Questions and Answers

September 6, 2023

HFS
Illinois Department of
Healthcare and Family Services

1. How can I get a duplicate pre-populated renewal (redetermination) form if I don't have a Manage My Case account and need to complete it quickly?

A. If your redetermination form is lost and you cannot use Manage My Case, call the DHS customer call center at 1-800-843-6154.

- If necessary, you can also obtain another renewal form by connecting with our call center. If calling is not an option, you can visit your local Family Community Resource Center (FCRC). To find your local FCRC visit, dhs.illinois.gov/officelocator.

2. Is there a standard PDF renewal form that hospitals and FQHCs could have in the event a customer loses their form?

A. No, there is not a PDF renewal form because redetermination forms differ depending on the population. They are also prepopulated and have a barcode at the bottom to ensure that when the redetermination is received by the State, it is applied to the correct case.

B. Customers who lose their renewal form should complete their renewal by creating a Manage My Case account, logging into an existing Manage My Case account or by requesting a new form from the customer call center which can be reached at 1–800-843-6154.

3. How many cases are expected to be renewed using the Ex Parte process?

A. We are currently averaging 50% of cases that can renew via the Ex Parte process. This means that for 50% of cases customers do not need to take action, unless they need to report changes not listed on the renewal form. As a result of expanding our systems and capabilities we are now able to run more electronic clearances on customers thus contributing to an increase in our Ex Parte percentage rates.

4. Can a customer have a Form A (Ex-Parte) renewal and still have to complete a renewal for SNAP and/or TANF?

A. Yes, if a customer has a Form A medical Renewal and also has SNAP and/or TANF, they would need to complete the renewal for SNAP and TANF.

Key Customer Notices

Medical Benefits Only Renewal Forms

- HFS2381A – Form A
- HFS2381 – Form B coversheet: Ready to Renew, goes with HFS643
- HFS643 (M, N, X)– Form B

Combined Snap Redetermination and Medical Benefits Renewal Form

- IL444-1893

Verification Check Lists - sent when proof documents are needed – with due date. Failure to return will result in case closure.

- IL444-0267 – Request for Verification documents
- 2378 VR– Verification of Resource Information (AABD)

Notice of Decision (NOD) - communicates decision (e.g. approval, denial, cancellation); contains lots of info and explains appeal rights

- 360C

5. If a customer has coverage reinstated during the 90-day reinstatement, will they still have the same MCO? Could they change MCO if they wanted to?

A. It depends on when your medical reinstatement is processed. Enrollment in the same Managed Care Plan can only happen if your reinstatement of coverage is posted to the state's Medicaid Management Information System (MMIS) *by the 90th day* after you lose coverage.

Please be aware that it can take up to two days after your reinstatement is processed for this information to be transferred to the state's MMIS. If the redetermination is processed *after the 90-day* reinstatement period, then you will have to go through the managed care plan selection process.

6. How will Managed Care Organizations (MCOs) partner with HFS during the unwinding?

A. MCOs often have more frequent communication with customers and will supplement HFS efforts to ensure Medicaid customers get important information during the unwinding. MCOs will provide HFS with more current contact information, and HFS will use that information to update addresses and emails in the eligibility system. MCOs will help inform customers of their redetermination date, conduct targeted outreach to Medicaid customers due for renewal, and help customers who lose coverage either re-enroll in Medicaid or transition to low-cost marketplace coverage.

7. What should a customer do if their renewal was submitted timely but they still get denied for missing the renewal deadline?

A. If a customer reports that their renewal was submitted timely but they still get denied for missing the renewal deadline they can submit proof to their assigned office of timely submission and/or appeal the decision.

B. Renewals are being processed and some renewals are being closed for failure to respond to a Verification checklist

8. For individuals changing coverage categories during the PHE or Unwinding year, e.g. youth turning 19 or ACA adults turning 65, how will those cases be handled?

A. Changes to a medical case will not be made until the case goes through a full redetermination, even if there is a renewal for another type of benefit such as SNAP. The exception to this would be if someone has left the household they were covered under. The individual who has left the household would need to complete a new application. Current Medicare customers who will be turning 65 during the unwinding period have been assigned a rede date aligned with their 65th birthday so that they will be redetermined based on AABD criteria and not ACA Adult criteria.

9. How many people are projected to lose their Medicaid coverage during the unwinding period?

A. Medicaid enrollment has swelled during continuous coverage, partially because people who normally come on and off coverage have all stayed continuously covered, and partially because of the economic and health-related consequences of the Covid-19 pandemic. We now have roughly 3.9 million people in Illinois enrolled in Medicaid, compared to roughly 2.9 million before the pandemic.

B. Nobody knows for sure how many people will lose Medicaid benefits, but we are taking steps to minimize loss as much as possible. A federal analysis estimated about 17% of people will lose Medicaid insurance based on historical patterns. If the federal estimate holds for our state, then around 700,000 will lose Medicaid coverage. Our estimate is more optimistic in that we believe we will be able to help eligible customers keep their benefits. We think about 32,000 people per month will lose Medicaid coverage, or 384,000 after the full unwinding period.

10. Is the state doing an email analysis to see who is opening and reading reminder emails and who is not? Does the state know percentages of different group(s) of Medicaid recipients losing coverage?

A. HFS and the managed care organizations are in the process of analyzing email open rates and text click through rates. They will be reported out as soon as that data is vailable.

11. What about the Family Planning Program? Could individuals no longer eligible for full Medicaid qualify for the Family Planning Program?

A. Yes, this may be an options for individuals who are no longer eligible for full Medicaid coverage. Redetermination forms will include a question asking if the individual(s) want to be considered for the Family Planning Program if they are no longer eligible for full Medicaid. The customer should check "Yes" to be considered for this coverage. As a reminder, The FPP does not cover all services but does provides a range of reproductive health and family planning related services to eligible Illinois residents regardless of age or gender. The program covers services and medications to prevent or plan pregnancy; education for preconception and fertility awareness; and reproductive medical and treatment services through face-to-face visits, including STI, HPV and HIV testing and STI treatment.

12. What will happen to those customers that will no longer be eligible for Medicaid?

A. Most people stop qualifying for Medicaid when they earn too much money. People who no longer qualify for Medicaid should ask their employer about a work-based health plan, or visit getcoveredillinois.gov to shop for quality, affordable coverage provided under the Affordable Care Act.

B. Get Covered Illinois offers free enrollment assistance and can help people find out if they qualify for financial help. Many people find plans for $10 or less per month after tax credits. When Notices are sent out to those individuals who are no longer financially eligible for Medicaid we will include information about Marketplace medical insurance coverage in their notice.

13. How do I prove my identity when creating a my Manage My Case account?

A. Three (3) ID Proofing services are available. They will be offered to the customer in the following order:

1. Secretary of State (SoS) – Verifies using a current SoIL Driver's License or State ID information. Temporary Visitors Drivers License (TVDL) can also be used.
2. Experian – Verifies identity using randomly generated questions based on previous addresses, tax data or ownership details.
3. Manual ID Proofing – If you can't use a state ID or driver's license and Experian identity proofing fails, you may submit a state identity proofing request form, available in **English** (PDF) and **Spanish** (PDF).

For more information, check out our quick guide to setting up a Manage My Case account in (**English**) (PDF) or (**Spanish**) (PDF)

14. If a customer does not have a Social Security Number, ID or credit history will they still be able to use manage My Case?

Yes, the customer will be able to use their Medicaid Individual ID number, available in the top right corner of all Notice of Decision letters, for account linking instead of a Social Security Number. If the customer does not have a State of Illinois ID, they can submit a state Identity Proofing Request Form, with proof documents available in English (PDF) and Spanish (PDF).

15. If the Medicaid recipient is a disabled youth or disabled adult child how is Identity Proofing completed when applying for benefits or creating a Manage My Case (MMC) account in ABE?

- A. It is always the Head of Household, the first person listed on the ABE application and the person that Notices are sent to, that is Identity proofed. Children under 18 cannot apply for and sign an application for benefits themselves unless they are an unaccompanied or emancipated minor, or a parent themselves.
- If the parent is not requesting benefits, the parent can complete an application for their youth or adult child and list themselves first as a non-requesting Head of Case/Head of Household. In this way, when Identity proofing is completed in ABE it will be based upon the parents information and not the child's information.
- If a case is already established for an adult child with the child as the Head of Household/Case, and if the individual does not have an ID, manual Identity Proofing will likely be required.

16. What is the ABE Availability schedule?

ABE is available daily except for Sundays when our technology team completes regular database maintenance between 6 AM - 10 PM CST. Any additional ABE maintenance activities will be communicated separately as needed to the appropriate staff.

ABE schedule during the Sunday maintenance window:

- 6 AM -11 AM CST- ABE is not available due to ABE database maintenance.
- 11 AM- 10 PM CST-ABE will have Limited Functionality due to IES data maintenance

During limited functionality, applications can be submitted in ABE (no identity proofing or clearances run) and documents can be viewed in Manage My Case (MMC) but nothing can be changed or submitted through MMC.

17. How can a customer or provider find a case redetermination due date?

Customer

- Automated phone line, must know Recipient Identification Number (RIN): 1-855-828-4995
- ABE Manage My Case at ABE.Illinois.gov: Found under the Benefits Details tab
- If you have an MCO you can call the MCO customer services phone number

Providers

- Automated phone line, must provide Recipient Identification Number (RIN) and Provider ID: 1-800-842-1461
- Use the Medi system case by case, or arrange a 270/271 HIPAA transaction report for all patients/customers that you see.

18. Can you tell us about the newly instituted grace period?

This grace period is for customers who did not return their redetermination by their due date.

- Permits the delay of procedural terminations for one month (approx. 30 days).
- The 643RNW Courtesy Renewal Form – Follow Up Letter:

    - Generated when a customer's redetermination has not been received.
    - Reminds customers to return their completed Form B by their new, extended due date.
    - Reminds customers of the various ways they can complete a redetermination.
    - Provides the customer an opportunity to indicate a reason if they do not wish to continue receiving medical coverage.