ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Questions and Answers for Customers Applying for Medicaid in Illinois
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Q: I received a notice in the mail to re-determine my eligibility for Medicaid. Do I have to respond?

A: Yes, you must respond to every notice asking you for more information related to your eligibility for State programs, even if none of your information has changed. If you do not respond, your coverage will end. Once a year, the State has to confirm that everyone who is getting Medicaid is still eligible to get it. That is what is called "redetermination." These notices will typically come from the Department of Healthcare and Family Services or the Department of Human Services. For more information about the Medicaid re-determination process, see the Frequently Asked Questions on the Medicaid Redetermination Project page of the HFS website: http://www2.illinois.gov/hfs/MedicalCustomers/eev/Pages/default.aspx

Q: How should I Add a Newborn to a Medicaid Case?

A: There are two options for adding a Newborn to a Medicaid case - **please DO NOT fill out a new application in ABE for the newborn.**

1) Call the DHS Helpline at 1-800-843-6154 and follow the appropriate prompts;
   OR
2) Contact the office that is managing the case, which can be found on the approval notice. To contact the office:
   a. Go to a local Family and Community Resource Center (FCRC) office. Many large FCRCs, especially those in Cook County, have "express desks" to quickly do this.
   b. Call the Bureau of All Kids at 1-866-255-5437.

Q: My application for health coverage through Medicaid was denied for failure to provide requested information or verification documents, what should I do now?

A: Applicants who are denied Medicaid for failure to provide requested documents have 60 days from the date of the denial notice to submit the documents to the office that sent the denial notice. If an applicant submits the requested documents within 60 days, the case will be re-opened. After 60 days, someone must reapply.

Additionally, applicants can appeal this and any other denial. This will allow them to dispute

the finding in the event that the caseworker does not find the additional information sufficient. It is generally best to appeal within 10 days of the denial notice.

Q: What if my SNAP benefits were also denied for failure to provide requested documents, what should I do?

A: Applicants who are denied SNAP for failure to provide requested documents will have their application reopened if the requested documents are provided by the 60th day after application and the household is eligible. SNAP benefits will be prorated as follows:

- If the documents are provided by the 30th day, benefits are prorated from the date of application.
- If the documents after the 30th day but by the 60th day, benefits are prorated from the date of cooperation.

Q: A Child is turning 19 and aging out of All Kids, what are their options for continued health coverage?

A: Children are no longer eligible for All Kids coverage when they turn 19. In many cases, these children will become eligible for the new ACA Adult Medicaid program.

If a client turning age 19 is in a medical only case, the Illinois Medicaid Redetermination Project (IMPR) will send the client renewal notice for the child to fill out and return to get re-enrolled in Adult Medicaid. If the client turning age 19 is in a cash or SNAP case and needs medical coverage after age 19, they should apply directly for medical by calling the DHS helpline at 1-800-843-6154 or applying through ABE.

If the client's income will make them eligible for Marketplace coverage, they can use a Special Enrollment Period, triggered by a loss of prior health coverage, to set up their coverage in advance so they can avoid a coverage gap. To find out what health coverage option is right for the soon-to-be 19 year old, start at www.getcoveredillinois.gov and click on "Explore your health coverage options."

Q: As a parent of a child who will be aging out of All Kids, what are my options for health coverage through Medicaid?

A: Parents or caregivers whose youngest child turns 18 will no longer be eligible for Medicaid through the Family Health Plan, even though the child will continue on All Kids until age 19. However, parents or caregivers may be eligible for health coverage through Medicaid in the new ACA adult Medicaid program. The Illinois Medicaid Redetermination Project (IMPR) will send the clients a renewal notice to fill out and return to get re-enrolled in Medicaid. The notice will be sent in the mail approximately 60 days before the parents/caretaker relatives are scheduled to lose health coverage. Please complete and return this form to the address on the form. Based your answers, the state will determine if you continue to be eligible for health coverage through Medicaid.

Q: I applied for health coverage at the Marketplace (healthcare.gov). They said they transferred my application to the state. When will I hear something?

A: We have received your application and have dedicated staff working overtime to aggressively review and process these applications, but it will take some time. We ask for your patience. If you received a letter from the FFM or were told that your application was sent to the state, **we have it and will process it – you do not need to contact us or do anything further unless we contact you to ask for more information.**

Q: The Marketplace open enrollment period ended on March 31, but I am still waiting to hear about my Medicaid application, will I be able to buy coverage on the Marketplace if my application is denied?

A: If your Medicaid application is denied because you have too much income or do not meet other eligibility requirements, you can still get health coverage on the Marketplace through a 60-day Special Enrollment Period. This is because you applied during the open enrollment period and you were "in line" waiting for your application to be processed. To buy coverage on the Marketplace after receiving a Medicaid denial, follow the steps below:

1. Call the federal Marketplace call center at 1-800-318-2596 and tell them you applied for health coverage during open enrollment, but received a denial after the March 31 deadline.
2. The Marketplace call center representative will "activate" your Special Enrollment Period and you will have up to 60 days from the date of your Medicaid denial to enroll in a Marketplace plan on www.Healthcare.gov
3. For additional help you can click here or call the Get Covered Illinois Help Desk at 1-866-311-1119, to find a specially trained Navigator in your community, who can help you enroll in a Marketplace plan during your Special Enrollment Period.
4. If your Marketplace application is referred back to Medicaid, email GOV.ILMarketplace@Illinois.gov and let them know what is happening, they will help.

Q: Will I be penalized for not having health coverage?

A: You will NOT be penalized by the federal government for not having health coverage during this period as long as you applied for health coverage on or before March 31, 2014 and were "in line" waiting for your application to be processed. However, once your Medicaid application is processed, if you are denied, you will need to buy health coverage on the Marketplace in order to meet the federal requirement to have coverage. If your Medicaid application is approved, Medicaid coverage meets the federal requirement for health coverage.

Q: I was denied Medicaid but I think the State made a mistake, what do I do?

A: If you think you were wrongly denied benefits (Medicaid, SNAP or cash assistance), you have the right to appeal and will be given a fair hearing. **An appeal must be filed with the agency that made the determination.** Check the last page of the denial notice for instructions on where to file an appeal. **If you are appealing the decision on your cash or**

medical benefits, you must do so within 60 days after the "Date of Notice." If you are appealing a decision about SNAP benefits, you must do so within 90 days after the "Date of Notice." If it is decided at the hearing that you may be entitled to benefits, those benefits may start from the date you applied."

Q: If I appeal my Medicaid denial, should I still go to the federal Marketplace to apply for coverage?

A: Because you have only 60 days from the date of your Medicaid denial to apply for and purchase coverage on the Marketplace, you should still go the federal marketplace to apply for coverage. If your income varies or you are not sure which health coverage program you qualify for, appealing your Medicaid denial and applying at the federal Marketplace will give you the most protection.

Q: I applied for Medicaid through ABE but haven't heard anything. What should I do?

A: We have received a large number of applications through ABE and are working through them as quickly as possible but it will take some time. **You do not need to contact us or do anything further unless we contact you to ask for more information.**

Q: How long will it take to process my application?

A: We have caseworkers in many offices working on the thousands of applications that came through ABE, on paper and from the Federal Marketplace but we have received a large number of applications all at once. So, there is no exact timeframe for processing.

Q: How can I be sure you have my application?

A: If you are worried that we do not have your application and you submitted your application through ABE, you can log back into ABE and check the status - if it says "Submitted," and shows your Tracking or "T" number, that means your application has been successfully sent to us! The status update through ABE cannot tell you if you were approved or denied. You will receive a notice by mail. If you applied another way, including over the phone, you can call the ABE Customer Call Center at 1-800-843-6154; follow the prompts as if applying over the phone. This will get you to a caseworker who can look up the information for you over the phone. The call center is busiest earlier in the week and during the lunch hour.

Q: How will I know when my application has been processed?

A: We will notify you when we approve or deny your application, or if we need additional information from you. We will call you or send a notice to the address on the application.

Q**: I applied a few months ago but have not heard anything. Should I just reapply?**

A: No, please **do not** reapply. If your application is pending, we will get to it as soon as possible. Applying again could cause additional delays.

Q: I applied on the Marketplace and was referred to Medicaid so I applied on ABE, do I need to cancel one of my applications? Which application will you process?

A: We will review your Marketplace and ABE applications together. You do not need to cancel or withdraw either application.

Q: If I already receive SNAP benefits, but want to apply for Medicaid, what should I do?

A: If you already receive SNAP, you can apply the same way as everyone else: 1) through ABE.Illinois.gov; 2) over the phone at the ABE customer Call Center (1-800-843-6154, follow the prompts to apply over the phone); 3) on paper, or 4) at a local Family and Community Resource Center (FCRC). If you would like to apply at your local FCRC you will need to fill out a paper application and take it or mail it to the FCRC. Since no interview is needed for Medicaid, you <u>do not</u> need to see a caseworker. A paper application is required because of the need for a signature.

Q: I need to change some information on my application, how do I do that?

A: **Medicaid**: To change information on an existing Medicaid application, **contact the office that has your application**. If you applied on ABE, log in and see what office is processing your application. If you applied at a local Family Community Resource Center (FCRC), contact the office where you applied. If you applied over the phone, call 1-800-843-6154 and follow the prompts as if you are applying for benefits as a new customer. This will get you to a caseworker who can look up the information for you over the phone. The ABE Customer Call Center tends to be busiest earlier in the week and over the lunch hour.

Marketplace: If you applied for health coverage on the Marketplace and need to report a change, log back in to your marketplace account, click on your application, and press the "Report a Life Change." Applicants can now report increases or decreases in income; add or remove household members; or report a change in address, a new pregnancy or a gain or loss in health coverage. This reported life change may alter a referral to Medicaid or the amount of advanced premium tax credit someone may be eligible for on the Marketplace.

Q: If I am approved for Medicaid, will it cover my doctor/pharmacy bills from the date I applied?

A: Medicaid may pay unpaid bills for Medicaid-covered health care services you received from a Medicaid provider in the three months before you submitted your application if you requested that. This is called retroactive coverage. For adults ages 19-64 who are not raising minor children, that retroactive coverage can go back only to January 1, 2014. Your approval notice will tell you the date your coverage started so read it carefully. Medicaid cannot reimburse you for bills you paid to a provider or pharmacy.

Q: I got a letter that said I was approved for Medicaid, now what?

A: Within 10 days of receiving the approval letter, you will receive a piece of paper that includes your Recipient Identification Number (RIN) – that is your "card", keep it safe. The RIN is what you give providers and pharmacies when you need care. Soon after getting your card, you will receive a client enrollment package in the mail. This will explain your health plan options, how to pick a health plan and how to pick primary care provider within that health plan. You have 60 days from the day you get your client enrollment packet to pick a health plan. If you do not pick a health plan, you will be assigned to one. Call the client enrollment services at 1-877-912-8880 (TTY: 1-866-565-8576) or go to www.enrollhfs.illinois.gov to learn more about your health plan options. Health plan options are different depending on where someone lives and what eligibility category the person is in.

Between the time you are approved for Medicaid and you join a health plan, you may go to any Medicaid provider who is accepting new patients.

Q: How do I find a Medicaid provider?

A: If you need to go to the doctor, go to www.Illinoishealthconnect.com or call Illinois Health Connect (IHC) at 1-877-912-1999 (TTY: 1-866-565-8577). For program information, view or download the IHC Member Guide at http://www.illinoishealthconnect.com/clients/memberguide.aspx . If you have not yet been approved for Medicaid, be sure to let the doctor's office know you have applied for Medicaid and are waiting to hear if you are eligible. You can also access a list of Medicaid providers seeing all patients at www.enrollhfs.illinois.gov.

Q: I want to withdraw my Medicaid application because I got other coverage or was able to create a new account and buy coverage on the Marketplace, what do I do?

A: To withdraw an application for Medicaid, SNAP or Cash Assistance for whatever reason, you can visit, mail or fax a letter **to the office that has your application**.

- If you applied on ABE, log in and see what office is processing your application.
- If you applied at a local Family Community Resource Center (FCRC), get it to the office where you applied.
- If you applied over the phone, call 1-800-843-6154 and follow the prompts as if you are applying for benefits as a new customer. This will get you to a caseworker who can look up the information for you over the phone. The ABE Customer Call Center tends to be busiest earlier in the week and over the lunch hour.

Please include the following information in your letter:

1) The name(s), address and phone number of the applicants on the application;
2) The method of applying (at the Marketplace, on ABE, over phone, by mail, in person at FCRC);
3) Your Marketplace application number, ABE tracking ("T") number OR case number **if possible**.
4) The benefits requested on the application (medical, SNAP, cash assistance).

Q: I need to report a change of information for my already approved Medicaid case how can do I that?

A: If you receive medical assistance, you must report any change that affects your benefits including a change in income (or assets for AABD), change in the number of people living in the household, a change of address, death, or discharge from a long-term care facility or skilled living facility. To report any required change you can: 1) mail it to the local Family and Community Resource Center (FCRC) that is maintaining your case or 2) call the ABE Customer Call Center at 1-800-843-6154 and follow the appropriate prompts. For more on reporting changes, go to: http://www.dhs.state.il.us/page.aspx?item=46873