HFS
Illinois Department of
Healthcare and Family Services

We improve lives.

Frequently Asked Questions

Health Benefits for Immigrant Adults (HBIA)
Health Benefits for Immigrant Seniors (HBIS)

The Health Benefits for Immigrant Adults (HBIA) and Health Benefits for Immigrant Seniors (HBIS) programs are state-funded programs created to provide medical coverage for immigrant adults and seniors who are ineligible for Medicaid due to their immigration status.

- Since the programs were initiated, customers were covered under HFS' Fee-for-Service (FFS) program model. Starting January 1, 2024, most customers are transitioning into managed care. The transition to managed care will be largely completed by April 1, 2024.
- Only those with other insurance or on spenddown will stay in HFS' FFS program. The rest will enroll in one of the HealthChoice Illinois Managed Care Organizations (MCOs).
- Managed care provides care coordination, added benefits and enhanced member support to help ensure the HBIA/HBIS populations receive needed services, including non-medical services, to address health related social needs. Materials are translated into primary languages and interpreters are available at every stage of interaction between the customer, the MCO and the provider.
- Starting 2/1/24, copayments and coinsurance ("cost-sharing") for certain hospital and surgical services, went into effect. Those enrolled in CountyCare will not have cost-sharing, as the MCO is waiving them. All other customers, including those in Fee-for-Service, may be charged only what is allowable under rule.
- Copays and cost-sharing may only be charged on the following services:
    - Non-emergency Inpatient Hospitalizations: $250 copayment per stay.
    - Non-emergency Hospital Outpatient Services or Ambulatory Surgical Treatment Center: 10% of what HFS would pay the provider. The amount an enrollee can be charged will vary depending on the service and the provider, and enrollees should check with their provider on whether they will need to pay an out-of-pocket cost for a service.
- Most services continue to be free for customers, including primary care visits, services provided at a Federally Qualified Health Center (FQHC) FQHC, prescription medications, non-surgical vision, dental and hearing services, vaccinations, transportation and more.

Enrollment:

Q: If I'm not already an HBIA or HBIS customer, can I enroll in one of the programs now?
A: No. New enrollment into the HBIA and HBIS programs was paused in 2023 in order to bring costs in line with the amount budgeted to pay for the programs.

Services:

Q: Are all Medicaid services covered for the HBIA/HBIS populations?
A: All Medicaid services, except those listed in the next question, are covered for the HBIA/HBIS populations. With the exception of those listed in the following question, all Medicaid services are covered for the HBIA/HBIS populations.

Q: What Medicaid services are not covered?
A: Long term care services, including nursing facility and home and community-based waiver services, are not covered. Transplant services are not covered except for kidney, bone marrow and stem cell transplants, which are covered.

Q: Are short term rehabilitation services allowed in a long-term care facility?
A: Yes, for those customers enrolled in a managed care organization, medically necessary post-acute **rehabilitation services** are covered in a nursing facility. This is in addition to services at a rehabilitation hospital and acute care hospital. Rehabilitation services in a facility are limited to no more than 90 days per episode and require a prior authorization from the MCO. Post acute rehabilitation services for those customers enrolled in Fee-for-Service are covered only in an acute or rehabilitation hospital setting.

Resources for those in Fee-for-Service (not enrolling in an MCO)

Q: Who is excluded from enrollment into an MCO?
A: Those with other insurance (in which case HBIA/HBIS is secondary) and those on spenddown will not enroll in managed care; they will stay in HFS' Fee-for-service program with claims paid by HFS.

Q: What is spenddown?
A: The spenddown program helps some people who have too much income or too many assets (like bank accounts and other resources) to qualify for full coverage in a given month. The program works a little like an insurance deductible. Once customers pay for or incur the cost of medical care up to or over their spenddown amount, full coverage is activated. Bills can be submitted and applied for several months at a time.

The amount of a monthly spenddown depends essentially on a customer's income and assets above the eligibility levels.

Q: If someone is not enrolled in an MCO, what help is available?
A: The Health Benefits Hotline provides support for anyone receiving medical benefits who are not enrolled in an MCO. Customers can call 1-800-226-0768 for help locating a provider. Choose option 2 for Spanish.

Enrollment in Managed Care Organizations (MCOs)

Q: Where can I get information about my MCO plan options and choose a plan?
A: Resources in English and Spanish can be found at enrollhfs.illinois.gov. Customers can also call the Client Enrollment Services line at 1-877-912-8880 (TTY: 1-866-565-8576) for information or to choose an MCO plan. Stay on the line to reach a customer services representative. Customers or their Approved Representative, will need either their Recipient Identification Number or Social Security Number to be able to speak to a representative. Translators are also available for other languages upon request.

Q: What is HealthChoice Illinois?
A: HealthChoice Illinois is the statewide managed care program that the HBIA/HBIS customers will enroll in, if required.

Q: What is managed care?
A: Managed care offers a full range of health care services while helping coordinate health care through care coordination. When someone enrolls in a managed care organization, they become a member of that health plan.

Q: What is Care Coordination and why is it important?
A: Care coordination through a Health Plan can help:

- Find a primary care provider (PCP) if you don't already have one
- Help manage health conditions like diabetes, high blood pressure, or asthma
- Give you information you need to stay healthy
- Help identify your health goals and create a care plan to achieve those goals

Q: What can a Care Coordinator help me do?
A: Some individuals will be assigned a care coordinator based on their health needs, but anyone can request a care coordinator. Care Coordinators will help members reach your goals. A care coordinator can:

- Answer questions about your care
- Help you find a doctor or specialist
- Help you transition out of a hospital or facility
- Help connect you with community resources

Q: What else is important to know about managed care?
A: In managed care, there is a network (group) of providers who work together to give you the healthcare you need. Once someone becomes a member of a health plan, they must visit doctors and other providers that are **in the health plan's network, unless there is a special agreement with an-out-of network provider**.

Q: What MCOs participate in the Healthchoice Illinois program?
A: Five (5) MCOs participate, they are listed below. Check out their websites for more information include provider and pharmacy lists, the member handbook and prescription drug list:

- Aetna Better Health of Illinois
  www.aetnabetterhealth.com/illinois-medicaid / 1-866-329-4701
- Blue Cross Community Health Plan
  www.bcbsil.com/bcchp/ | 1-877-860-2837
- CountyCare Health Plan (Cook County only)
  www.countycare.com | 1-855-444-1661
- Meridian Health Plan (Former Youth in Care Only)
  corp.mhplan.com/en/member/illinois | 1-866-606-3700
- Molina Healthcare
  www.molinahealthcare.com | 1-855-687-7861

Q: What should a customer consider in choosing an MCO plan?

A: The most important thing to consider is the network of providers, including pharmacies. Check with existing providers to see what MCO(s) they accept. Also consider whether the MCO is waiving cost-sharing requirements and what extra benefits they offer.

Cost-Sharing in the form of Copayments & Coinsurance:

Cost-sharing, in the form of copayments and coinsurance for specific services, went into effect on February 1, 2024. Most covered services will continue to be free for HBIA and HBIS customers.

Q: Will everyone in HBIA and HBIS have cost-sharing?
A: Customers in Fee-for-Service and most MCOs may be charged cost-sharing by their chosen medical provider. CountyCare Health Plan, an MCO serving customers in Cook County, has waived cost-sharing so anyone enrolled in CountyCare will not be charged cost-sharing. This means hospitals or surgical centers will not charge CountyCare members any out-of-pocket costs.

The remaining four MCOs and HFS (Fee-for-Service) have not waived copayments or coinsurance, which means that hospitals or surgical centers can charge those members cost-sharing in the form of allowable copayments and coinsurance.

Q: What cost sharing is permitted?
A: Per administrative rule, copayments and coinsurance **may only be** charged on the following services:

1. Non-emergency Inpatient hospitalizations: $250 copayment per stay

   For this purpose, a hospital is a general acute care, psychiatric, or rehabilitation hospital. If the hospital determines the admission is an emergency, there is no copayment.

2. Non-emergency Hospital Outpatient Services or Ambulatory Surgical Treatment Centers: Coinsurance will be in the amount of 10% of what HFS would pay the provider.

   - These are for services such as hip and knee replacements, eye surgeries, outpatient therapies, including physical therapy and occupational therapy, as well as treatments like chemotherapy.

   - The amount charged for coinsurance will differ depending on the service and the provider. Enrollees should check with the provider about whether

   - they will have coinsurance for a service. The provider may not be able to give a total dollar amount until after the procedure but can tell a customer whether there will be coinsurance.

- Some of these services may be available without cost-sharing at a provider that bills as a physician and not a hospital. In some cases, customers can choose providers that do not charge coinsurance.

Q: I understood that copays were also going to be required for non-emergency hospital ER services, but that requirement was removed. Is that true?
A: HFS submitted an amendment to the administrative rule to remove a previously planned $100 copay for non-emergency hospital ER services.

Q: How do I know if something is an emergency medical condition?
A: Ultimately, the hospital staff determines if a medical condition qualifies as an emergency, but HFS defines an emergency medical condition as a condition with symptoms severe and painful enough that a reasonable person would think they are life-threatening and need immediate medical care. Individuals who have severe symptoms that could be life threatening should not hesitate to seek immediate treatment, and in those instances will not have cost sharing requirements.

No copayment or coinsurance may be charged for an **emergency service** needed to evaluate or stabilize an emergency medical condition.

Q: Do hospitals need to apply for Emergency Medical for HBIA/HBIS customers served in the Emergency Department?
A: No, hospitals should not submit an application for Emergency Medical for people enrolled in HBIA/HBIS.

Q: Will services provided at an urgent care setting or immediate care setting have coinsurance?
A: Urgent care and immediate care clinics should not charge coinsurance because they are not part of a hospital. To be sure, ask the clinic before the appointment if they will charge coinsurance.

Q: What services will continue to be free with no cost-sharing?
A: Many services will continue to be free, including services or visits to:
- Primary care provider offices or Federally Qualified/Rural Health Centers (FQHCs and RHCs) Federally Qualified Health Center (FQHC) - Illinois | Page 9 (npidb.org).
- Public health departments
- Community mental health providers
- Non-surgical vision, dental, and audiology providers
- Prescriptions at pharmacies
- Durable medical equipment (DME)

- Vaccines, including those received at a pharmacy,
- Transportation

Other services may be free, if received and billed by a provider that is not a hospital. Customers should check with the provider to see if there will be coinsurance. Customers can ask their MCO or HFS to help find providers that will not charge a coinsurance.

Q: Which MCOs are charging copayments/coinsurance and which are not?

A: CountyCare, an MCO serving customers in Cook County, has waived all copayments and coinsurance. This means hospitals or surgical centers will not charge CountyCare members any out-of-pocket costs.

The remaining four MCOs and HFS (Fee-for-Service) have not waived copayments or coinsurance, which means that hospitals or surgical centers can charge those members cost-sharing in the form of allowable copayments and coinsurance. It is the responsibility of the provider to collect any copay or coinsurance, not the MCO.