ILLINOIS DEPARTMENT OF Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

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Medicaid Advisory Committee
Public Education Subcommittee Meeting

Thursday, October 20, 2011
10:00 a.m. to 12:00 p.m.

401 S. Clinton St., Chicago – 7th Floor Video Conference Room
201 S. Grand Ave. East, Bloom Bldg., Springfield – 3rd Floor Video Conference Room

Agenda

1. Introductions

2. Approval of the Meeting Minutes from August 25, 2011 (attached)

3. CHIPRA Child Health Quality Demonstration Grant Overview (attached)

4. Durable Medical Card – AVRS script (attached)

5. Long Term Care Eligibility Rulemaking

6. Updates:
   - HFS Hotline address change project
   - AKAA statistics (see chart attached)
   - Illinois Health Insurance Exchange Legislative Advisory Committee
   - MIPPA – Medicare Savings Program
   - Eligibility Verification and MOE (see letter attached)

7. Announcements:
   - 2nd National Children's Health Insurance Summit http://www.kidscoverageconference.com/index.php
   - Framework presentation – next agenda
   - UX2014 presentation – next agenda
   - Pub Ed Membership – need downstate representation

8. Open Discussion

9. Adjourn

Please confirm whether you plan to attend by responding to HFS Webmaster via e-mail, HFS.webmaster@illinois.gov, or by phone at 312-793-1984.

A conference call will be made available for persons who cannot attend in person. If you wish to call in, please request the number when you confirm your attendance.

This notice is also available at http://www.hfs.illinois.gov/mac/news

Illinois Department of Healthcare and Family Services
Public Education Subcommittee Meeting
August 25, 2011.

401 S. Clinton Street, Chicago, Illinois
201 S. Grand Avenue East, Springfield, Illinois

Committee Members Present
Kathy Chan, IMCHC
Susan Vega, Alivio Medical Center
Margaret Stapleton, Shriver Center (for John Bouman)
Robin Scott, CDPH (for Kenzy Vanderbroek)
Henry Taylor, Mile Square Health Center
Terri Gendel, Age Options

Committee Members Absent
Courtney Hedderman, AARP
Judy King, Consumer Advocate
Tamela Milan, Westside Health Start
Hardy Ware, East Side Health District
Suzanna Gonzalez, Mac Neal Hospital

Interested Parties
Margaret Dunne, Beacon Therapeutic
Andrea Kovach, Shiver Center
Diane Montanez, Alivio Medical Center
Jessica Williams, CPS
Esther Schiamarella, CHHC
Nelson Soltman, Legal Assistance Foundation
John Jansa, Progress CIL
Michael Lafond, Abbot
Naden Israel, Heatland Alliance
Maria Shabanova, Maximus (HSED)
Jacqueline Gonzalez, CHHC
Deborah Mathews, DSCC
Diane Montanez, Alivio Medical Center
Lucero Cervantes, ICIRR
Dairy Velazquez, ICIRR
Callie Dendinos, Shiver Center
Dionne Haney, Illinois State Dental Society
Ollie Idowll, IPMCA

HFS Staff
Jacqui Ellinger
Lynne Thomas
Donna Drew
Robyn Nardone
Victoria Nodal
Glenda Mason
Cathy Jarrett
Dennis Leonard
Sallie Becherer
Veronica Archundia

DHS Staff
Jennifer Hrycyna

Illinois Department of Healthcare and Family Services
Public Education Subcommittee Meeting
August 25, 2011.

The MAC Public Education Subcommittee was called to order at 10:01 a.m.

1. **Introductions.** Andrea Kovach chaired the meeting. Attendees in Chicago and Springfield introduced themselves.

2. **Review of Minutes.** Jennifer Hrycyna recommended a change under the section "Open to the Committee" by replacing the phone stamps with the Phone System Interview. The minutes were approved as amended.

3. **Address Change Process**
   Dennis Leonard, from the Division of Medical Programs, indicated that as part of a collaborative effort to improve our customer service and the accuracy of address information, beginning July 14, 2011, the customer HFS hotline has been supporting the Department of Human Services in the processing of requests to update changes of address and telephone numbers. This service is only available for medical cases and excludes the Medical Field L.O. 200. Mr. Leonard remarked that from the time when this initiative was launched, the HFS hotline has processed 1,200 address change requests.

4. **State Medicaid Reform Implementation**
   Jacqui Ellinger, Deputy Administrator of the Medical Programs, discussed two handouts. One of them was the letter that director Julie Hamos sent in April, 2011 to the Center for Medicare & Medicaid Services (CMS) seeking federal guidance regarding the changes under Medicaid Reform, which would require increasing the verifications for income and residency. The second handout was the response received in June from CMS which indicates that the implementation of such procedural changes would constitute a violation of Maintenance of Effort (MOE). Ms. Ellinger added that CMS had implied that Illinois could conduct electronic verification as much as possible.

   Jacqui noted that, in the meantime, the eligibility rules for Healthcare Reform have been released, and it's clear that the federal government is putting great emphasis in automation. HFS, in collaboration with DHS, is making significant progress in developing a new automated Secretary of State (SOS) Illinois residency verification protocol that would allow staff to match applicant data against the driver license and state identification records. She added, in the event that it is not possible to verify the applicant's residency electronically, staff will follow existing policy to obtain a verification. She remarked that HFS and DHS are committed to taking the measures that are federally allowed to confirm that the information people provide is correct and to ensure the integrity of our programs. HFS expects that the automated connection with the Secretary of State will be in place by late fall.

5. **Updates:**
   Web Redetermination: Jennifer Hrycyna, from DHS, reported that the Department of Human Services is currently working on the development of an online redetermination process which will enable recipients to complete and submit their redetermination forms over the Internet. She remarked that the intention is to offer a channel which would be more user-

friendly than the Phone System Interview (PSI), since the web page redetermination format provides help screens and more details about how to answer questions. The rollout of the redetermination web page is expected to target medical cases only. Meanwhile DHS is seeking an official response from the federal government regarding a waiver for SNAP cases, since SNAP policy requires a face-to-face interview once a year.

All Kids Alert: Vicky Nodal, from HFS, reported that the intention of the All Kids alert issued in April was to clarify existing policy about documentation requirements for non-citizens applying for medical benefits, which was prompted by an audit showing that the All Kids Unit was not receiving the documentation necessary in those particular cases. In response to the concerns and questions that were raised, HFS issued a revised alert in July that clarifies who needs to provide additional information and specifies the type of documentation that is required.

Stepparent Income. Vicky Nodal stated that DHS caseworkers recently received a memorandum that clarifies the appropriate procedure to determine medical eligibility for undocumented children when there is a stepparent in the home, his or her income must be counted in all instances. She remarked that the policy is different for children who are citizens or qualified legal immigrants. For this second group of children, DHS always counts the total household income, and, if the stepparent's income causes a child to be ineligible under All Kids Assist, then DHS completes a second determination of eligibility without the stepparent's income. Ms. Nodal noted that the All Kids Unit counts stepparent's income for all children, regardless of their immigration status. She added that the issuance of this memorandum was prompted by an audit, and the intention is to provide clarification to case workers at the DHS Local Offices.

Eligibility System for Health Care Reform. Jacqui Ellinger discussed a power point presentation developed by Mike Koetting, HFS Deputy Director of Planning and Implementation, that provides a general context for the integrated eligibility system. The presentation represents preliminary work in preparation for Health Care Reform. She noted that there is a strong governance group that involves the Department of Insurance (DOI), the Department of Human Services (DHS), and Healthcare and Family Services (HFS). The goal is to develop a "virtual department of eligibility," a system that further integrates the ability to support the existing programs that involve TANF, SNAP, and medical programs.

Kathy Chan, from IMHC, provided an update regarding the Illinois Health Insurance Exchange Legislative Study Committee, which is a bipartition task force, comprised by three members from each caucus. The task of the study committee is to have a report by September 30th and provide recommendations for the Health Benefits Exchange, with the intent of having legislation ready for the fall legislative veto session. There was robust discussion among members. Some participants recommended replicating the function of the All Kids Application Agents as a "navigator or help-promoter" for individuals who may require additional help in accessing and navigating the medical system.

Illinois Department of Healthcare and Family Services
Public Education Subcommittee Meeting
August 25, 2011.

6. Announcements

MIPPA. Jacqui Ellinger introduced the MIPPA topic. She indicated that this is federal legislation that modified the enrollment process for seniors and people with disabilities who are interested in applying for Medicare cost sharing benefits. She noted that HFS has implemented the changes required by the federal government and currently, is in the process of updating its rules. Several members questioned the process outcomes. Due to time constraints, and in order to clarify in detail the application process, as well as to address committee members' concerns, it was agreed to schedule a follow-up conference with HFS staff from the Bureau of Medical Eligibility and Special Programs.

Rulemaking: Jacqui Ellinger advised committee members as of August 26, 2011, HFS is publishing the rules in the Illinois Register to codify the following changes:

- All Kids program required by PA 96-1501, Medicaid Reform, changes made to 89 Ill Adm Code 123.
- Rules codifying changes required by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 – Illinois Register July 15, 2011, Vol 35, Issue 29 pp.11094-11125, Changes made to 89 Ill Adm Code 102, 110, and 120.

Committee members were invited to review the filings and submit any comments as directed in the Illinois Register.

7. Revised 2011 Meeting Schedule

Committee members discussed the motion to meet every other month during the remainder of the year, and it was agreed to meet on 10/20 and12/08. The motion was voted upon and unanimously approved.

8. Open Discussion

Kathy Chan inquired if there has been any reaction from the public regarding the recent income cap for the All Kids program. Lynne Thomas, Chief of the Bureau of All Kids, indicated that there have been very few inquiries. She added, however, the hotline has received some comments from families whose children's eligibility will end June 30, 2012.

Blue Cross and Blue Shield recently announced a period of open enrollment for "child only" insurance policies on its web site that ended on August 15, 2011, and it is anticipated that there will be another opportunity to enroll between January and July 2012.

9. Next meeting/adjournment

The next meeting is scheduled for October 20, 2011, from 10:00 a.m. to 12:00 p.m. The August 25, 2011 session was adjourned at 12:04 p.m.

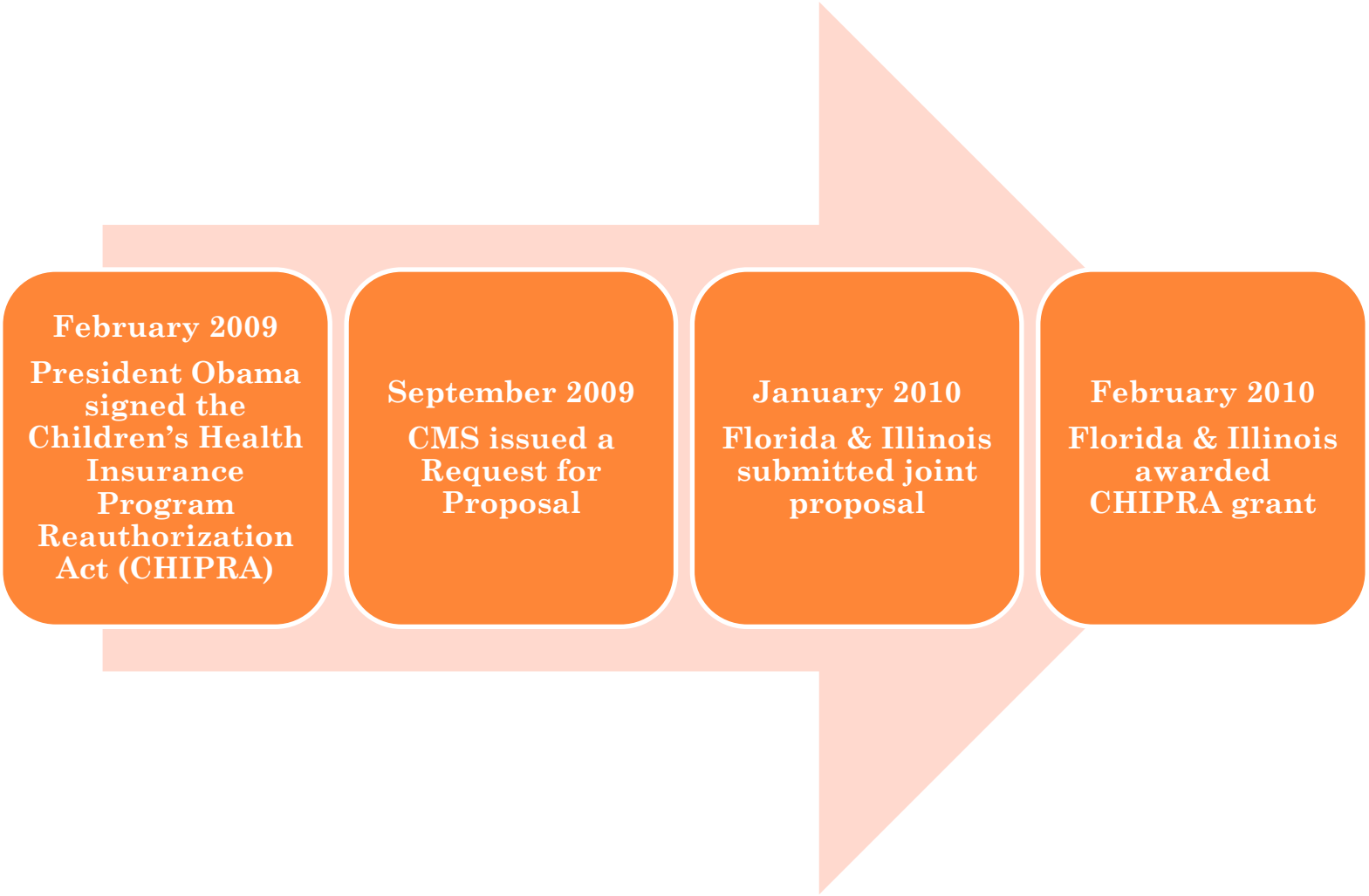
CHIPRA Child Health Quality Demonstration Grant

Medicaid Advisory Committee
Public Education Subcommittee
October 20, 2011
Gwen Smith, IL CHIPRA Grant
Project Director

TOPICS TO BE COVERED

- Project origin and timeline
- Child health quality objectives/current status
- Project structure/stakeholders

PROJECT ORIGIN



FEDERAL GOALS

- To experiment with and evaluate promising ideas for improving the quality of children's health care under Medicaid and CHIP
- By 2013, establish a Pediatric Quality Measures Program (PQMP) assimilating information learned from CHIPRA Demonstrations

CHIPRA GRANT CATEGORIES

- **Category A**: Measure and report on 24 child health quality measures, AKA "initial core measure set"
- **Category B**: Coordinate child health quality reporting with new health information system development including health information exchange and electronic health records
- **Category C**: Test or enhance provider based models to improve primary care delivery
- **Category D**: Develop and test a pediatric electronic health record
- **Category E**: Create other means of improving child health care quality, access or delivery

THE 10 WINNING TEAMS

Colorado/ New Mexico	**Florida/ Illinois**	Maine/Vermont
Maryland/ Georgia/ Wyoming	Massachusetts	North Carolina
Oregon/Alaska/ West Virginia	Pennsylvania	South Carolina
	Utah/Idaho	

PROJECT TIMELINE

- Year 1 (2/22/10 to 2/21/11):
  - Refined the proposal with input from key participants
  - Revised workplan submitted to CMS 11/22/10
- Years 2-5 (2/22/11 through 2/21/15):
  - Implementation and evaluation

CATEGORY A GOALS

Category A: Measure and report on 24 child health quality measures, AKA core measures

- Implement the core measures
- Test/develop additional measures (C, E)
- Make data available to providers, assure data is "actionable", and can be used for quality improvement (C)
- Make data available to the general public and consumer advocates and assure it meets their needs (C)
- Determine impact of measure on quality, consumer education and policy decisions

CATEGORY B GOALS

Category B: Coordinate child health quality reporting with new health information system development including health information exchange and electronic health records

- Coordinate CHIPRA efforts with other HIE/HIT efforts (OHIT and EHR Provider Incentive Program)
- Align CHIPRA core measures with Meaningful Use
- Make data accessible/useful to providers (A, C)
- Use technology to improve quality of children's health care
- Assess impact of accessible data on quality (C)

CATEGORY C GOALS

Category C: Test or enhance provider based models to improve primary care delivery

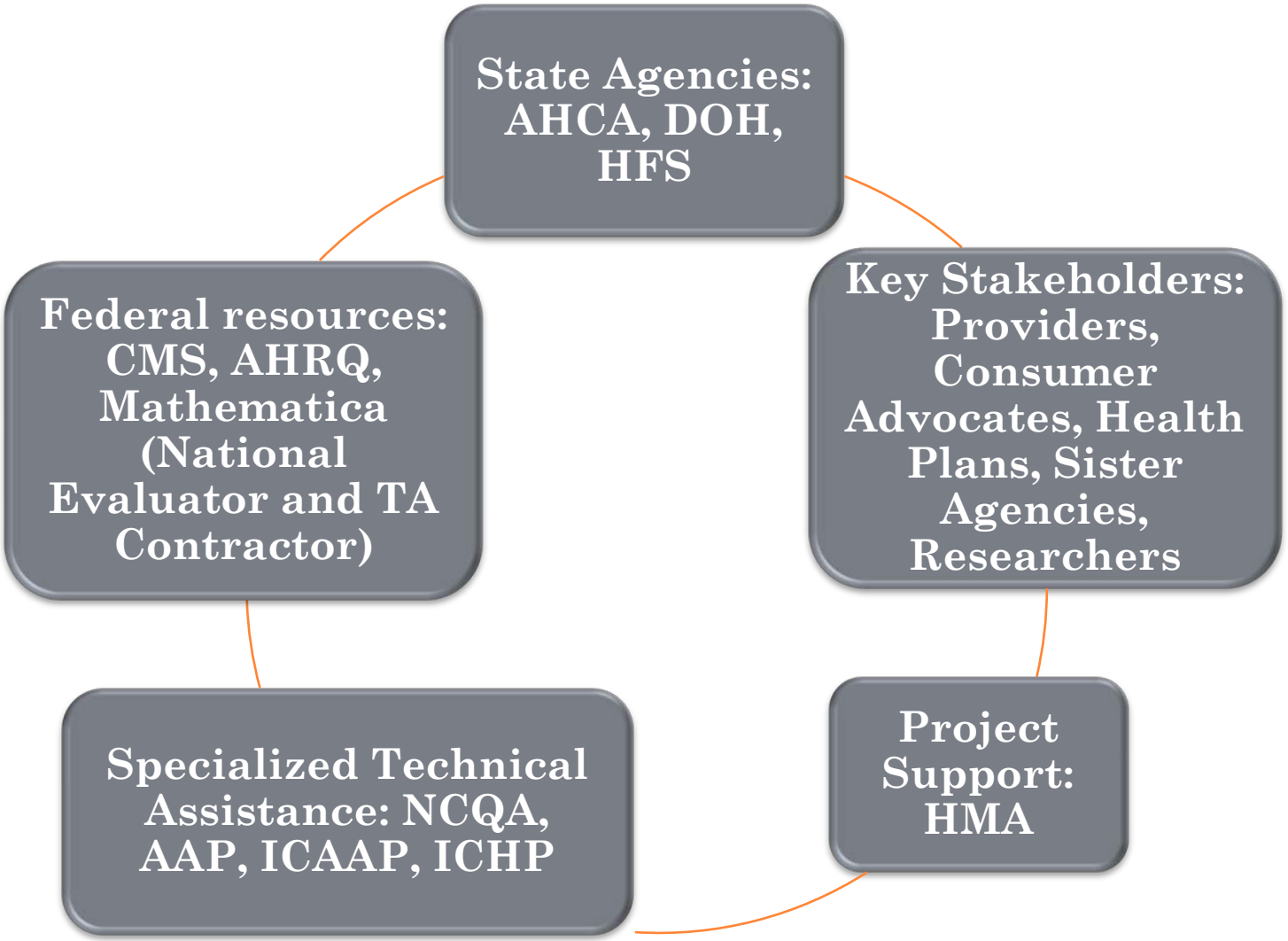
- Assess 200 practices on degree of “medical homeness”
- Provide support to practices in achieving medical home recognition
- Develop and implement QI initiatives in 30-60 practices; tie to “Maintenance of Certification”
- Implement an automated referral and feedback process

CATEGORY E GOALS

Category E: Create other means of improving child health care quality, access or delivery

- Establish and publish minimum care standards (prenatal and interconception) (C)
- Minimum data set of prenatal care information accessible to all physicians involved and the delivery hospital (B)
- Recommend high-risk prenatal and interconception interventions
- Develop automated process to identify high-risk pregnant and postpartum women and notify providers (C)
- Develop public education strategy – preconception, prenatal and interconception

KEY PLAYERS


State Agencies: AHCA, DOH, HFS
Federal resources: CMS, AHRQ, Mathematica (National Evaluator and TA Contractor)
Key Stakeholders: Providers, Consumer Advocates, Health Plans, Sister Agencies, Researchers
Specialized Technical Assistance: NCQA, AAP, ICAAP, ICHP
Project Support: HMA

STAKEHOLDERS

- Wide stakeholder representation
  - Providers
  - Provider organizations
  - Consumer advocacy organizations
  - Sister agencies
  - Academia/ Researchers
- Participation open to any interested parties/individuals

QUESTIONS

Gwen Smith
Gwen.Smith@Illinois.gov
217-557-5438

Automated Voice Response System (AVRS)
SCRIPT - CUSTOMER ACCESS (10-14-11)

With the implementation of durable medical cards, clients will no longer receive a paper card that guarantees coverage for a specified time period. For this reason, the Customer Access AVRS script is being developed to provide a resource for clients to confirm HFS medical benefits coverage for themselves and for family members via a toll-free number. In addition to the continued receipt of case specific eligibility determination notices and program handbooks, this script will provide them with some of the eligibility information that they now receive from paper medical cards.

The Customer Access AVRS script is modeled after the Medical Provider AVRS script and will use the same logic that is already built into the system that providers use to confirm eligibility. The messages below that are in italics are what the callers will actually hear. Not all of the "Recipient Eligibility Messages" listed will be heard. The messages heard will depend on the program that the person is covered under.

AVRS GREETING

Welcome to the Illinois Department of Healthcare and Family Services Automated Voice Response System. This system can be used to check medical eligibility.
*To continue in English, please press **1** now.* (In Spanish) *To continue in Spanish, please press **2** now***.** **[If we can't get the Spanish script programmed, we may have to go back to: (in Spanish) "If you do not speak English, press 0 to speak to an operator or remain on the line and someone will assist you shortly".]**

*If you need to know if you or a family member is covered for medical benefits and you are calling from a touch-tone phone, press **1** now. If you are a provider, press **2** now. If you are not calling from a touch-tone phone, stay on the line and someone will assist you shortly.*

*If you are unable to follow these instructions, press **0**.*

AVRS VERIFICATION

Please enter the member's nine-digit Social Security number **(or,** *Healthcare and Family Services nine- digit medical card number***)** *followed by the pound key.*

[Invalid identification number]
The Social Security (or medical card number) number you entered is not valid.
(Repeats2x)

[Third attempt - invalid number]
[Repeats invalid Social Security or medical card number] *Please refer to your Social Security* (or*, Healthcare and Family Services Medical) card to find the correct number and call back or press 0 to reach an operator.* (If 0 not pressed) *Thank you for calling the Healthcare and Family Services Automated Voice Response system. Goodbye.*

[Verified Social Security (or medical card) numbers are sent to main menu]

AVRS MAIN MENU

1. *To get instructions to use this system, please press **1**.*
   [Caller is directed to AVRS DIRECTIONS]
2. *To check eligibility for yourself or a family member, please press **2.***
   [Caller is directed to AVRS ELIGIBILITY INQUIRY]
3. *To end this call, please press **9.***
4. *If you do not know the member's nine-digit Healthcare and Family Services medical card number, and want to speak to a hotline operator, please press **0.***
   [Caller is transferred to BMC hotline staff.]
5. *To repeat this option, please press **7.***

AVRS ELIGIBILTY INQUIRY

1. *Enter the member's nine-digit medical card number of the person for whom you are checking now.*
2. *Enter today's date or another date of service. For example, September first, 2011 would be entered as 0 9 0 1 2 0 11.*

[Valid criteria will direct caller to AVRS RECIPIENT ELIGIBILITY MESSAGES]
[Invalid criteria]
The number you entered is not valid. The correct number is printed on the person's Healthcare and Family Services medical card. Please enter the correct number now.

The date you entered is not valid. Please enter today's date or another date of service. For example, September first, 2011 would be entered as 0 9 0 1 2 0 11.

AVRS RECIPIENT ELIGIBILTY MESSAGES

[Depending on the eligibility of the recipient, the following messages could be heard:]

1. *The person is eligible on (DATE).* **[System enters the date of service entered if different from today's date. This message is used alone when no other conditions apply, for example a child with AK Assist coverage with no co-pays].**

2. *The person is not eligible on (DATE).* **[System enters the date of service entered if different from today's date.]**

3. *The person is not eligible on (DATE) because they have not met spenddown. Call your local Family Community Resource Center for more information, or*

press 0 if you need help finding their number. **[System enters the date of service entered if different from today's date.]**

4. *The person is eligible on (DATE). However, the following conditions apply. Please listen carefully.* **[System enters the date of service entered if different from today's date. This message is used when additional conditions apply and additional messages will be heard.]**

5. **[Future eligibility information is supplied only when today's date is input as the date of service.]** *As of today, the person is eligible for medical services until (DATE).* **[If eligible on today's date, the system enters the last day of the eligibility period according to the Authorization Schedule. For example, if 08012011 is entered for a Group 00 case, the date will be August 31, 2011. If the date entered is 08152011 (after schedule cut off for September), the date will be September 30, 2011. Additional messages may follow if applicable.]**

6. **[The date of service entered is Spenddown Split Bill]** *The person is eligible but will be responsible to pay for some medical services they got on (DATE). For more information, look at your Notice of Determination of Monthly Spenddown Met.* **[System enters the date of service entered.]**

7. **[Recipient Restriction Program]** *The person is eligible but may only see a specific physician or get prescriptions filled at a specific pharmacy. Please call 1-800-325-8823 for more information.*

8. **[QMB only]** *The person is eligible as a Qualified Medicare Beneficiary only. This means that only the Medicare coinsurance and deductibles are covered.*

9. **[Person has part A, B or D Medicare coverage]** *The person is eligible but has Medicare too. That means that Medicare will be billed for any Medicare covered services.*

10. **[Medicaid Presumptive Eligibility program]** *The person is eligible only for outpatient services. That means the person is not covered for hospital inpatient or Long Term Care services.*

11. *The person is enrolled in a **managed care** plan. You may contact (name of the plan) at 1-800 (phone # for recipient's Managed Care plan) for information about services.*

12. *Beginning (DATE), the person will be enrolled in a managed care plan. You may contact (name of the plan) at 1-800 (phone # for recipient's Managed Care plan).*

13. **[This message is used for GA Family and Children cases – should only be used for adults.]** *The person is eligible and is covered for limited medical and hospital benefits under the General Assistance program.*

14. **[This message is used for GA-Transitional Assistance for adults.]** *The person is eligible and is covered for limited medical benefits under the General Assistance program, but is not covered for hospital services.*

15. *The person is eligible, but organ transplant services are not covered.*

16. *The person is eligible for renal dialysis only.*

17. *The person is eligible under the Veterans Care Program.*

18. **[All Kids and FamilyCare Premium]** *The person is enrolled in Premium Level (insert 1 through 8) of the All Kids or FamilyCare program. They must pay copayments for some services. For information about copay amounts, please*

look at the approval letter you received from the Department, or visit the web site: www.allkids.com/pocket.html

19. **[All Kids and FamilyCareShare]** *The person is enrolled in the All Kids or FamilyCare Share program. They must pay copayments for some services. For information about copay amounts, please look at the approval letter you received from the Departmen.*

20. **[All Kids Prior Coverage; copays do not apply]** The person is eligible under the All Kids program.

21. The person is eligible for Illinois Healthy Women family planning services only.

22. **[Copay]** *This person may have a copay for certain services or drugs. For information about copay amounts, please look at the approval letters you received from the Department.*

Once the eligibility inquiry is completed, the following messages will be heard:

23. *To hear the results of this inquiry again please press one.*
24. *To perform another inquiry for the same recipient using a different date of service please press two.*
25. *To perform another inquiry for a different recipient please press three.*

AVRS DIRECTIONS

This system lets you get Healthcare and Family Services information using your phone. You will need to enter certain information such as the Healthcare and Family Services medical card number, the Social Security number and dates of service for the persons you are calling about.

*At any time during the call, you can press **7** to repeat the last message; **9** to end the call; or **0** to speak to an operator*. Operators *are available Monday through Friday except state holidays from 8:30 am to 4:45 pm.*

To use this automated system, you will need the following information: the nine-digit Social Security number and the nine-digit medical card number of the person whose eligibility you want to check; and the date for which you want to check eligibility. You can do up to six eligibility checks per call.

*If you do not know the nine-digit medical card number but you have the person's name and date of birth or social security number**,** you may press **0** to speak with an operator.*

You must enter a specific date to check eligibility. You may enter today's date or another date of service. First enter the two-digit number for the month, then the two-digit number for the day and then the four-digit number for the year. For example, January 1, 2012, would be entered as 0 1 0 1 2 0 1 2. Please note: If you enter today's date, you will get information for today plus any remaining portion of the person's eligibility period. Because this system can only give eligibility information up to a certain date in the future, you may need to call back later to check eligibility for later dates.

[Returns caller back to AVRS ELIGIBILITY MENU]

	AKAA			Family			Total
Received	26,968	35%		50,316	65%		77,284
Processed	26,044	35%		48,523	65%		74,567
Approved	23,739	91%		28,383	58%		52,122
Denied	2,305	9%		20,140	42%		22,445

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services
Children and Adults Health Programs Group

September 30, 2011

Julie Hamos, Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL. 62763-0002

Dear Ms. Hamos:

I am writing to respond to your request for guidance related to the proposed changes to the annual Medicaid redetermination process currently in use by the State of Illinois. In your April 29, 2011 letter you wrote CMS seeking guidance on how to implement the procedural changes required by the State's Medicaid reform law, without triggering a violation of the Maintenance of Effort (MOE) requirements of the Affordable Care Act. These changes include increasing income and residency verification requirements and eliminating "passive" renewal. The State proposed new eligibility procedures, which would be implemented in "a manner that ensures program integrity and complies with Federal law and regulations while minimizing unnecessary barriers to enrollment." Achieving a well-functioning eligibility process that achieves the highest level of program integrity and at the same time assures access for eligible low-income and disabled individuals is a shared goal of Federal and State governments.

After several meetings with DHFS staff to review the income and residency verification requirements currently in place, the specifics of the proposed changes, and the options included in the State's letter, CMS provided guidance to the State on these issues in a letter dated June 24, 2011. CMS focused on these issues first, at the State's request, because the State law included a July implementation date for these provisions. In our letter, CMS informed the DHFS that requiring applicants to submit more documentation of income and residency than is currently required would not be consistent with the statutory MOE requirements, but we advised that the State could employ additional electronic data matches to assure more effective verification of income and residency. As we have discussed, additional electronic verification represents an effective and efficient refinement to current processes and procedures.

This letter provides further guidance on the issues raised in your April letter concerning changes to the renewal process, including verification of income. According to your letter, the new State law would require beneficiaries to respond to the renewal notice, effectively eliminating the State's "passive" renewal process and at a minimum, supply verification of one month's income from all sources required for determining continued eligibility of beneficiaries at their annual review.

It is not consistent with the MOE requirement to eliminate the "passive" renewal process. As noted in our February 25, 2011 letter to State Medicaid Directors that offers guidance on the MOE requirement (available at http://www.cms.gov/smdl/downloads/SMD11001.pdf), policy changes that would make the renewal process more restrictive and burdensome and thereby have the effect of restricting eligibility, would constitute a violation of the MOE provisions of the law. However, we understand and share your interest in ensuring that individuals are appropriately determined eligible for Medicaid.

After reviewing your process, we agree that the State of Illinois should change its "passive" renewal process which relies on data contained in the case record to more robustly confirm ongoing eligibility. Specifically, the State would actively incorporate the use of data matching with sources of current income information to update and supplement the case record information. The process could be improved by using data matching to make current income information (such as SSA, Employment Security, Income tax records) available. This information would enable the State to make more reliable determinations that the child remains eligible, and then no further action would be required of the family. To the extent that this information indicates a change in income that brings continued eligibility into question, the Medicaid agency could then request the additional information needed to complete the redetermination process. The use of these electronic data sources can also support verification of income for individuals who report a change, or are already required to respond to their renewal, without requiring an increase in documentation and creating any additional burden on a beneficiary.

Notably, the use of electronic data sources to verify income is already required by Section 1137 of the Social Security Act, and is common practice for most States. In addition, longstanding CMS policy requires that agencies renew eligibility for beneficiaries by first evaluating information available to the agency in the case record or from other available data sources and if the information is sufficient to determine continued eligibility then coverage is renewed. This process of using existing case information or other data available to the agency to redetermine eligibility is fully explained in the April 7, 2000 State Medicaid Director letter (available at http://www.cms.gov/smdl/downloads/smd040700.pdf) which clarifies the Federal requirements for redetermining Medicaid eligibility, in particular ex parte reviews. Lastly, acting on information related to changes is a requirement of current regulation as specified in CFR 42 Section 435.916(c).

We believe that this more active and modernized approach to renewals combined with the State's plan to begin electronically verifying residency will assure program integrity without creating a burdensome (to the State and individual) paper-based process. It will also ensure that the State complies with current statutory requirements in Section 1137 of the Act regarding the use of electronic data sources as part of the income verification process. As specified in our June 24th letter, if you decide to move forward with these approaches, please submit a plan for our review.

I hope that this letter provides the guidance you need related to the State's renewal procedures and MOE. CMS is committed to assisting the State of Illinois in its efforts to ensure program integrity while at the same time maintaining access to needed health care services for all

individuals eligible for Medicaid and ALLKids. If you have any additional questions please feel free to contact me at (410)786-5647.

Sincerely,

Victoria Wachino
Director

cc:
Cindy Mann, Director, CMCS
Verlon Johnson, ARA, CMS Region V