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, Pages 1 through 44 and Pages 59 through 72

10. SUBJECT OF AMENDMENT:
Medicaid Managed Care - HealthChoice Illinois

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: Felicia Norwood

14. TITLE: Director of Healthcare and Family Services

15. DATE SUBMITTED: 3-23-18

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: March 23, 2018

18. DATE APPROVED: October 3, 2018

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Ruth A. Hughes

22. TITLE: Associate Regional Administrator

23. REMARKS:

State: Illinois

Citation	Condition or Requirement

1932(a)(1)(A)

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

The State of Illinois enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) 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 described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq. the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.2
42 CFR 438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☒ MCO
   a. ☒ Capitation
   b. ☒ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. ☐ PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Other (please explain below)

State: Illinois

Citation	Condition or Requirement

3. ☐PCCM entity

   a. ☐Case management fee

   b. ☐Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))

   c. ☐Other (please explain below)

   If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:

   Provision of intensive telephonic case management

   ☐ Provision of face-to-face case management

   ☐ Operation of a nurse triage advice line

   ☐ Development of enrollee care plans.

   ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program

   ☐ Oversight responsibilities for the activities of FFS providers in the FFS program

   ☐ Provision of payments to FFS providers on behalf of the State.

   ☐ Provision of enrollee outreach and education activities.

   ☐ Operation of a customer service call center.

   ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.

   ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.

   ☐ Coordination with behavioral health systems/providers.

   ☐ Coordination with long-term services and supports systems/providers.

   ☐ Other (please describe): _____

42 CFR 438.50(b)(4) C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. *(Example: public meeting, advisory groups.)*

If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110)

State: Illinois

Effective January 1, 2018, Illinois implemented HealthChoice Illinois, which consolidated the Integrated Care Program (ICP) and Family Health Plan-Affordable Care Act (FHP-ACA) Program, both of which were authorized under 1932(a) State Plan authority, as well as the state's Managed Long Term Services and Supports 1915(b) waiver program. HealthChoice Illinois was established pursuant to the completed Medicaid Managed Care Organization Request for Proposal (RFP) 2018-24-001, and expands managed care statewide effective April 1, 2018.

Illinois' processes to gather and incorporate public input on the design and implementation of ~~the statewide mandatory Medicaid managed care program, known as~~ HealthChoice Illinois, included a variety of Department of Healthcare and Family Services (Department) meetings with other state agencies that have Medicaid operational responsibility, provider associations, and consumer advocates. The Department had many planning sessions with the Department of Children and Family Services (DCFS). Meetings of the Medicaid Advisory Committee (MAC) and its subcommittees were held and were open to the public. Two Medicaid managed care subject matter hearings were held by the Illinois General Assembly's House Appropriation Human Services Committee in March and April of 2017 that included testimony from a range of organizations. A dedicated webpage, titled "Medicaid Managed Care RFP," was launched on the Department's website in February 2017 and updated throughout the competitive procurement process by posting relevant materials, such as the managed care model contract. An offeror/bidder conference, open to the public, was held on March 10, 2017. Throughout the procurement process, the Department received and reviewed exceptions, comments and questions regarding the posted managed care model contract, and incorporated changes deemed to substantively improve the contract document.

Regarding initial implementation, the Department works with the Illinois Association of Managed Health Plans and various provider organizations to encourage relationship building and understanding of the goals of HealthChoice Illinois. These organizations include associations representing nursing facilities, behavioral health providers, public health departments, FQHCs and rural health centers, emergency transportation providers and hospitals. The Department released a series of educational provider notices aimed at educating providers on the roll-out of HealthChoice Illinois. The Department is working with the managed care organizations (MCOs) to establish a "speakers' bureau" of representatives from all HealthChoice Illinois contracted MCOs, to be available to provide technical assistance and education in multiple forums throughout Illinois.

Illinois' formal process to ensure Federally recognized tribes are aware of changes to the State's Medicaid program includes informing the sole Indian Health Services provider, American Indian Health Services of Chicago (AIHSC), in writing of the proposed changes, description of any expected impact, and a copy of available, relevant documents. State policy provides AIHSC a minimum two-week comment period. On January 24, 2018, the State provided notice and request for comment to AIHSC regarding this State Plan Amendment authorizing HealthChoice Illinois. AIHSC had no comments concerning implementation of Health Choice Illinois.

Ongoing public involvement occurs through the State's various advisory committees and holding ad-hoc meetings, hearings and forums. MCOs are contractually required to routinely convene an enrollee advisory and community stakeholder committee which ensures an ongoing mechanism for enrollees and community to provide direct feedback and recommendations on managed care implementation and operations.

State: Illinois

D. 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 PCCMs and PCCM contracts (including for PCCM entities) 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 beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C) 42 CFR 438.10(g)(2)(vii)	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)	5. ☒	The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) CFR 438 1903(m)	6. ☒	The state assures that all applicable managed care requirements of 42 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.
1932(a)(1)(A) 42 CFR 438.4 42 CFR 438.5 42 CFR 438.7 42 CFR 438.8 42 CFR 438.74 42 CFR 438.50(c)(6)	7. ☒	The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	8. ☐	The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 75.326	9. ☒	The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.

State: Illinois

Citation	Condition or Requirement
42 CFR 438.66	10. Assurances regarding state monitoring requirements: ☒ The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.
1932(a)(1)(A) 1932(a)(2)	E. Populations and Geographic Area. 1. **Included Populations.** Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E),** and the geographic scope of enrollment. Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column. Under the **Notes** column, please note any additional relevant details about the population or enrollment. Effective January 1, 2018, approximately 1.9 million individuals residing in the Illinois counties covered by managed care who were actively enrolled in an ICP, FHP-ACA or MLTSS managed care program contracted MCO, transitioned to HealthChoice Illinois as an enrollee of: (1) their existing MCO; (2) the "partner MCO" of an MCO that did not continue into HealthChoice Illinois; or (3) a newly selected or auto-assigned MCO. Effective April 1, 2018, HealthChoice Illinois expanded statewide, as indicated in the chart below. For the period 1/1/2018 through 3/31/2018, HealthChoice Illinois' geographic area was those counties previously authorized for the ICP, FHP-ACA, and MLTSS programs.

State: Illinois

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by	Notes
1. Parents and Other Caretaker Relatives	§435.110	X			Statewide	
2. Pregnant Women	§435.116	X			Statewide	
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118	X			Statewide	
4. Former Foster Care Youth (up to age 26)	§435.150	X			Statewide	
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119	X			Statewide	
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X			Statewide	
7. Extended Medicaid Due to Spousal Support Collections	§435.115	X			Statewide	

State: Illinois

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120	X			Statewide	
9. Aged and Disabled Individuals in 209(b) States	§435.121	X			Statewide	
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135	X			Statewide	
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137	X			Statewide	
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138	X			Statewide	
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA	X			Statewide	
14. Disabled Adult Children	1634(c) of SSA	X			Statewide	

B. Optional Eligibility Groups

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by	Notes
1. Optional Parents and Other Caretaker Relatives	§435.220					Not covered
2. Optional Targeted Low-Income Children	§435.229					Not covered
3. Independent Foster Care Adolescents Under Age 21	§435.226					Not covered
4. Individuals Under Age 65 with Income Over 133%	§435.218					Not covered
5. Optional Reasonable Classifications of Children Under Age 21	§435.222	X			Statewide	Children that don't meet IV-E
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA			X	Statewide	

State: Illinois

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230	X			Statewide	
8. Individuals eligible for Cash except for Institutionalized Status	§435.211	X			Statewide	
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217	X			Statewide	
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232					Not applicable to Illinois
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616	§435.234	X			Statewide	
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236					Not covered by this authority
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA					Not covered by this authority
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA					Not covered
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m)(1) of the SSA	X			Statewide	
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII) of the SSA					Not covered
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV) of the SSA			X	Statewide	
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI) of the SSA					Not covered
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) of the SSA					Not covered
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219					Not applicable – IL uses 1915(c) waiver authority

State: Illinois

Citation | Condition or Requirement

3. Partial Benefits

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by	Notes
21. Family Planning Services	§435.214					Not covered
22. Individuals with Tuberculosis	§435.215					Not covered
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213			X	Statewide	

C. Medically Needy

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by	Notes
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)			X	Statewide	
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)			X	Statewide	
3. Medically Needy Children Age 18 through 20	§435.308			X	Statewide	
4. Medically Needy Parents and Other Caretaker Relatives	§435.310					Not covered
5. Medically Needy Aged	§435.320			X	Statewide	
6. Medically Needy Blind	§435.322			X	Statewide	
7. Medically Needy Disabled	§435.324			X	Statewide	
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330			X	Statewide	

2. **Voluntary Only or Excluded Populations.** Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

   Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

State: Illinois

Citation Condition or Requirement

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		X	Statewide	
"Dual Eligibles" not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare			X		Dual eligibles enrolled in MMAI or not receiving LTSS are excluded; Duals receiving Medicaid LTSS will be mandatorily enrolled thru 1915(b) waiver
American Indian/Alaskan Native— Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	X		Statewide	
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120			Statewide	This population will be mandatorily enrolled thru 1915(b) waiver
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3) of the SSA			Statewide	This population will be mandatorily enrolled thru 1915(b) waiver
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145			Statewide	This population will be mandatorily enrolled thru 1915(b) waiver
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227			Statewide	This population will be mandatorily enrolled thru 1915(b) waiver
Children with Special Health Care Needs - 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.				Statewide	This population will be mandatorily enrolled thru 1915(b) waiver

* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

State: Illinois

Citation | Condition or Requirement

3. **(Optional) Other Exceptions.** The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals. Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	V	E	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance		X	Persons with comprehensive third-party insurance
Reside in Nursing Facility or ICF/IID--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).			These beneficiaries are mandatorily enrolled
Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program		X	Persons enrolled in MMAI
Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program		X	
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).			These beneficiaries are mandatorily enrolled
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.		X	
Other (Please define):		X	Persons incarcerated in a county jail, IL Department of Corrections facility, federal penal institution, juvenile justice facility; Persons forensically committed to a State-operated psychiatric hospital

State: Illinois

Citation	Condition or Requirement

1932(a)(4)
42 CFR 438.54

F. Enrollment Process.

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))

   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

      State with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

   b. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.

      i. Please indicate the length of the enrollment choice period:

   c. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.

      i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).

      ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:

State: Illinois

Citation	Condition or Requirement

2. For **mandatory** enrollment: (see 42 CFR 438.54(d))

   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).

   In accordance with 42 CFR 438.10(c)(4), the Department developed standardized definitions for the terms listed at 438.10(c)(4)(i) and provided to all HealthChoice Illinois contracted MCOs with the directive that if any enrollee materials require any of these terms, the MCO must utilize these definitions. The Department created a model enrollee handbook which was provided to MCOs with the direction that if the enrollee handbook utilized any of these terms, the MCO must utilize these definitions. The terms and definitions were also reflected in the enrollee handbook template given to the MCOs. Many enrollee notices are developed by the Department for statewide distribution through the contracted Client Enrollment Services broker. For routine notices to enrollees that are sent directly by an MCO, the MCO is required to use these terms and definitions.

   In accordance with 42 CFR 438.10(e) and 438.54(d)(3), the Department, in collaboration with and through its contracted Client Enrollment Services broker, provides written notices to potential enrollees by direct mail. The written notices (enrollment packets) include information on MCO choices, timeframes for choosing a MCO, MCO and primary care physician (PCP) automatic assignment if an active choice is not made, each MCO's general benefits and extra benefits offered to their members, tips to assist an individual in selecting a MCO and PCP, switch/change periods and timeframes, how to work with their MCO once enrolled, information on the managed care program, care coordination and populations not mandatorily required to enroll, and how to get additional assistance (e.g., provider directory details). Samples of the written notices are available on the Department's Client Enrollment Services website and online enrollment portal. Potential enrollees may request this material in alternate languages or formats.

   b. ☒If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the State's default enrollment process.

      i. Please indicate the length of the enrollment choice period: 30 days

State: Illinois

Citation	Condition or Requirement

c. ☒ If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.

i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

Newly eligible potential enrollees have a thirty (30) day active enrollment period to select a MCO. When a selection is not made within that period, the potential enrollee is enrolled by default assignment to a MCO. All such enrollees have a ninety (90) day change period after the effective enrollment date to select another MCO. As part of the initial enrollment packet, potential enrollees are advised of the default enrollment process that assigns the potential enrollee to a MCO in the event the potential enrollee does not make an active choice.

The Department's default enrollment process makes assignment, using an algorithm, to a qualified MCO. The HealthChoice Illinois managed care contract specifies that a qualified MCO cannot be subject to the intermediate sanction described in 42 CFR 438.702(a)(4), and must have the capacity to enroll prospective enrollees. The contract also specifies that enrollees already enrolled with an MCO are given priority to continue such enrollment over potential enrollees, in the event the MCO does not have capacity to accept all those seeking enrollment. The algorithm attempts to preserve existing provider-enrollee relationships, and utilizes paid claims data to attempt to identify an existing provider-enrollee relationship. The algorithm also considers: the assignments of family members; the geographic location of the enrollee and provider; provider specialty; panel capacity limits set by the Department, MCOs and providers; and may consider costs and quality outcomes of the MCO.

d. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.

i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).

State: Illinois

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.54	3. 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.
42 CFR 438.52	a. ☒ The state assures that, per the choice requirements in 42 CFR 438.52: i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3); ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State; iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.
42 CFR 438.52	b. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties: ☒ This provision is not applicable to this 1932 State Plan Amendment.
42 CFR 438.56(g)	c. ☒ 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 2 months or less. ☐ This provision is not applicable to this 1932 State Plan Amendment.
42 CFR 438.71	d. ☒ The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met. The State assures that the requirements of 42 CFR 438.71 will be met prior to January 1, 2019 .

1932(a)(4)
42 CFR 438.56

G. Disenrollment.

1. The state will ☒ / will not ☐ limit disenrollment for managed care.

2. The disenrollment limitation will apply for 12 months (up to 12 months).

3. ☒ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.

4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. *(Examples: state generated correspondence, enrollment packets, etc.)*

Medicaid beneficiaries receive notice of their right to disenroll without cause within the written notices (enrollment packets) issued by the Client Enrollment Services, through verbal education provided by customer service representatives assisting an individual with MCO selection, via online education materials (www.enrollhfs.illinois.gov), and in the welcome packet, member handbook and other materials issued to each beneficiary by the MCO they have selected.

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

6. Cause for disenrollment from a HealthChoice Illinois contracted MCO are those reasons delineated in 42 CFR 438.56.

State: Illinois

Citation	Condition or Requirement

H. Information Requirements for Beneficiaries.

1932(a)(5)(c)
42 CFR 438.50
42 CFR 438.10

☒ The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible.

Complete the chart below to indicate every State Plan-Approved services that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.

In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Inpatient hospital services	3.1-A	1	1
Outpatient hospital services	3.1-A	1	2. a
Rural Health Clinic services	3.1-A	1	2. b
Federally Qualified Health Center services	3.1-A	1	2. c
Laboratory and x-ray services	3.1-A	1	3
Nursing facility services for individuals 21 and older	3.1-A	2	4. a
EPSDT services for individuals 21 and younger	3.1-A	2	4. b
Family planning services and supplies for individuals of	3.1-A	2	4. c
Face-to-Face Tobacco Cessation Counseling Services for	3.1-A	2	4. d
Physician services	3.1-A	2	5. a
Medical and surgical services furnished by a Dentist	3.1-A	2	5. b
Podiatrist services	3.1-A	2	6. a
Optometrist services	3.1-A	3	6. b
Chiropractor services	3.1-A	3	6. c
Social workers	3.1-A	3	6. d
Psychologists	3.1-A	3	6. d
Home Health – nursing	3.1-A	3	7. a
Home Health – home health aide	3.1-A	3	7. b
Home Health – DME	3.1-A	3	7. c
Home Health – Physical Therapy, Occupational Therapy and Speech pathology and audiology services	3.1-A	3A	7. d

State: Illinois

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Clinic services	3.1-A	4	9
Dental services	3.1-A	4	10
Physical Therapy	3.1-A	4	11. a
Occupational Therapy	3.1-A	4	11. b
Speech Pathology and Audiology services	3.1-A	4	11. c
Prescribed Drugs	3.1-A	5	12. a
Dentures	3.1-A	5	12. b
Prosthetic devices	3.1-A	5	12. c
Eyeglasses	3.1-A	5	12. d
Diagnostic services	3.1-A	5	13. a
Screening services	3.1-A	6	13. b
Preventive services	3.1-A	6	13.c
Rehabilitative services	3.1-A	6	13. d
Services for individuals age 65 or older in IMDs	3.1-A	6	14. a-c
Intermediate care facility services	3.1-A	7	15. a
Intermediate care facility services – public institution	3.1-A	7	15. b
Inpatient psychiatric facility services for individuals under 22	3.1-A	7	16
Hospice	3.1-A	7	18
Case management	3.1-A	8	19. a
TB related services	3.1-A	8	19. b
Extended pregnancy services for women	3.1-A	8	20. a-b
Ambulatory prenatal care for pregnant women during a presumptive eligibility period by a qualified provider	3.1-A	8A	21
Nurse Practitioner Services	3.1-A	2; 7; 8A	5. a; 17; 23
Transportation	3.1-A	9	24. a
Nursing facility services for patient under 21	3.1-A	9	24. d
Emergency hospital services	3.1-A	9	24. e
Program of All-Inclusive Care for Elderly	3.1-A	10	27
Freestanding Birth Center Services	3.1-A	10A	28
All 1915(c) Persons with Disabilities Waiver covered services – IL.0142			
All 1915(c) Persons with Brain Injury Waiver covered services – IL.0329			
All 1915(c) Persons with HIV or AIDS Waiver covered services – IL.0202			
All 1915(c) Supportive Living Program Waiver covered services – IL.0326			
All 1915(c) Persons who are Elderly Waiver covered services – IL.0143			

State: Illinois

Citation		Condition or Requirement
1932(a)(5)(D)(b)(4) 42 CFR 438.228	J.	☒ The state assures that each MCO has established an internal grievance and appeal system for enrollees
1932(a)(5)(D)(b)(5) 42 CFR 438.62 42 CFR 438.68 42 CFR 438.206 42 CFR 438.207 42 CFR 438.208	K.	Services, including capacity, network adequacy, coordination, and continuity. ☒ The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.
1932(c)(1)(A) 42 CFR 438.330 42 CFR 438.340	L.	☒ The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.
1932(c)(2)(A)	M.	☒ The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.

State: Illinois

Citation	Condition or Requirement

42 CFR 438.350
42 CFR 438.354
42 CFR 438.364
1932 (a)(1)(A)(ii)

N. 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.)*

Contracted MCOs were determined through competitive procurement and based on the highest overall scores. Proposal submissions were evaluated on completeness, accuracy, veracity and quality of information. The technical proposal section of the Medicaid Managed Care Organization Request for Proposal (RFP) was valued at a total maximum of 500 points; sections and corresponding points were as follows:

1) Overall approach to improving healthcare quality, ensuring acces, and controlling cost trends – 100 points
2) Integration of behavioral and physical health – 80 points
3) Information technology – 70 points
4) High-needs children – 50 points
5) Long-term services and supports – 50 points
6) Payment reform and value-based payment – 50 points
7) Care management and utilization management – 40 points
8) Provider requirements – 40 points
9) Operations – 20 points

The competitive procurement also included an oral presentation and financial proposal: these sections were valued at a maximum of 100 and 300 points, respectively.

4. ☐ The selective contracting provision in not applicable to this state plan.

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/Incentive payment~~

~~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~~

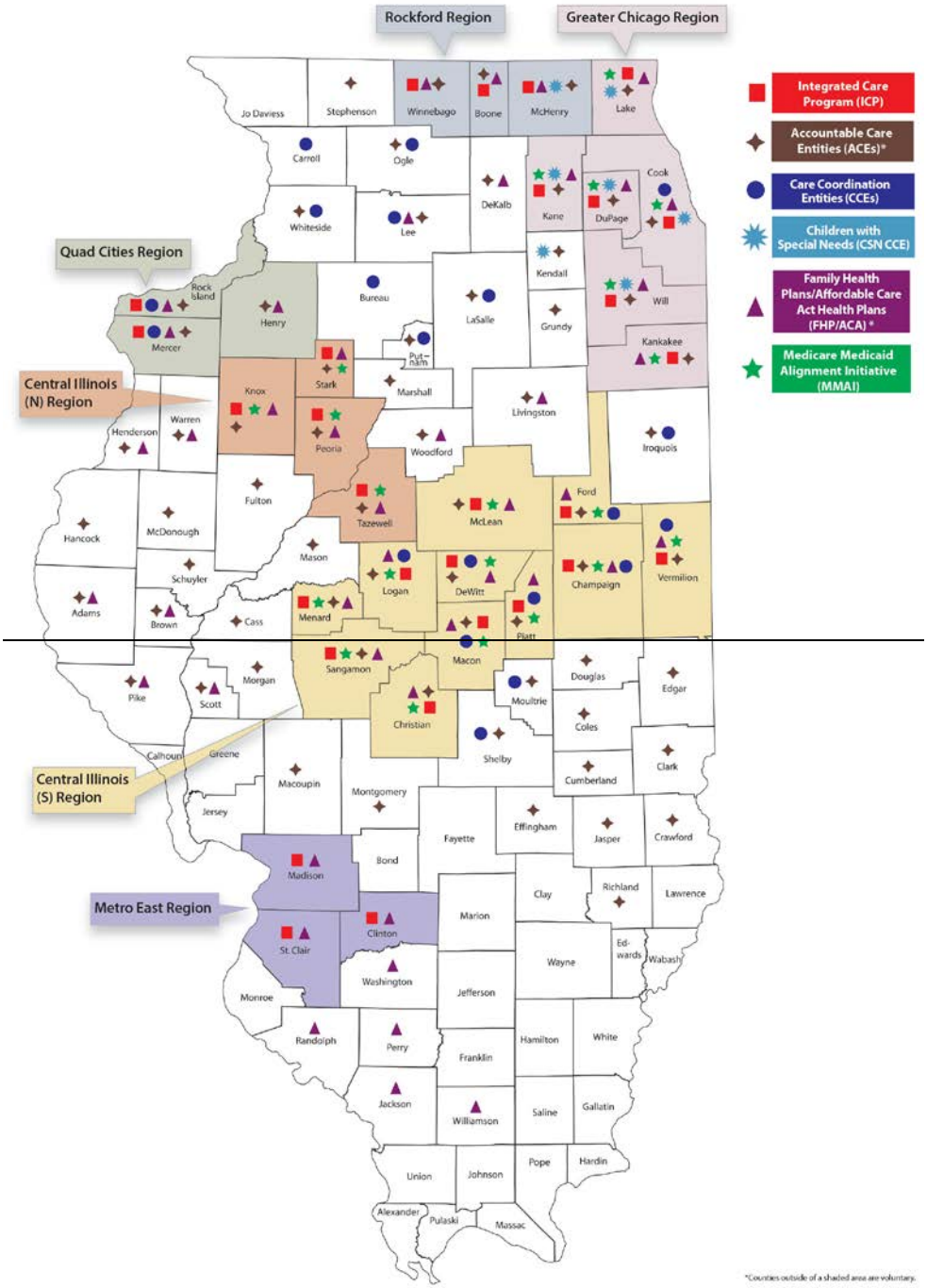
STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	**Condition or Requirement**

~~B. Care Coordination by County and Population~~



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,

Citation	Condition or Requirement

Maternal and Child Health Clinics as defined in 89 *Ill. Adm. Code* 140.461(f)(1), and encounter rate clinics as defined in 89 *Ill. Adm. Code* 140.461(b). In areas where there may be a limited number of PCPs, or to increase access to care generally, the department may allow advanced practice nurses, as defined in 89 *Ill. Adm. Code* 140.435, to enroll as PCPs.

☑ iv. A bonus/incentive payment.

Primary care providers (PCPs), described in subsection B.2.iii., shall be eligible to receive an annual bonus payment for each patient to which they provided a qualifying service under a bonus measurement.

a. PCPs will qualify if they meet or exceed the previous year's HEDIS 50th percentile benchmark, or the benchmark established by the Department, for one or more bonus measurements.

b. Bonus payments will be based upon critical measures such as immunizations for children, developmental screenings for children, asthma management, diabetes management, and breast cancer screenings. All measures will be described on the Department's website.

c. Annual bonus payments will be set by the Department and listed on the Department's website. If the PCP meets or exceeds the benchmark for a particular measured service, a bonus payment will be made for each patient that received the measured service. If the PCP does not meet the benchmark, there will be no bonus payment made for any patients, whether they received the service or not.

☐ v. A supplemental payment.

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

1905(t)
42 *CFR* 440.168
42 *CFR* 438.6(c)(5)(iii)(iv)

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.

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

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
	☑ v. Incentives will be made available to both public and private PCCMs. ☑ 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 PCCM program. Attendees included the Illinois State Medical Society, the Illinois Chapter of the American Academy of Pediatrics, the Illinois Academy of Family Practice, federally qualified health centers, rural health clinics, school-based clinics, local health departments, medical schools, the Cook County Bureau of Health Services, MCOs, and others. The State Medicaid agency will continue to consult with these groups on a quarterly basis.
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). N/A. ii. County/counties (voluntary). N/A. iii. Area/areas (mandatory). Beginning December 1, 2006, a mandatory PCCM program will be implemented as follows: • Effective December 1, 2006, Cook, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, and Will counties. • Effective January 1, 2007, Boone, Bureau, Carroll, DeKalb, Fulton, Henderson, Henry, JoDaviess, Knox, LaSalle, Lee, Marshall, Mercer, Ogle, Peoria, Putnam, Rock Island, Stark, Stephenson, Tazewell, Warren, Whiteside, Winnebago, Woodford counties. • Effective March 1, 2007, all remaining counties.

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, Coles, Crawford, Cumberland, DeKalb, Douglas, Edgar, 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 the Illinois Health Connect PCCM 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).~~

~~None.~~

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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 PCCMs and PCCM 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 PCCMs will be met.
1932(a)(1)(A) 42 *CFR* 438.6(c) 42 *CFR* 438.50(c)(6)	☐ 6. The State assures that all applicable requirements of 42 *CFR* 438.6(c) for for payments under any risk contracts will be met.
1932(a)(1)(A) 42 *CFR* 447.362 42 *CFR* 438.50(c)(6)	☑ 7. The State assures that all applicable requirements of 42 *CFR* 447.362 for payments under any non-risk contracts will be met.
45 *CFR* 74.40	☑ 8. The State assures that all applicable requirements of 45 *CFR* 92.36 for procurement of contracts will be met.

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

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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. All individuals not otherwise excluded in sections (E) and (F) of this attachment.
	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. *[Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.]*
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 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 PCCM, 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 PCCM in accordance with the policies of the program, including the ability to change their PCP one time per month.
1932(a)(2)(A)(i) l42 *CFR* 438.50(d)(3)(i)	☐ iii. Children, under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 *CFR* 438.50(d)(3)(iii)	☐ iv. Children, under the age of 19 years, who are eligible under the Act.
1932(a)(2)(A)(v) 42 *CFR* 438.50(3)(iii)	☐ v. Children, under the age of 19 years, who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 *CFR* 438.50(3)(iv)	☐ vi. Children, under the age of 19 years, who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 *CFR* 438.50(3)(v)	☐ vii. Children, under the age of 19 years, who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the State in terms of either program participation or special health care needs.
	E. Identification of Mandatory Exempt Group
1932(a)(2) 42 *CFR* 438.50(d)	1 Describe how the State defines children who receive services that are funded under section 501(a)(1)(D) of title V. *[Examples: children receiving services at a specific clinic or enrolled in a particular program.]* Children identified as either receiving services from, or participating in, a particular program will be identified through the use of paid claims data.

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

State: **Illinois**

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.]* Recipient database and self-identification.
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.

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.~~ ~~• 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) 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) 2. State process for enrollment by default

42 *CFR* 438.50 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.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
	ii. The relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). Providers who enroll to become PCCM providers will be assigned clients as described below. iii. The equitable distribution of Medicaid recipients among qualified MCOs and PCCMs 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.]* Providers who enroll to become PCCM providers will be assigned clients as described below.
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.]* Each household with a potential enrollee will receive an initial enrollment packet and, 30 days later, a second enrollment notice. The second notice will contain the name of the PCP with whom the potential enrollee will be assigned if a choice is not made. If a choice is not made within 30 days from the second enrollment notice, the potential enrollee will be auto-assigned. The State will send a confirmation letter within three business days that will include: the enrollee's assigned PCP and his or her contact information; the effective date of PCP coverage; information about requirements of the PCCM program, such as the need to get referrals from the PCP and 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.]*~~

~~The State will send a confirmation letter within three business days which shall include, the enrollee's assigned PCP and his or her contact information; the effective date of PCP coverage; information about requirements of the PCCM program such as the need to get referrals from PCP and the benefits of preventive and primary care; and information about how to request a PCP change. As enrollees may change delivery systems or PCPs every 30 days, the 90-day requirement does not apply.~~

~~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 assignment to a PCP or MCO in the voluntary program.~~
- ~~Existing provider-client relationships based on paid claims data.~~
- ~~The geographic location of the client and the PCP.~~
- ~~Family members' PCP assignments.~~
- ~~Provider specialty (*e.g.*, would not assign an adult to a pediatrician).~~
- ~~Special needs of the client, if known.~~
- ~~Capacity limits set by the HFS and limits set by the provider.~~
- ~~Eligibility of provider for auto-assignment~~

~~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.]*~~

~~The State will monitor trends from a "Monthly Enrollee Assignment Report." This report will include: the number of enrollees in the PCCM program that selected a PCP; the number that switched PCPs and the reason for the switch, if known; the number of enrollees that were auto-assigned to a PCP; and, a summary of enrollment activities conducted during the month, by county and region.~~

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
1932(a)(4) 42 *CFR* 438.50	**I. State assurances on the enrollment process.** Place a check mark to affirm the State has met all of the applicable requirements of choice, enrollment, and re-enrollment. ☑ 1. The State assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM 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 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 PCCMs. ☐ 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 N/A months (up to 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). 4. Describe any additional circumstances of "cause" for disenrollment (if any). This amendment describes a PCCM program wherein recipients may change PCCMs every 30 days. 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).

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
	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 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).** • 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. • 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.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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.~~

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 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~~	~~Subsequent withheld amounts will be negotiated. The withheld amount will be combined with an additional bonus amount funded by the Department so that total funding of the incentive pool shall be equal to five percent (5%) of the Capitation rate. An equal portion of the incentive pool will be allocated to each P4P Metric. If Contractor reaches the target goal on a P4P Metric, Contractor will earn the percentage of the incentive pool assigned to that P4P Metric. Withholds of Contractor's Capitation payment will begin with the January 15, 2012. For purposes of measuring P4P Metrics for the initial implementation, calendar year 2010 will be considered the initial baseline year and calendar year 2012 will be considered the initial measurement year. 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. Similarly, for expansion of the Integrated Care Program (ICP), the baseline will be the latest complete calendar year preceding the implementation of the program. The first measurement year will be the first complete calendar year of the program. The P4P metrics for the first three years are specified in the contracts with the MCOs. They include metrics such as preventive visits, behavioral health supports, dental utilization, disease specific therapies, ambulatory care follow up, medication management, and community retention. P4P metrics, baselines and goals for future years will be negotiated.~~
~~1905(t)~~ ~~42 CFR 440.168~~ ~~42 CFR 438.6(c)(5)(iii)(iv)~~	~~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.~~ ~~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 will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM 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.~~

Citation	Condition or Requirement
	~~vi. Incentives will not be conditioned on intergovernmental transfer agreements.~~
	~~vii. Not applicable to this 1932 state plan amendment.~~
~~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 researched various integrated care models through literature and reaching out to other state Medicaid programs. The state held many meetings with clients, client advocates and providers to assist with the development of the program, development of the RFP to solicit the contractors, and to guide the implementation of the program. Invitees and attendees included representatives from:~~ ~~• other state agencies, such as the 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, IL Occupational Therapy Association, Illinois Homecare Council, Illinois Primary Health Care Association;~~ ~~• individual providers;~~ ~~• client advocates, such as Centers for Independent Living, IARF, Area Agencies on Aging, IL Council on Developmental Disabilities, AIDS Foundation of Chicago, The ARC of Illinois, The Hope Institute for Children and Families, Equip for Equality, Campaign for Real Choice in Illinois, Center for Developmental Disabilities Advocacy and Community Supports, National Alliance on Mental Illness IL, AARP;~~ ~~• local health departments;~~ ~~• private companies, such as pharmaceutical companies;~~ ~~• American Indian Health Services of Chicago and~~ ~~• members of the Illinois General Assembly.~~ ~~• The State will 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 stakeholders meetings.~~

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
07/13	• The State's tribal consultation process included contacting the American Indian Health Services of Chicago (AIHSC) on April 6, 2011, to notify them of the State's intention to submit this SPA. A copy of the State's administrative rule was provided, and a meeting was set up on April 7, 2011, to discuss the consultation process, including this proposed amendment. On May 13, 2011, a draft copy of this SPA was provided to the AIHSC for review and comment. The AIHSC was notified on July 2013 of the State's intent to submit a SPA expanding the Integrated Care Program.
1932(a)(1)(A)	5. The state plan program will___/will not_X_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory__X__/ voluntary_____ enrollment will be implemented in the following county/area(s):
01/17	i. county/counties (mandatory) Du Page, Kane, Kankakee, Lake, Will Cook, Boone, McHenry, Winnebago, Knox, Peoria, Stark, Tazwell, Clinton, Madison, St. Clair, Henry, Mercer and Rock Island counties.
01/17	ii. county/counties (voluntary) Effective January 1, 2017 – April 30, 2017: Champaign, DeWitt, Ford, McLean, Vermillion, Christian, Logan, Macon, Menard, Piatt and Sangamon Effective May 1, 2017: Champaign, Dewitt, Ford and Vermillion
	iii. area/areas (mandatory)_____
	iv. area/areas (voluntary)_____
	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. **X** 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. **N/A** The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A)	3. **X** The state assures that all the applicable requirements of section

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation		Condition or Requirement
42 CFR 438.50(c)(3)		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.	**X** 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.	**X** The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6.	**X** 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) 447.362 for 42 CFR 447.362 42 CFR 438.50(c)(6)	7.	**N/A** The state assures that all applicable requirements of 42 CFR payments under any nonrisk contracts will be met.
45 CFR 74.40	8.	**X** The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i) 1. List all eligible groups that will be enrolled on a mandatory basis.

The following individuals residing in the counties listed in subsection B.5.i.:

- 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.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

~~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.~~
~~*(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*~~

~~1932(a)(2)(C)~~
~~except when~~
~~42 CFR 438(d)(2)~~

~~ii. **X** Indians who are members of Federally recognized Tribes 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.~~

~~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.~~

~~1932(a)(2)(A)(iii)~~
~~42 CFR 438.50(d)(3)(ii)~~

~~iv. ____Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.~~

~~1932(a)(2)(A)(v)~~
~~42 CFR 438.50(3)(iii)~~

~~v. ____Children under the age of 19 years who are in foster care or other out-of-the-home placement.~~

~~1932(a)(2)(A)(iv)~~
~~42 CFR 438.50(3)(iv)~~

~~vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.~~

~~1932(a)(2)(A)(ii)~~

~~vii. ____Children under the age of 19 years who are receiving services~~

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
42 CFR 438.50(3)(v)	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 Groups
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: **X** i. program participation, ____ ii. special health care needs, or ____ 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. **X** i. yes ____ ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt 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.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
~~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 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~~ ~~Children under 19 years of age;~~ ~~Individuals eligible for Medicare Part A or enrolled in Medicare Part B; and~~ ~~Participants with spend-down; and~~ ~~Participants who are presumptively eligible; and~~ ~~Participants in the Illinois Breast and Cervical Cancer program; and~~ ~~Participants with comprehensive third party insurance;~~ ~~Participants eligible through Illinois Healthy Women; and~~ ~~Participants eligible through Asylees and Torture Victims.~~
~~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~~

Citation	Condition or Requirement

~~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-recipient relationships will be considered based on historical claims data and requests by the recipient.~~

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

~~The Integrated Care 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 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.)*~~

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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, 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.)*

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

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 Broker. This information guide will provide information regarding disenrollment rights, including without cause during the first 90 days of enrollment.

iv. 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 assignment to a PCP in the Primary Care Case Management Program
- Existing provider client relationship based on claims data.
- The geographic location of the client and PCP.
- Special needs of the client, if known.
- Capacity limits set by HFS or the provider.
- Provider panel status.
- Performance on quality measures may be factored into the auto-assignment algorithm in the future.

07/13

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

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.

Citation	Condition or Requirement

1. ~~**X** 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 does not have capacity to accept all who are seeking enrollment under the program.~~

2. ~~**X** The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM 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. ~~**N/A** The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.~~

   ~~**X** This provision is not applicable to this 1932 State Plan Amendment.~~

4. ~~**N/A** 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.)~~

   ~~**X** This provision is not applicable to this 1932 State Plan Amendment.~~

5. ~~**X** 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 2 months or less.~~

   ~~This provision is not applicable to this 1932 State Plan Amendment.~~

~~1932(a)(4)~~ ~~J. Disenrollment~~
~~42 CFR 438.50~~

1. ~~The state will **X** /will not use lock in for managed care.~~

2. ~~The lock in will apply for 12 months (up to 12 months).~~

3. ~~Place a check mark to affirm state compliance.~~

   ~~**X** 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).~~

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
	An Enrollee may request, orally or in writing, to disenroll from Contractor at any time for any of the following reasons: (i) the Enrollee moves out of the Contracting Area; (ii) Contractor, due to its exercise of Right of Conscience, does not provide the Covered Service that the Enrollee seeks; (iii) the Enrollee needs related Covered Services to be performed at the same time, not all of the related services are available through Contractor, and the Enrollee's PCP or other Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk; or (iv) 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.
	K. Information requirements for beneficiaries
	Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	**X** 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 programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	L. List all services that are excluded for each model (MCO & PCCM)
07/13	The covered services in the initial implementation of the Integrated Care Program are being phased in through three service packages. Service package I will include all non-long term care services, including pharmacy, alcohol and substance abuse services and all medical services for nursing facility residents and all HCBS waiver participants. Service package II will include all nursing facility services and HCBS waiver services except those designed for individuals with developmental disabilities. Service package III will include the HCBS waiver services for individuals with developmental disabilities and ICF/DD services. The only excluded services in all three service packages are services provided in a State operated psychiatric hospital as a result of a forensic commitment and services provided through local education agencies.
07/13	The ICP expansion will include both Service package I and Service package II on the initial date of implementation in each region as follows: Rockford Region: Boon, McHenry, Winnebago effective July 2013 Central Illinois Region: Champaign, Christian, DeWitt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazwell, Vermilion effective August 2013. Metro East Region: Clinton, Madison, St. Clair effective September 2013 Quad Cities Region: Henry, Mercer, Rock Island effective October 2013 City of Chicago: as defined as areas with zip codes that begin with "606" effective February 2014.

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

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
1932 (a)(1)(A)(ii) 07/13	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 **X** /will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option. 2. **X** 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.)* Through its research the State determined that the correct number of MCOs to make the program sustainable with the limited number of potential enrollees was two. 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

CMS-10120 (exp. 2/11/2011)

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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) 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 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)~~ ~~1. The State will contract with an:~~

~~1932(a)(1)(B)(ii)~~

~~42 *CFR* 438.50(b)(1)~~ ~~☐ 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)~~

~~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. 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.~~

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**

☐ 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' 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 will receive a monthly PMPM for individuals enrolled within the Coordinating Entity. The PMPMs will be based on the population for which the Coordinating Entity is coordinating care. The Department will provide these rates in each Coordinating Entity 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.

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.~~

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
	☐ v. A supplemental payment. ☐ vi. Other. *[Please provide a description below.]*
1905(t) 42 *CFR* 440.168	3. For States that pay a PCCM or Coordinating Entity on a fee-for-service basis,incentive payments are permitted as an enhancement to the PCCM or Coordinating Entity's case management fee, if certain conditions are met.
42 *CFR* 438.6(c)(5)(iii)(iv)	*[If applicable to this State plan, place a check mark to affirm the State has met all of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).]* ☑ i. Incentive payments to the PCCM or Coordinating Entity will not exceed 5% of the total FFS payments for all Medicaid services 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. ☑ v. Incentives will be made available to both public and private PCCMs or Coordinating Entities. ☑ 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 CCE program during both the development of the program and on-going as the Department proceeds with the implementation of the CCE program. Participants in the process has included other state agencies, and community and provider organizations, such as but not limited to:~~ ~~• State agencies: Division of Mental Health, Division of Developmental Disabilities and the Department on Aging;~~ ~~• Provider associations, such as the Illinois Hospital Association, Illinois Association of Rehabilitation Facilities, Illinois Primary Health Care Association;~~ ~~• Individual providers;~~ ~~• Client advocates, such as Centers for Independent Living, IARF, Area Agencies on Aging; and~~ ~~• Local health departments.~~ ~~The State is committed to continue to have meetings with representatives from the above listed entities throughout implementation and on an on-going basis. These meetings will be through ad-hoc requests and regularly scheduled committee 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).~~ ~~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 operate as a Coordinating Entity.~~ ~~iii. Area/areas (voluntary)~~ ~~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.~~

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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) and PCCM (Coordinating Entity) 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 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.~~

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
	~~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.~~

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) 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, 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 in accordance with the policies of the program, including the ability to change their PCP one time per month.~~
~~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.~~ ~~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.~~

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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:~~

~~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.~~

~~vi. Individuals enrolled in a presumptive eligibility program.~~

Citation	Condition or Requirement

~~vii. Individuals enrolled in limited benefits programs.~~

~~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.~~

~~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.**

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

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 Networks will be assigned clients as described below. The Coordinating Entity'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.

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement

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 in a mandatory county who does not voluntarily select a managed care plan (which includes a Coordinating Entity) 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 (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 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.~~

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

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	**Condition or Requirement**

~~[Material Removed]~~

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

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	**Condition or Requirement**

~~[Material Removed]~~

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
1932(a)(4) 42 *CFR* 438.50	**I. State assurances on the enrollment process.** Place a check mark to affirm the State has met all of the applicable requirements of choice, enrollment, and re-enrollment. ☑ 1. The State assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM or 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. 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 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).

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 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).

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

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

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.

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)~~ **~~B. General description of the program and public process.~~**

~~1932(a)(1)(B)(ii)~~

~~42 *CFR* 438.50(b)(1)~~ ~~*[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.~~

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.

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.

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):

MANDATORY ENROLLMENT IN HEALTH PLANS

Citation	Condition or Requirement
~~01/17~~	~~i. County/counties (mandatory).~~ ~~Cook, Lake, Kane, DuPage, Will, Kankakee, Winnebago, Boone, McHenry, Rock Island, Henry, Mercer, Knox, Stark, Peoria, Tazewell, McLean, Madison, St. Clair, and Clinton counties.~~
~~01/17~~	~~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.~~ ~~Effective January 1, 2017 – April 30, 2017: Champaign, DeWitt, Ford, McLean, Vermillion, Christian, Logan, Macon, Menard, Piatt and Sangamon~~ ~~Effective May 1, 2017: Champaign, Dewitt, Ford, McLean and Vermillion~~
	~~D. 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.~~

MANDATORY ENROLLMENT IN HEALTH PLANS

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*~~

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.~~

MANDATORY ENROLLMENT IN HEALTH PLANS

Citation	Condition or Requirement
	F. 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.]* ii. 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.

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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.~~

~~v. 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.~~

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.

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

CMS-10120 (exp. 2/11/2011)