HR1 Module 6: Common Questions and Answers Regarding Medicaid Changes

September 15, 2026

HFS
Illinois Department of
Healthcare and Family Services

HFS
Illinois Department of
Healthcare and Family Services

OUR VISION FOR THE FUTURE

We improve lives.

- We address social and structural determinants of health.
- We empower customers to maximize their health and well being.
- We provide consistent, responive service to our colleagues and customers.
- We make equity the foundation of everything we do.

This is possible because:

We value our staff as our greatest asset.

We do this by:

Fully staffing a diverse workforce whose skills and experiences strengthen HFS.

Ensuring all staff and systems work together.

Maintaining a positive workplace where strong teams contribute, grow and stay.

Providing exceptional training programs that develop and support all employees.

We are always improving.

We do this by:

Having specific and measurable goals and using analytics to improve outcomes.

Using technology and interagency collaboration to maximize efficiency and impact.

Learning from successes and failures.

We inspire public confidence.

We do this by:

Using research and analytics to drive policy and shape legislative initiatives.

Clearly communicating the impacts of our work.

Being responsible stewards of public resources.

Staying focused on our goals.

HFS' Guiding Principles

- **Mitigate harm** as much as possible.
- Ensure eligible **Illinoisans receive and maintain the coverage and benefits** for which they qualify.
- Ensure the Illinois Medicaid program maintains the ability to **cover as many health care services as possible**.

HR1 Education Webinar Series: Goals and Objectives

- Equip our Providers and Partners with the education and tools necessary to assist our customers
- Assure that our Providers and Partners are sharing the same message as HFS and DHS
- Minimize the number of eligible customers who lose coverage

Housekeeping

- Automated captions have been enabled for this webinar. To view them, click on the “more” option with three dots at the bottom of your screen. There you should have the option to turn on closed captioning.
- All participants are muted and in listen-only mode.
- If you’d like to ask a question, click on the Q&A or Slido icon at the bottom of your webinar screen and type your question into the box.
- We will be monitoring questions and will have time for in-person Q&A after our planned presentation.
- We may not be able to answer every question asked, but we will have a record of all your questions and will use them as a guide for future resources and presentations.
- After the webinar, we’ll post the presentation slides with English and Spanish subtitles, and a video recording of this presentation, on the Federal Resource Center page on the HFS website.

HR 1 Education Series Module 6

Agenda

- Common Questions and Answers
- Communications and Toolkit

Work Requirement Questions

Question: Monthly Income

If a customer has an income of $580 or more a month but works less than 80 hours of work in a month, will they meet work requirements?

Answer: Monthly Income

- Yes.
- $580 in income under the Modified Adjusted Gross Income (MAGI) rules meets work requirement without needing to count hours.
  - The State uses Modified Adjusted Gross Income (MAGI) to determine financial eligibility for most Medicaid programs.
  - MAGI is determined using a combination of tax filing rules, excluded and included income, and relationship rules.
  - MAGI includes some unearned income.
- When a customer completes an application, they indicate tax filing status and relationships on the application, and the State caseworker will determine the MAGI for the household.
- If the customer has an income of less than $580/month, the hours they work can be combined with hours of community service (volunteering), unpaid work or internships, education less than half time, to achieve the required 80 hours per month.
- The $580/month does not need to be earned income and does not necessarily have to be earned by the customer who needs to meet work requirements.

Question: Community Service

Can you tell us more about volunteer hours? What type of volunteering counts, how does the customer prove they volunteered, and is there specific form to complete?

Answer: Community Service

- Community service includes non-partisan activities in a structured program, such as at a church, school, or nonprofit organization
- In 2027, the State will accept self-attestation of volunteer hours
- Serve Illinois – Volunteer Connector
- Register | Create Your Account | Galaxy digital – Volunteer Opportunities

Question: Work Requirement (W/R) Proof

What proof will be required to show the customer has met the work requirement?

Answer: Proof of Work Requirement(W/R)

- The State may be able to verify income/work hours through our data sources and we will look to these sources before asking the customer to verify income.
- If a customer is performing unpaid work or volunteering, self-attestation will be accepted in 2027 with the individual attesting to the information being true and correct under penalty of perjury.

Questions about Exemptions and Exceptions

Question: Homelessness Exemption

Will homelessness qualify as an exemption from work requirements?

Answer: Homelessness

- No, homelessness in and of itself will not qualify as a work requirement exemption.
- Many individuals who are unhoused or unstably housed will qualify for other exemptions, but their housing status alone will not exempt them.

Question: Adults with Disabilities

If a person is recognized as disabled by the Social Security Administration (SSA), and they are in the ACA Adult medical coverage category, should they immediately request to be moved to the AABD Medicaid category?

Answer: Adults with Disabilities

- Medicaid coverage categories for adults with disabilities is not a simple decision.
- They may have income and/or assets that exceed the AABD Medicaid coverage category, so they are only eligible for the ACA Adult Medicaid group.
- If an ACA Adult has a disability, before requesting a categorical change, assess whether their income and assets might exceed requirements for the AABD group.
- If the customer is confident they will meet the income and asset criteria for AABD they can request the switch by contacting 1-877-805-5312 if a medical only case, 1-800-843-6154 for multi-benefit cases, by visiting an office, or through ABE Manage My Case.
- Adults with disabilities who are only eligible as ACA adults, can submit a request for an exemption from W/R if unable to work or meet other requirements.

Question: Medical Frailty

- Does the State have more information on the determination of Medical Frailty?
- Are there certain conditions that will categorically meet this exemption?

Answer: Medical Frailty HR 1 baseline

- The HR1 statute defines medically frail or individuals who otherwise have special medical needs as those:
  - 1) with a substance-use disorder (SUD);
  - 2) with a disabling mental disorder;
  - 3) with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living;
  - 4) with a serious or complex medical condition; or
  - 5) who are blind or disabled (as defined in section 1614 of the Social Security Act)

IFR Changes: Narrowing the Definition of Medical Frailty

The Interim Final Rule (IFR) released on June 1st narrowed the definition of who is Medically Frail (MF) “enough” to get an exemption from new work requirements.

- "Medical frailty will depend on the **condition significantly impairing their ability to comply** with the community engagement requirement."

Takeaway: In many cases, **a diagnosis alone will not be sufficient** to meet the standard for a medical frailty exemption, and **additional information will be needed**. This may be gathered from data available to HFS or may require additional documentation from customers.

Illinois Status on Medical Frailty

- New guidance released by CMS in September defined three tiers of medical frailty codes:
  - Tier 1: Diagnoses that alone are sufficient to be considered medically frail
  - Tier 2: Diagnoses alone that do NOT indicate significant impairment to work, but states can identify impairment when combined with other diagnoses or utilization (i.e., CPT codes, HCPCS codes, etc.)
  - Tier 3: Insufficient evidence OR no data for Tier 1 and Tier 2
- For Tier 3, an individual in Illinois will need to attest to their health condition on their application, redetermination forms, the screener, the soon to be available exemption request form, or in Manage My Case.
- Illinois is considering several approaches to medical frailty code lists, including lists developed by other states and academic experts.

Question: Caretaker Exemption

Can multiple people in a household use caretaker of disabled adult exemption for the same person in the same house?

Answer: Caretaker Exemption

- Yes.
- Multiple people can share caretaking responsibilities for a disabled adult or a child in a household.
- Questions will be asked within the application, redetermination, or exemption request, and the customer will be able to use this answer for all individuals for which the exemption applies.

Redeterminations

Question: Look Back Period at Redetermination

What months will the State look at for W/R compliance when a rede is completed in 2027?

Answer: Look Back Period

- Redeterminations completed in 2027 will look back to the last redetermination or initial application for a single month that met the W/R.
- The first time a customer completes a rede in 2027 their lookback may be as long as12 months, while a subsequent rede will be 6 months.
- If the customer is requesting an exemption, the qualifying reason must generally exist during their current certification period.

Question: Redetermination Form A

Will customers currently receiving Form A(ex-parte) redeterminations and not required to respond, also have their 6 month rede for Medicaid satisfied by ex-parte?

Answer: Redeterminations

- The state will try to verify work requirement compliance or exemption from work requirement for as many people as possible through our data interfaces.
- Individuals with income that can be verified through our interfaces whether earned or unearned, who meet or are exempt from the work requirement, will receive the Form A (ex-parte) Redetermination paperwork.
- Those that cannot be verified will receive a Form B.

Miscellaneous Questions

Question: Newborn Retroactive Eligibility

Will HR1 have any effects on retro-eligibility for newborns? Specifically, will the reduced reinstatement window affect the timeframe in which newborns can have their benefits instated once they are born?

Answer: Newborn Retroactive Coverage

- A baby is automatically eligible for Moms & Babies as a “deemed newborn” when the mother was enrolled in or eligible for medical coverage at the time of the baby's birth under any of the following medical programs:
  - Moms & Babies, FamilyCare, All Kids Assist, AABD, ACA Adult, Former Foster Care
- If the baby was not deemed, meaning the mother was not a recipient of or eligible for full Medicaid at the time of the baby’s birth, an application for the baby would need to be received within ***2 months*** of the baby's birth. A baby born to a pregnant woman who is receiving Family Health Spenddown (met or unmet) at the time of the baby's birth is not automatically eligible. In this situation, the state would determine eligibility of the baby based on All Kids income eligibility.

Question: Revolving Door Limit

Is there a revolving door policy around regaining Medicaid eligibility for people who lost medical coverage because they did not meet work requirements at redetermination and are trying to get coverage again?

Answer: Revolving Door Limit

- A customer that loses medical benefits does not need to wait a certain amount of time before re-applying for medical benefits.
- While individuals who lose Medicaid coverage can immediately reapply, they should determine a way to meet or be exempt from W/R in order to be approved for medical coverage if they are an ACA adult.
- Note: ABE limits new applications from the same individual to once per month.
- If the customer believes they were denied in error, they should submit an Appeal rather than submitting a new application.

Revolving Door - Marketplace

- If an individual is denied Medicaid, they can apply for Marketplace, however, depending on denial reason they may not be eligible for premium tax credits.
  - If an individual is denied Medicaid due to W/R non-compliance and no exemption, they will not be eligible for premium tax credits (PTC).
  - If an individual is denied Medicaid due to income or other reason not related to W/R, they may be eligible for PTC.

Buttons in ABE Manage My Case(MMC)

- Will the availability of the Renew My Benefits button change due to HR1 changes?
- Will the Manage My Work Requirements button always be visible in MMC?

MMC Buttons

- The Medicaid Work Requirements button will show in ABE MMC for ACA adults who don't have "Not Applicable" as their Medicaid W/R status.
- All ACA Adults who are subject to the work requirement will see this button.
- The Medicaid W/R information won't show in MMC until 1/1/2027.
- Individuals will be able to submit Exemption Requests through the Screener which goes live 9/18/26.
- Renew my Benefits will display 60 days before end of current cert period - 30 days before due date. Will continue to display until:
    - Renewal is received or,
    - End of 90-day reinstatement period

Question: Medi Access

I don’t have Medi access – How can I get that?

Answer: Medi Access

- Medicaid Providers and/or Application Agents can request Medi access using their provider ID through a 3-step process:
  - Register with the State of Illinois for a Digital Identity
  - Register with Department of Healthcare and Family Services (HFS)
  - Register to use Specific HFS Applications

- The HFS **MEDI Home** page will guide you through this quick and easy three-step process. The **Getting Started with MEDI** in the right Navigation bar on this page will take you right to Step 1!

HFS
Illinois Department of
Healthcare and Family Services

Stakeholder Toolkits and Communications

Overall Communications Objectives

1. Increase customer awareness that changes are coming
2. Clearly explain who is affected and who is exempt
3. Provide simple, accessible instructions for those who must act
4. Minimize confusion, call center strain, and procedural disenrollment
5. Meet all federal notice and accessibility requirements

Messaging Toolkits | HFS

- **Phase 1 Toolkit available in 15 languages**
- **Non-Citizen HR 1 Toolkit available in 7 languages**
- **Phase 2 Toolkit currently available in English and Spanish**
- **Social Media**
  - Use our images, and messaging for Social Media Posts, text messaging and newsletters
- **Flyers and Palm Cards**
  - Post flyers in highly visible areas in your clinics waiting rooms, community centers, schools, churches, food banks and anywhere else you see our shared customers.
  - Print flyers and palm cards to hand to customers at check in or check out.
  - Put them in bags at food pantries or in school bags



Help Communicate Changes to Customers

Community partners can help minimize customers losing benefits by:



Helping customers **navigate changes to eligibility** requirements



Using the **Phase 1Toolkit** to assist with **address updating**



Helping IDHS and HFS **learn more about challenges** customers are facing



Using the **Phase 2 Toolkit** to help customers **understand changes to application and work** requirements

Additional Website Information

- Federal Resource Center
  - HFS Toolkits
  - Webinar Recordings and Slide Decks
  - FAQ coming soon
- My Healthcare HFS Customer page
- Upcoming Changes to Medicaid – Customer page
  - General Changes to Medicaid – English Flyer (pdf)
  - General Changes to Medicaid – Spanish Flyer (pdf)