Illinois Department of Healthcare and Family Services
Public Education Subcommittee Meeting
December 12th, 2012
Approved Final Meeting Minutes
401 S. Clinton Street, Chicago, Illinois
201 S. Grand Avenue East, Springfield, Illinois

Committee Members Present
Kathy Chan, IMCHC
Sonja McGrath, SIU School of Medicine
Paula Ramos, Community Health Care (via phone)
Susan Vega, Alivio Medical Center
Nadeen Israel, Heartland Alliance
Andrea Kovach, Shriver Center (for Margaret Stapleton)
Margaret Dunne, Beacon Therapeutic
Henry Taylor, Mile Square Health Center (via phone)

Committee Members Absent
Hardy Ware, East Side Health District Medical Center
John Jansa, Molina HealthCare

HFS Staff
Jacqui Ellinger
Lynne Thomas
Arvind Goyal
Mike Koetting
Mike Jones
Robyn Nardone
Mercy Sanchez
Tia Sawhney
Gabriela Moroney
Sally Becherer
Laura Jaskierski, DOI
Veronica Archundia

Interested Parties
Jane Longo, HMA
Claudia Forrest, Maximus
Erika Walton, Maximus
Maribeth Stein, Age Options
Marissa Kirby, IARF
Victoria Bigelow, Access to Care
Teresa Hursey, Aetna
Brian Reardon, Hospital Sister Health System
Tanni Lovelace, SIU School of Medicine
Diane Fager, CPS
Brittany Ward, Beacon Therapeutic
Jacqueline Gonzalez, CHHC
Deborah Mathews, DSCC
Sheri Cohen, CDPH
Christine Cazeau, Illinois Health Connect
Dr. Derek Lanier, Meridian Health Plans
Susan Melczer, MCHC
Corey Barnes, The Public Health Organization
Dr. Judy King, Consumer Advocate (via phone)
Mala Suri, Blue Cross Blue Cross/Shield (via phone)
Barbara Goodlove, Blue Cross/Shield of Illinois (via phone)
Mona Martin, Consultant (via phone)

DHS Staff
Sharon Dyer-Nelson

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1. **Introductions**
   Kathy Chan chaired the first hour of the meeting, and Sue Vega handled the chairmanship during the second hour. Attendees in Chicago and Springfield introduced themselves.

2. **Review of Minutes**
   The October 12th, 2012 minutes were approved.

3. **Integrated Eligibility System**
   Sharon Dyer-Nelson indicated that HFS and DHS continue working hard to install the new Integrated Eligibility System (IES) by October 2013, which is a new computerized system that will be used to determine eligibility for Medicaid, SNAP, and TANF. Ms. Nelson indicated a computerized system called "Bridges," which is already operating in Michigan, will be transferred and modified to respond to the needs of the Illinois operating system. This has been a challenge, since a great deal of the terminology and medical policy used in Michigan differs from that used in Illinois. In order to improve and change from case-load to task-based, as well as streamline the application process, the department anticipates possible delays. She noted that a lot of these changes are part of internal processing and should not have implications for clients.

4. **Transparency Website**
   Tia Sawhney explained that, under the law, HFS discloses data that is publicly available under the Health Insurance Portability and Accountability Act (HIPAA). She discussed HFS motto "No data without words". In addition to data that we routinely make publicly available as a result of state Transparency Act, as well as due to federal reporting requirements, Ms. Sawhney noted that HFS responds to requests for information under the Freedom of Information Act (FOIA).

   The following are links for the HFS Transparency website, in addition to a useful enrollment file, and various reports:
   http://www2.illinois.gov/hfs/agency/Transparency/Pages/default.aspx
   Enrollment
   http://www2.illinois.gov/hfs/agency/Program%20Enrollment/Pages/default.aspx
   Various reports
   http://www2.illinois.gov/hfs/agency/Pages/Reports.aspx

   Jacqui Ellinger stated that Ms. Sawhney could be invited for future meetings if the committee has specific requests.

5. **Enhanced Eligibility Verification (EEV)/Maximus Contract**

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Michael Koetting provided a background for EEV, indicating that it was mandated by the SMART Act, which required HFS hire an outside vendor (Maximus) through an expedited procurement process. EEV will facilitate and enhance the annual eligibility screening of clients. This initiative will be launched in January, 2013, and will include the creation of a new centralized eligibility redetermination unit, for which DHS will add 200 case workers. Mr. Koetting emphasized that Maximums will only make recommendations to the state case workers who will make all final decisions on redeterminations.

Mr. Koetting introduced Erika Walton and Claudia Forrest who made reference to the handout, "Illinois Enhanced Eligibility Verification Project Fact Sheet", which provided a description of the operating process. There was a robust discussion with committee members concerning the details of this process, especially the benefits of having specialists who have the experience and understanding of the medical programs. There will also be bilingual customer services representatives for Spanish, Polish, and other Eastern European languages, in a call center in Chicago and the availability of pre-paid return mail envelopes.

Claudia Forrest reminded committee members to continue sharing their concerns with HFS staff regarding cases with special circumstances of which Maximus should be aware in order to minimize the difficulties that clients may have in communicating with the vendor and complying with the redetermination process. More updates will be offered in the future and EEV will remain an agenda item for upcoming meetings.

6. ACA Update

Navigator Program: Laura Jaskierski reported that, on November 16th, the state of Illinois submitted its "blueprint application" to the federal Department of Health and Human Services (HHS), declaring its intention, during the first year, of having a state-federal partnership to operate the Health Insurance Exchange. Subject to legislative approval, this will become a state exchange; otherwise, the federal government will continue to operate it. Ms. Jaskierski noted that the "blueprint" is an evolving document, which is currently under review for approval by the federal government. Within this partnership, Illinois will have the opportunity to operate some of the plan management and consumer assistance functions of the Health Insurance Exchange, while the federal government will do the rest.

Under the consumer assistance portion of this plan, the Illinois Department of Insurance (DOI) will run the In-Person Assistance (IPA) function of the Exchange, which is separate and distinct from the Navigator program. The IPA program will function as a supplement to the Navigator program by serving populations that are geographically and demographically distinct from the Navigator program. Entities will be able to select among three separate levels of grants when applying for the IPA program. The Level 1 grants will offer up to $25,000 per year and will support basic enrollment activity. The Level 2 grants will be between $25,000 and $75,000 and will require enrollment activities under Level 1, in addition to outreach involving public media promoting awareness of the Exchange and other

coverage programs. Level 3 grants will be between $75,000 and $150,000, and recipient organizations will be expected to provide all Level 2 activities, plus a large scale, statewide, specifically targeted promotion that is closely coordinated with both the state and federal governments.

House Bill 6253: Gabriela Moroney indicated that, currently, there is a gap in Medicaid coverage for adults without dependent children, age 19-64, who have income under 133% of the Federal Poverty Level. These adults are not disabled and often employed, but work at low wage or part-time jobs without access to health insurance. She noted that newly introduced HB 6253, which will be considered in the January legislation session, provides the opportunity to finance these uninsured persons. As one of the central goals of the Affordable Care Act (ACA), the federal government is offering generous federal matching funds to the states in an effort to cover this newly eligible population: 100% reimbursement for the first three years, and then being phased down to 90% by 2020. Ms. Moroney encouraged members to contact their legislators in support of HB 6253 and to add their organizations to the list of supporters by contacting the HFS Legislative Director, Selma D'Souza, at Selma.D'Souza@illinois.gov

7. Updates:

Medical Card: Robyn Nardone reported that substantial progress has been made with respect to the annual paper card. HFS staff started working on the production of inserts that will be delivered, along with the medical cards that clients receive, to make them aware of the upcoming changes. A three-fold brochure will be sent with new medical cards to explain the card and provide additional resources regarding eligibility. In order to facilitate a smooth transition, the department is planning to send a notice to providers to inform them about this change. There will also be flyers in both English and Spanish that will be posted on the HFS website. Ms. Nardone noted that providers will be responsible for verifying eligibility before they offer services.

Cook County Waiver: Jane Longo indicated that CountyCare is a new medical benefits program which has been authorized under a federal waiver from the Centers for Medicare and Medicaid Services. Ms. Longo noted that medical services are provided by a network which includes Cook County Health and Hospital System (CCHHS), as well as a designated group of CountyCare network partners. Ms. Longo presented a flyer that included a hotline number and a summary of eligibility requirements, as well as benefits covered within this program. Beginning Monday, December 17th, applicants may either apply in person or by phone. Ms. Longo may be contacted for further questions regarding CountyCare at jlongo@healthmanagement.com

AKAAs Status: Lynne Thomas provided an update concerning AKAAs who currently available to assist families in order to submit their All Kids applications. She reported that HFS has reviewed and processed No-TAP agreements with 217 AKAAs, including

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community-based organizations, daycare centers, local governments, medical providers, and licensed insurance agents.

Children's Enrollment: Lynne Thomas referred to the handout "Enrolled Children Calendar 2012." Attendees received an updated chart showing the number of children who were enrolled for medical benefits from 2006 to 2011 and from January to August, 2012.

8. Open Discussion and Announcements:

Ms. Ellinger acknowledged the contribution and participation of Sonja McGrath, who had announced her upcoming retirement from SIU School of Medicine, effective December 31, 2012. The department accepted her resignation from this committee. Ms. Ellinger extended an invitation for people to submit requests to serve on this committee by December 31st, 2012.

Client Communication: Due to time constrains, this aspect of the agenda was postponed for future meetings.

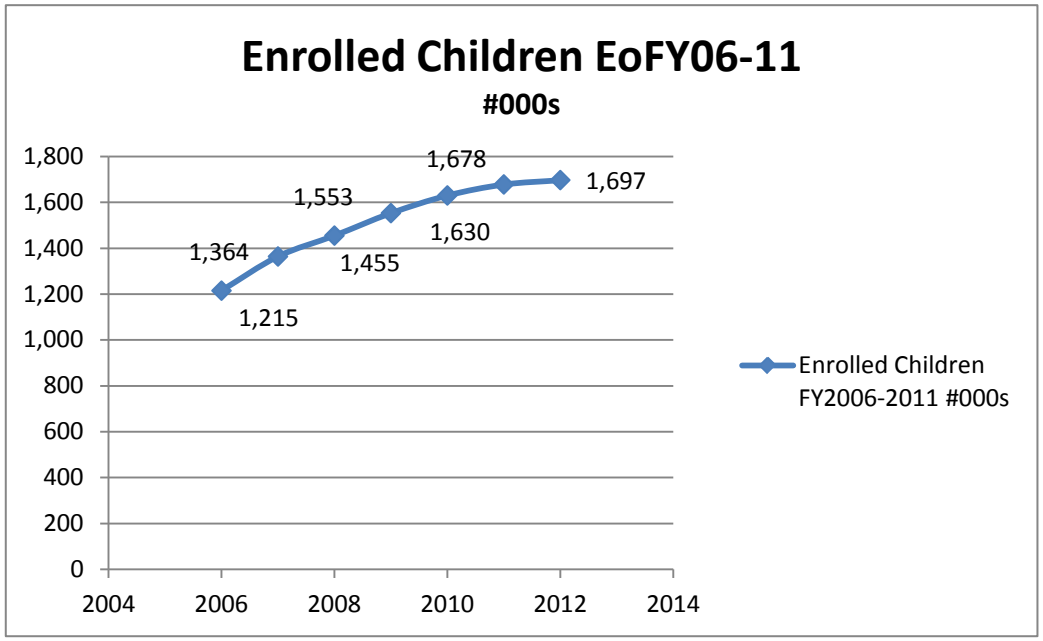
2013 Proposed Meeting Schedule: A proposed meeting schedule was presented for 2013; however, committee members only agreed upon the first proposed meeting date of February 14, 2013. Committee members were encouraged to provide agenda suggestions for the next meeting.

Open Meeting Act and Annual Ethics Training: Sue Vega reminded committee members that December 15th, 2012 is the final date to complete ethics training, while the OMA electronic training should be completed before December 31, 2012. Members were advised that failure to comply could result in a recall of their positions with the committee.

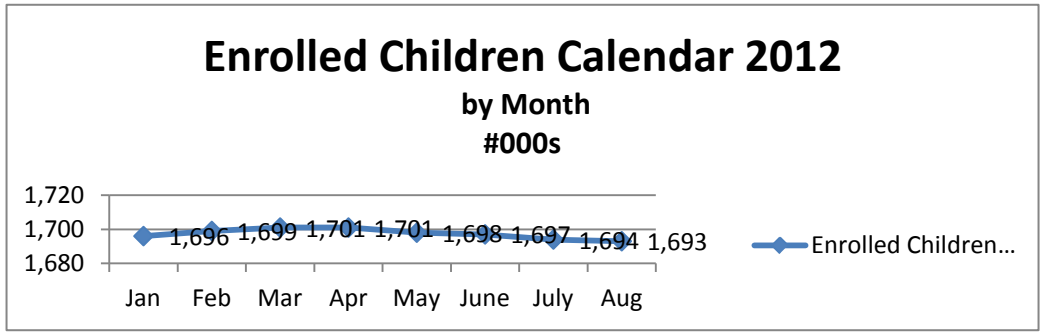
9. Adjourn

The meeting was adjourned at 11:21 a.m. The next meeting is scheduled for February 14th, 2013, from 10:00 a.m. to 12:00 p.m.

End of FY	Enrolled Children FY2006-2011 #000s
2006	1,215
2007	1,364
2008	1,455
2009	1,553
2010	1,630
2011	1,678
2012	1,697



End of Month 2012	Enrolled Children #000s
Jan	1,696
Feb	1,699
Mar	1,701
Apr	1,701
May	1,698
June	1,697
July	1,694
Aug	1,693



MEDICAID FINANCING FOR THE UNINSURED UNDER THE AFFORDABLE CARE ACT

HB6253

SUMMARY:

Today, for adults without dependent children, no matter how poor are, they are not eligible for Medicaid. This gap in coverage is eliminated by the Affordable Care Act (ACA). HB6253 authorizes Illinois to take advantage of the ACA to provide healthcare under Medicaid to about 342,000 low-income Illinois citizens who are currently uninsured. The ACA offers generous federal matching funds for this newly eligible population: 100% for the first 3 years, then phased down to 90% by 2020.

The legislation has three parts:

- It revises the Public Aid Code to eliminate the coverage gap for adults ages 19 through 64 whose income is at or below 133% of the Federal poverty level (the level required by ACA). This is the current level of eligibility for parents and other caretaker relatives raising dependent children.
- It provides that the state will establish the specific benefit package for these newly eligible adults through rule, which at a minimum must cover 10 "essential health benefits" including hospitalizations, pharmaceuticals, mental health and substance use disorder services, preventive and wellness services, chronic disease management and more.
- It amends the moratorium on new eligibility categories to take advantage of the favorable federal match rates.

HOW WE ALL BENEFIT:

This legislation will enable Illinois to receive federal revenue to cover the costs of providing healthcare to uninsured, low-income adults, and thereby replace costs already borne by Illinois taxpayers and numerous other institutions. That's why everyone benefits from HB6253:

1. <u>Keeps people healthier:</u> The legislation will provide access to healthcare services for low income adults, not now covered by Medicaid but often with complex health and behavioral health conditions. Healthier people result in reduced costs to Medicaid and to local governments, community agencies and healthcare providers.

2. Brings new Medicaid dollars into Illinois: Through 2016, this legislation will bring an estimated $5.7 billion into Illinois in Medicaid provider payments for the newly eligible adults, with no net state costs for their healthcare.

3. Replaces state GRF spending with 90%-100% federal match. Although Illinois has made progress in limiting healthcare and certain human services to Medicaid-eligible clients, there are still pockets of GRF expense funded with no federal match, much of it on behalf of people who will become eligible for Medicaid under this legislation. Going forward, these expenses will be federally matched at 100% for the next three years, subsequently declining to 90%.

4. Reimburses hospitals and clinics for uncompensated and charity care for the uninsured: Medicaid reimbursements funded with the new federal match will be available for healthcare providers who now collect little or no payments for the uninsured, and routinely have to shift costs to those with private health insurance.

5. Increases federal reimbursements to Cook County Health & Hospitals System: The new federal 1115 Waiver for the newly eligible Medicaid clients now reimburses at 50% match (authorized by the SMART Act), but will increase reimbursements to 100% match as of January 1, 2014, if this legislation is approved by the General Assembly. If not, these clients of Cook County would become uninsured again, with $0 federal reimbursement.

6. Replaces local spending for the care of the uninsured: By enrolling low-income uninsured adults in Medicaid, the legislation will provide federal dollars to alleviate pressure on county and local governments for healthcare costs now borne by local health departments, social service agencies, homeless shelters, mental health clinics, drug treatment centers, township organizations and the like.

HB6253 IS SUPPORTED BY (list in formation):

Illinois Hospital Association , AARP Illinois, Access Living, Age Options, AIDS Foundation of Chicago, Alexian Brothers Center for Mental Health, American Nurses Association Illinois, Area Agency on Aging(Northwestern, Western and Northeastern Illinois), Asian Health Coalition, Association House of Chicago, Campaign for Better Healthcare, Center for Housing and Health, Chicago Alliance to End Homelessness, Chicago House and Social Service Agency, Citizen Action Illinois, Community Counseling Centers of Chicago, Community Elements, Corporation for Supportive Housing, Doctors Council SEIU, Ecker Center for Mental Health, Equip for Equality, Families and Children's Network(FCAN), Health and Disability Advocates, Health and Medicine Policy Research Group, Healthcare Alternative Systems, Heartland Alliance for Human Needs and Human Rights, Heritage Behavioral Health Center, Howard Brown Health Center, Illinois Alcoholism and Drug Dependence Association, Illinois Alliance for Retired Americans, Illinois Assistive Technology Program, Illinois Association of Rehabilitation Facilities, Illinois Coalition for Immigrant and Refugee Rights(ICIRR), Illinois Collaboration on Youth, Illinois Maternal and Child Health Coalition, Illinois Network of Centers for Independent Living, Illinois Partners for Human Service, Illinois Primary Health Care Association, Illinois Public Health Association, Illinois Society for Advanced Practice Nursing, Independence Center, Lurie Children's Hospital, Lutheran Social Services of Illinois, March of Dimes, Men & Women In Prison Ministries, Mental Health America of Illinois, Mental Health Summit, Metropolitan Asian Family Services , Metropolitan Chicago Breast Cancer Task Force, Metropolitan Family Services, NAMI of Greater Chicago, National Alliance on Mental Illness(NAMI) of Illinois, NAMI Cook County North Suburban (NAMI CCNS), NAMI DeKalb, Kane South and Kendall Counties (NAMI DKK), National Association of Social Workers-Illinois Chapter, Next Steps- NFP, Northwestern Illinois Center for Independent Living, Organization of the NorthEast, Ounce of Prevention Fund, Planned Parenthood of Illinois, Prairie Center, Sacred Creations, SEIU Healthcare Illinois, Sargent Shriver National Center on Poverty Law, Southwest Organizing Project(SWOP), Statewide Independent Living Council, Supportive Housing Providers Association, TASC, Inc., The Arc of Illinois, Thresholds, Township Officials of Illinois, Trilogy, United Power for Action and Justice, Voices for Illinois Children.

For more information, contact Kurt Anderson, Governor's Office of Legislative Affairs at Kurt.Anderson@illinois.gov or Selma D'Souza, HFS Legislative Director, at Selma.D'Souza@illinois.gov

11/28/12

Illinois State Partnership Exchange
Blueprint Application Summary

Overview

On Friday November 16th, the state of Illinois submitted its Blueprint Application to the federal Department of Health and Human Services (HHS). This application will be reviewed by HHS for approval, allowing the state to proceed in partnership with the federal government to operate Illinois' health insurance Exchange beginning on January 1, 2014.

The Blueprint Application is an evolving document. As the partnership progresses and the state of Illinois continues to work towards a state-based Exchange, the document will be adjusted and expanded. However, it will remain a procedural document that is meant to detail workflow within and between agencies of state government. The full Blueprint Application is available here.

In a state partnership, Illinois had the opportunity to apply to operate some of the plan management and consumer assistance functions of the Exchange, leaving the remaining functions to be operated by the federal government. The Blueprint Application is a technical document that lays out how the state will coordinate with the federal government in the first year of the Exchange and how the state internally will carry out its plan management and consumer assistance responsibilities under the partnership. HHS will use this document as evidence that Illinois can meet its obligation for operating the plan management and consumer assistance functions.

Plan Management

The plan management portion of the Blueprint Application details the process the Illinois Department of Insurance (DOI) will undertake to recommend Qualified Health Plans (QHPs) for certification to HHS. The state was required to detail components related to plan management, including:

- The transition process for individuals currently in the Illinois Pre-Existing Condition Insurance Plan (IPXP). These individuals will transition to coverage through the Exchange on January 1, 2014.
- DOI's process to recommend QHPs for federal certification according to requirements detailed in federal regulations. This includes describing how DOI will ensure that issuers and health plans meet each of the QHP certification standards, the process DOI will use to evaluate issuers and health plans against each of the QHP certification standards, and any differences specific to stand-alone dental plans and the Small Business Health Options Program (SHOP). It also includes a description of the state entities responsible for QHP review, including a description of roles and responsibilities of each entity as they relate to QHP certification standards, and a description of the integration between the Federally-facilitated Exchange and DOI.
- DOI's process for reviewing licensure, solvency, product pricing, rating variation, plan rating, rate review, third-party accreditation, service area and network adequacy, essential health benefits, marketing standards, non-discrimination standards, quality standards, transparency reporting, multi-state plans, and several other criteria.
- DOI's capacity to ensure QHPs' ongoing compliance with QHP certification requirements and the ability to recertify, decertify, and manage the appeal of decertification determinations.

Plan management functions required for QHP review and recommendation are similar to the typical regulatory responsibilities of the Department. The Affordable Care Act requires new areas of review, but

the state will leverage the processes and workflows that are already established and in use within DOI and the Department of Public Health.

Consumer Assistance

The consumer assistance portion of the Blueprint Application details the process DOI will undertake to administer the In-Person Assistance (IPA) functions of the Exchange, as well as the oversight functions for the Navigator program in Illinois. The state was required to detail components related to consumer assistance, including:

- Describing a process to support and oversee aspects of the Federally-facilitated Exchange Navigator program, including ensuring that Navigators are adhering to the training and conflict of interest standards established by the Federally-facilitated Exchange and to the privacy and security standards developed by the Federally-facilitated Exchange.
- Describing the in-person assistance program, distinct from the Navigator program, including a process to operate the program consistent with Federally-facilitated Exchange guidance, policies, and procedures. Illinois plans to operate the IPA program with goals similar to the Navigator program: to help consumers access the expanded subsidized health insurance coverage programs and reformed and re-organized insurance markets that will result from the Affordable Care Act. The IPA program will act as a supplement to the Navigator program and will not serve redundant purposes or populations. To distinguish the IPA program, Illinois will ensure that entities contracted through the program serve populations geographically and demographically distinct from the Navigator program.

DOI is well-prepared to take on administrative duties, with experience overseeing similar programs, including the Senior Health Insurance Program (SHIP) and producer licensing, as well as experience in providing direct assistance to consumers through the Office of Consumer Health Insurance (OCHI).

Privacy, Security and Oversight

The partnership model also requires the state to perform privacy, security and oversight functions. The Blueprint Application details the process the Department of Insurance will undertake to administer these cross-cutting functions, including:

- Describing the written policies and procedures regarding the privacy and security standards.
- The process for maintaining an accurate accounting and analysis of all activities, receipts, and expenditures, and providing periodic reports in relation to the activities undertaken by the Exchange to HHS as required, including enrollment statistics, consumer satisfaction reports, relevant audit reports and any required state and federal reporting.
- Describing the contractual, outsourcing, and partnership agreements with vendors and/or state and federal agencies for all Exchange activities and functionality as needed, including data and privacy agreements.

MAC/Public Education Subcommittee

2013 Proposed Meeting Schedule

2013 Meeting Dates (Subject to Change)	**Time**	**Location**
February 14, 2013 April 11, 2013 June 13, 2013 August 8, 2013 October 10, 2013 December 12, 2013	10:00 a.m. – Noon	**Chicago:** 401 South Clinton, 7th Floor HFS Side Director's Videoconference Room Chicago, Illinois 60607 **Springfield:** 201 South Grand Avenue, East Division of Medical Programs Videoconference Room Springfield, Illinois 62763

Illinois Enhanced Eligibility Verification Project Fact Sheet

Background

The Illinois Enhanced Eligibility Verification (EEV) Project arose from an emergency procurement authorized by the Save Medicaid Access and Resources Together (SMART) Act of 2012 to secure services of a Vendor to verify eligibility for Medicaid through use of data matching resources. The contract was awarded to MAXIMUS Health Services, Inc. with a subcontract to HMS for the data matching component.

Objectives

To improve the integrity of the State's Medicaid eligibility determination and allow the State to evaluate cases with greater efficiency, particularly for redetermination, by:

- Establishing an online portal for state workers to easily manage cases, collaborate, and interface with various databases needed to support the verification process
- Digitizing information flow and eliminating paperwork, and by automating many of the manual processes involved in collecting information for case processing
- Providing beneficiaries with more accessible way to verify the status of their eligibility redetermination

Challenges

- All 2.7 million clients currently enrolled in the State's Medicaid program must be renewed annually
- State needs to ensure that those who qualify for benefits receive them, while at the same time ensuring those not eligible do not receive them
- Compressed timeline for going live required an expedited implementation

Scope of Work

- MAXIMUS will review cases using a proprietary system, developed by HMS, a Texas firm that assembles data from multiple data sources. Using business rules, the system indicates cases that are potentially ineligible for medical benefits.
- While some of the data can (and will) be verified entirely through electronic means, conflicting and/or missing data will require customer contact.
    - For cases where no benefits other than Medical benefits are involved, MAXIMUS will contact clients who will have 10 business days to supply additional information. MAXIMUS staff will review these cases and provide specific recommendations using State approved policies and procedures. The State Caseworkers will determine if the recommendation is correct, and complete the Redetermination in the Automated Case Management System (ACM) based upon both the data in the ACM system plus any new data collected by MAXIMUS.
    - Where the case includes SNAP or cash assistance, the clients will be contacted by the State Caseworkers per current procedures. They will use the data collected by MAXIMUS/HMS plus other data generated pursuant to redeterminations for other programs to make a final decision on eligibility.
- The HMS data matching system will be integrated with the State's existing systems and databases, as well as federal and other third-party systems
- The project will connect a variety of new databases not previously available and integrate those with existing systems and data bases in a sophisticated way that will enhance value from this data
- Bigger benefit, however, is the ability of MAXIMUS to bring technology and processes from other states that, in a matter of months, will significantly enhance the ability to efficiently apply information to the re-determination processes
- MAXIMUS will provide beneficiaries with access to dedicated customer support and a variety of tools to confirm the status of their case in the eligibility redetermination process and submit required documentation:

- Illinois Medical Redetermination Hotline: a call center staffed with Customer Service Representatives from 7AM to 10PM specifically trained to handle Medicaid eligibility questions and inquiries
- Performance payment conditioned on appropriate customer response—time to answer, number of calls abandoned, etc
- Multiple channels for submitting documentation: online, in-person, and fax

Implementation

- Joint MAXIMUS-DHS/HFS workgroups are developing the system and business requirements, as well as workflows.
- Next steps include executing system configuration and developing algorithms to meet specific Illinois requirements, as well as the development of the Policies and Procedures to be used by MAXIMUS Eligibility Specialists and call center staff.
- The table below outlines at a high-level select implementation activities.

Elements	Description
Staffing	✓ Recruit and hire approximately 500 MAXIMUS staff for local call center • More than 40 management and professional positions • Approximately 450 eligibility specialist and call center representatives, with multi-lingual and multi-cultural capabilities ✓ Train MAXIMUS staff and state workers ✓ Provide capacity overflow for technology/data management from additional 40 employees located in Dallas, Texas
Facility	✓ Identify, lease, and complete site configuration with furnishings for a 100-seat call center, more than 400 eligibility specialists in teams, as well as a document and mail processing center and support area
Voice & Data Networks	✓ Typical order and delivery of circuits is two months
Data Matching Technology	✓ Configure the existing technology to meet Illinois specific eligibility requirements ✓ Interface with state, federal and commercial income-, asset- and residency-related databases ✓ Build an internet portal to communicate with state caseworkers and databases ✓ Test all elements of the system

About MAXIMUS

- Largest Medicaid Managed Care Enrollment Broker – touching 52% of all beneficiaries
- Largest CHIP administrator – 59% of market
- MAXIMUS has decades of experience with large scale government programs and transformational changes and is the eligibility and enrollment service administrator for nearly 20 million Medicaid and CHIP beneficiaries
- MAXIMUS has 60 customer call centers across North America:
  - Nationally averaged over 2 million agent-assisted calls per month across all call centers
  - Texas Eligibility Support project's multi-site contact centers handled more than 5.15 million calls with more than 1,600 staff in 2012
  - California Medicaid and CHIP programs averaged 319,000 outbound calls per month
- Typical timeframe from start-up to "go live" ranges from six to nine months
- The extensive experience in implementing call center operations allows MAXIMUS to leverage proven processes and tools that help reduce this timeframe without "cutting corners"

DRAFT not for distribution

countycare

What is CountyCare?

CountyCare is a Medicaid program for adults.

Potential members that qualify for CountyCare will get the following SERVICES:

- Inpatient hospital services
- Outpatient hospital services
- Emergency room
- Prescription Drugs
- Physician
- Clinic Services
- Lab and X-ray
- Family Planning
- Hospice
- Public Transportation
- Advanced Practice Nurse
- Subacute alcohol abuse
- Subacute substance abuse
- Mental Health Services
- Dental (limited to 19 & 20 year olds)
- Nursing facility (limited to 30 days after a hospitalization)
- Therapy and rehabilitation
- Targeted Case Management (behavioral health)

Who is eligible?

To qualify for CountyCare, potential members must:

- Live in Cook County
- Be 19-64 years old
- Have income at or below 133% of the Federal Poverty Level ($14,856 individual, $20,123 couple)
- Not be eligible for Medicaid, Medicare or CHIP
- Be a legal immigrant for five years or more or be a US citizen
- Have a social security number or have applied for one

How can I apply?

Call 312-864-8200 or toll free 1-855-444-1661 to apply by phone or to find a CCHHS facility or participating FQHC location to apply in person.

We can help you find out if you should apply for CountyCare! You can call us at 312-864-8200 or toll free 1-855-444-1661. We are open Monday- Friday 8am to 8pm, and Saturday 9am to 2pm.

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS