Illinois Department of Healthcare and Family Services
Public Education Subcommittee
Approved Final Meeting Minutes
February 9th, 2017

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

Committee Members Present
Kathy Chan, Cook County Health & Hospitals System
Margaret Stapleton, Shriver Center
Lauren Angeles, for Sue Vega Alivio Medical Center
Sherie Arriazola, TASC
Erin Weir, Molina Healthcare
Kathy Waligora, for Nadeen Israel, EverThrive Illinois
Connie Schiele, HSTP (by phone)
Sergio Obregon, CPS (by phone)
Ramon Gardenhire, AFC
Brittany Ward, Primo Center for WC
Hardy Ware, East Side Health District (by phone)
John Jansa, Health & Disability Advocates

HFS Staff
Jacqui Ellinger
Lauren Polite
Elizabeth Lithila
Avery Dale
Arvind Goyal
Margaret Dunne
Veronica Archundia

Committee Members Absent

DHS
Patricia Reedy

Interested Parties
Paula Campbell, IPHCA
Dave Herman, Ameri Health
Jason Brokaw, Ameri Health
Ralph Schubert, UIC DSCC
Jill Hayden, Meridian
Cyrus Winnett, IAMHP
Sandy DeLeon, Ounce of Prevention
Anna Wojeik, VI Health
Nicole Kazee, Erie Family Health
Enrique Salgado Jr., WellCare Health Plans
Jessie Beebe, AFC
Jackie Jackson, Blue Cross & Blue Shields
Jessica Rhoades, Legal Council for Health and Justice
Luvia Quiñones, ICIRR
Anna Carvallio, LaRabida Children Hospital
Tammy Smith, Blue Cross & Blue Shields
Laura Jones,
Chris Gu, Patient Innovation Center

Interested Parties (by phone)
Susan Melczer, Illinois Health and Hospital Association
Christy Johnston, Premier Governmental Health Services
Nelson Soltman,
Dave Lecik, Illinois Department of Aging
Kristin Hartsaw, DuPage Federation on Humans Services Reform

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1. **Introductions**
   Chairperson Kathy Chan, from CCHHS, conducted the meeting. Attendees in Chicago and Springfield introduced themselves.

2. **Review of Minutes**
   Ramon Gardenhire made a motion to approve the minutes from the December 1st meetings, which was seconded by Margaret Stapleton. The minutes were approved by a vote of ten members in favor and zero opposed.

3. **Care Coordination Update**
   Robert Mendonsa provided a care coordination report. He announced that the Managed Care Provider Complaint portal is expected to be up and running by the third week of February. He noted that this portal will provide an avenue through which medical providers will be able to submit complaints to HFS about issues encountered with any of the Illinois Medicaid Manged Care Organizations (MCOs). He added that the complaint portal will offer a secure way to report any unsuccessful attempt to resolve a concern involving a Managed Care Organization. Mr. Mendonsa asserted that the main goal of this initiative is to address and answer MCO-related questions in a secure, electronic format. It is expected that MCOs will respond to urgent complaints within two business days (such as the case of immediate prescription needs or access to care needs) and 15 business days for all other issues.

   Mr. Mendonsa emphasized that in order to have a complaint reviewed by an HFS staff member, it is imperative that the issue must first have been taken to the MCO involved. He advised that detailed instructions about the provider complaint portal can be found at:
   https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/ManagedCareComplaints.aspx
   He noted that there is no change in protocol for the resolutions of any complaints involving clients in Medicaid Fee-for Service, which should be directed to HFS at: 877-782-5565.

   Robert Mendonsa indicated that during December of 2016, HFS temporarily suspended the mandatory managed care enrollment into the Family Health Plans (FHP) and ACA Health Plans in the Central Illinois Region. The counties affected are Champaign, Christian, DeWitt, Ford, Logan, Macon, Menard, Piatt, Sangamon, and Vermilion. He indicated that individuals who were dis-enrolled from Health Alliance Connect, as of December 31, 2016, became regular fee-for service, and therefore, they can access services using the Healthcare and Family Services Medical card. Members are not permitted to enroll in Molina at this time since there is not a choice of MCOs. However currently enrolled Molina members can remain enrolled. Robert Mendonsa ended his presentation indicating that the Quality Care reports will be published during the summer of 2017.

4. **Public Education Subcommittee Charge**
   Chairperson Kathy Chan led a discussion about the Public Education Subcommittee Charge. She indicated that, in accordance with the Medicaid Advisory Committee (MAC), anytime during the first two meetings of the year, committee members should have the opportunity to discuss, offer, and proposed changes to the Public Education Subcommittee charge. Sherie Arriazola asked if issues related to access could be included within the domain of the Public Education Subcommittee or Quality Care Subcommittee. Kathy Chan suggested providing specific details regarding this inquiry so that they can be further discussed with the MAC, which is the entity that has the authority to amend the charge of any of the subcommittees. Ms. Chan encouraged committee members to offer any additional suggestions to veronica.archundia@illinois.gov

   John Jansa recommended improving communication among the subcommittees in order to ensure awareness of issues discussed in the various subcommittees. Kathy Chan noted that she presented a

summary of the issues discussed during the Public Education Subcommittee to the full MAC meeting held on December 1st, 2016. This report was published along with the agenda and meeting materials for the Medicaid Advisory Committee. Mr. Jansa's recommendation will be scheduled for further discussion at the next Medicaid Advisory Committee on May 5th, 2017.

5. ABE/IES Update

Jacqui Ellinger provided an ABE/IES update, indicating that HFS and DHS will continue efforts at identifying any potential coding problems in the system in the effort to lower the risk of errors for the completion of the Integrated Eligibility System (IES). Kathy Chan indicated that, even though medical providers are eager to see that IES Phase Two is launched, it is more important to get it right than rushing it. Ms. Ellinger noted that, although IES will not be perfect, it has been a huge endeavor to replace a complex system that has been operating for the past 30 years. HFS has not yet made a decision as to when IES Phase Two will be launched.

6. Medicaid Redetermination Update

Elizabeth Lithila discussed a handout regarding the redetermination report; she noted that the numbers remain consistent with those of previous reports. Erin Weir suggested that, in order to have a better understanding of the tendencies and trends concerning the clients' redetermination process and outcomes, it would be helpful to indicate a specific number of clients instead of percentages. Elizabeth Lithila will take the suggestion into consideration. She also noted that the IMRP reports continue to be published on the HFS web site:
https://www.illinois.gov/hfs/SiteCollectionDocuments/IMRPQtrlyReport(Q2FY2017).pdf

7. Criminal Justice Update

Elizabeth Lithila reported on the combined efforts among DHS, HFS, and DOC to develop a pilot project accessing state medical benefits for IDOC inmates. She said that the main focus has been to ensure that all inmates are enrolled before their release. Currently, HFS and DHS are waiting for the Department of Corrections and the Department of Innovation and Technology (DoIt), in order to complete the installation of special computers so that inmates will be able to submit their applications electronically.

Kathy Chan asked if the DOC applications are being processed like a regular ABE application. Elizabeth indicated that DHS selected two FCRCs to process these applications to identify issues and identify best practices. Sherie Arriazola asked about the letter that inmates will receive prior to their release. Elizabeth indicated that the IDOC Community Release Change Form will be printed by the DOC facility as part of the paperwork that inmates receive upon their release.
Elizabeth also provided her contact information in order to address any additional concerns:
Elizabeth.Lithila@illinois.gov

8. Open Discussion and Announcements

Avery Dale discussed a notification recently sent to a selected group of clients, titled "HFS Courtesy Letter to Clients with Medicaid Spenddown." Mr. Dale said that this notice targeted 8,300 individuals who have received Medicaid through Spenddown for at least one month during 2016. The notice explains that getting Medicaid coverage through Spenddown is not considered MEC (Minimum Essential Coverage) by the IRS. Therefore, recipients could be subject to a tax penalty. However, having Medicaid through Spenddown does make these individuals eligible to apply for a hardship exemption from the personal responsibility tax, as is indicated within the letter.

Avery Dale reported that HFS sent 2.2 million 1095-B forms to every household in which at least one person had minimum essential coverage though Illinois Medicaid for at least one month during 2016.

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Avery said that the 1095-B form shows the months in which someone was covered by Medicaid and is used for informational purposes to help people fill out their tax returns. He added that people may also use a printout from MEDI which shows coverage for the year, or some other proof of insurance. Mr. Dale suggested that if a customer does not receive the letter or receives it but suspects that the information is not accurate; the individual should call the ABE Customer Call Center (1-800-843-6154) or contact a staff member at any FCRC who can review the coverage indicated within the system to check for any errors. Local Office staff members can update an address and send another copy as well as reprint a form that was misplaced or never received.

Chairperson Kathy Chan stated that she will be absent during the next Public Education Subcommittee scheduled for April 13th, 2017. Ramon Gardenhire recommended that Nadeen Israel chair the meeting. Although Nadeen was not present at the February 9th meeting, Kathy Waligora, who was representing Nadeen, stated that she had received an e-mail confirmation that Nadeen had agreed to chair the April meeting.

Lauren Polite reported that there has been a positive response to the 2017 Get Covered Illinois campaign during Open Enrollment on the Marketplace. She indicated that upon conclusion of the open enrollment period and beginning February 1st, there would no longer be staff answering the Get Covered Illinois phone number. Instead there would be an automatic message telling people to contact Healthcare.gov (1-800-318-2596) for marketplace questions or the ABE Customer Call Center (1-800-843-6154) for Medicaid questions. A small staff of 3-4 remains at GCI under the Illinois Department of Insurance.

Jacqui Ellinger stated that there has been an effort to make the ABE Call Center more responsive by hiring additional staff members. They have received appropriate IES training. Managers have adjusted how phone calls are being queued in order to improve customer service. Kathy Chan inquired if is it possible to provide a grid showing the different customer service numbers and describing the various program functions and purposes.

Sergio Obregon reported that during the upcoming weeks, the Chicago Public Schools will resume providing assistance to families interested in applying for medical coverage and food stamps benefits. He added that CPS, in partnership with community organizations, will be coordinating efforts so that families can receive the assistance needed to apply for and maintain their benefits.

John Jansa asked what materials HFS needs to review before MCOs are authorized to send announcements to their members, particularly in terms of client brochures and promotional materials. He asked if there will be an opportunity for the Public Education Subcommittee to review any of these materials. He is specifically interested in any materials that focus on care coordination and access to care.

Finally, Chairperson Kathy Chan reminded members of the committee to send their agenda topic recommendations to veronica.archundia@illinois.gov

9. Adjournment

The meeting was adjourned at 12:02 p.m. The next meeting is scheduled for April 13th, 2017, between 10:00 a.m. and 12:00 p.m.

Dear Illinois Healthcare Member, January 12, 2017

Attention: The information on this letter applies to you ONLY IF you are required to file federal taxes.

Under the Affordable Care Act (ACA), most people are required to have health coverage for the entire year that meets certain "Minimum Essential Coverage" (MEC) standards. Persons who do not have MEC may have to make a Shared Responsibility Payment when they file their taxes unless they qualify for an exemption.

Our records show you or someone in your household got Medicaid by meeting spenddown for one or more months in 2016. Eligibility for Medicaid because of spenddown is possible when someone uses medical receipts or bills, or pays the state a certain amount of money to meet their spenddown.

While full **Medicaid is considered MEC, receiving Medicaid through spenddown is NOT considered MEC according to the IRS .** However, special tax rules do allow someone eligible for Medicaid through spenddown to request a 'hardship exemption'. If an exemption request is approved, the Marketplace will give an Exemption Certificate Number (ECN) to put on a federal income tax return exempting the person from a Shared Responsibility Payment.

Follow these steps to apply for the hardship exemption. Apply as soon as possible.

Step 1: Look through your records to see what month(s) you or someone in your household had Medicaid by meeting spenddown. If you don't have records, you can still apply for a hardship exemption.

Step 2: Get an ***Application for Exemption from the Shared Responsibility Payment for Individuals who Experience Hardships*** at: https://marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf

Step 3: Read the instructions on the form. Start filling out the form on page 2. Page 3, Question 8 lists the hardship reasons. If you received Medicaid because you met spenddown for at least one month out of the year, fill in the circle for #14 and write in the following [Note, if you don't know the specific months, put in the months you think you were eligible through spenddown]:

[*The name of the person who met spenddown***] had 209(b) Medicaid coverage because he or she met the spenddown amount in at least one month during 2016.** [*He or she*] **got medical coverage for** [*enter the months and year the person had spenddown coverage*] **and did not get coverage for** [*enter the months and year the person did not get coverage*] **because** [*he or she*] **did not meet spenddown.**

Step 4: Make a copy of the hardship exemption application and keep it with your other health care information. You do **NOT** need to send copies of medical records or notice of coverage. **Mail only the original application to:** 465 Industrial Blvd London, KY 40741

- A tax preparer can help you with your hardship exemption application.
- You can also get help by calling the Marketplace Call Center at 1-800-318-2596, TTY 1-855-889-4325.

Estimado beneficiario de servicios de salud en Illinois, 12 de enero de 2017

Aviso Importante: La información incluida en esta carta está dirigida a usted SOLAMENTE SI usted está obligado a presentar una declaración federal de impuestos.
De acuerdo a la Ley de Cuidado de Salud, también conocida como Affordable Care Act (ACA), se requiere que la mayoría de las personas tengan cobertura de salud por todo el año, y así cumplir con el requisito de Cobertura Mínima Esencial, conocido en inglés como (MEC). **Las personas que no tengan MEC podrían tener que pagar una multa o "Shared Responsibility Payment" cuando hagan su declaración de impuestos, a menos que califiquen para una excepción.**

Nuestros registros indican que usted o alguien en su hogar recibió Medicaid en 2016, ya sea por uno o varios meses al haber cumplido con su "obligación de pago" o "spenddown." La elegibilidad de Medicaid por medio del programa de spenddown es posible cuando alguien envía facturas, recibos médicos, o paga al Estado cierta cantidad de dinero para cumplir con su obligación de pago. En los avisos en inglés **a esto se conoce como "meeting your spenddown."**

De acuerdo al IRS recibir cobertura completa de Medicaid se considera como MEC, pero recibir Medicaid a través de spenddown NO es considerado MEC. Sin embargo existen reglas fiscales que permiten a ciertas personas que reciben Medicaid por medio del programa de spenddown solicitar una "excepción por dificultad". Esto se le conoce en inglés como una petición de "hardship exemption." Si se aprueba la petición de excepción, el "Mercado de Seguros Médicos" o "Marketplace" enviará a esa persona un Número de Excepción Certificado llamado "Exemption Certificate Number (ECN)" para que lo escriba en su declaración federal de impuestos sobre el ingreso y así la persona estará evitando pagar una multa, conocida en inglés como "Shared Responsability Payment."

Siga estos pasos para solicitar la excepción por dificultad. Aplique lo más pronto posible.

Paso 1: Revise sus registros para saber en qué mes o meses, usted o alguien en su hogar recibió Medicaid por medio del programa de spenddown. Si usted no tiene esta información, no importa ya que aún puede solicitar la excepción por dificultad o "hardship exemption."

Paso 2: Obtenga el formulario de excepción, conocido en inglés como "*Application for Exemption from the Shared Responsibility Payment for Individuals who Experience Hardships" en el sitio web*:
https://marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf

Paso 3: Lea las instrucciones y llene el formulario en la página 2. En la página 3, Pregunta 8, enliste sus razones de dificultad. Si usted recibió Medicaid debido a que cumplió con su obligación de pago por lo menos uno o más meses durante el año, marque el círculo de la pregunta número 14. Recuerde, si no sabe los meses específicos, escriba los meses que usted cree fue elegible a través del programa de sependdown, y escriba lo siguiente:

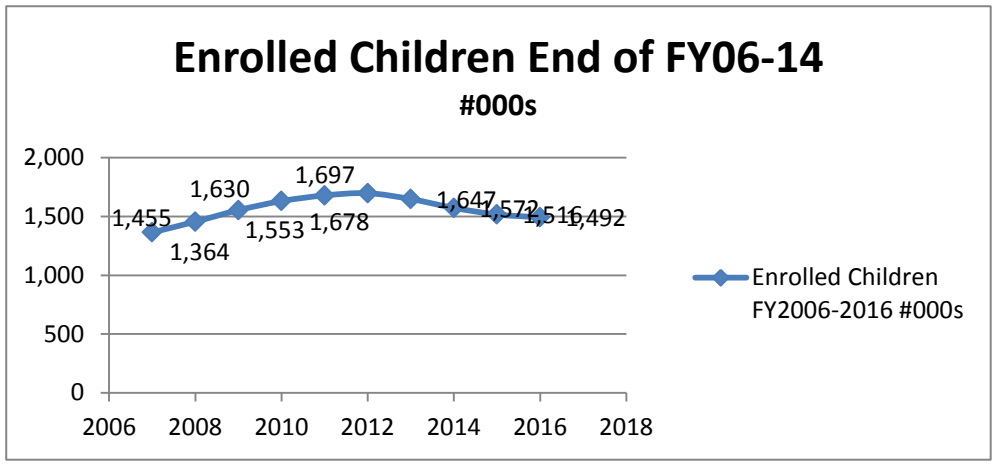
> *El nombre de la persona que cumplió con su obligación de pago*] **tuvo 209(b) cobertura de Medicaid debido a que él o ella cumplió con su obligación de pago por lo menos un mes durante 2016.[***Él o ella***] recibió cobertura médica por [***escriba los meses y el año que la persona recibió cobertura por medio del programa de spenddown***] y no recibió cobertura para** [*escriba los meses y año que la persona no recibió cobertura*] **debido a que [**él o ella**] no cumplió con su obligación de pago.**

Paso 4: Haga una copia y guarde la solicitud de excepción para sus registros personales. Usted **NO** necesita enviar copias de los documentos o avisos de su cobertura médica. **Envíe solamente la solicitud original a: 465 Industrial Blvd London, KY 40741**

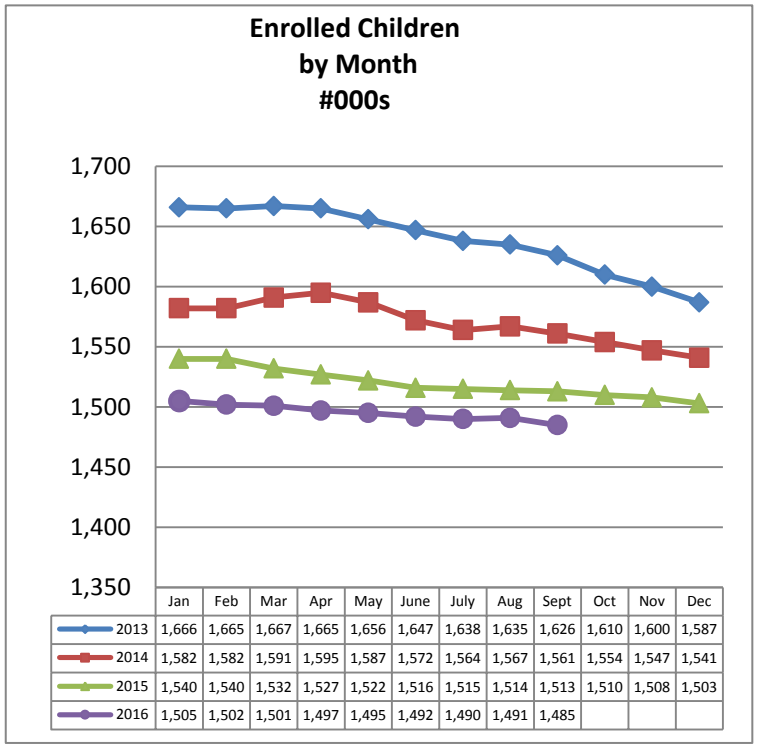
- Un preparador de impuestos puede ayudarle con su solicitud de excepción de dificultad.
- También puede obtener asistencia por medio del Centro de Ayuda del Mercado de Seguros de Salud llamando al 1-800-318-2596, TTY 1-855-889-4325.

Children's Enrollment

End of FY	Enrolled Children FY2006-2016 #000s
2007	1,364
2008	1,455
2009	1,553
2010	1,630
2011	1,678
2012	1,697
2013	1,647
2014	1,572
2015	1,516
2016	1,492



End of Month 2013	Enrolled Children #000s	End of Month 2014	Enrolled Children #000s	End of Month 2015	Enrolled Children #000s	End of Month 2016	Enrolled Children #000s
Jan	1,666	Jan	1,582	Jan	1,540	Jan	1,505
Feb	1,665	Feb	1,582	Feb	1,540	Feb	1,502
Mar	1,667	Mar	1,591	Mar	1,532	Mar	1,501
Apr	1,665	Apr	1,595	Apr	1,527	Apr	1,497
May	1,656	May	1,587	May	1,522	May	1,495
June	1,647	June	1,572	June	1,516	June	1,492
July	1,638	July	1,564	July	1,515	July	1,490
Aug	1,635	Aug	1,567	Aug	1,514	Aug	1,491
Sept	1,626	Sept	1,561	Sept	1,513	Sept	1,485
Oct	1,610	Oct	1,554	Oct	1,510		
Nov	1,600	Nov	1,547	Nov	1,508		
Dec	1,587	Dec	1,541	Dec	1,503		



Medicaid Redetermination Data

I. Case Level Maximus Related Redetermination Activity Summary (reflects month in which action was taken)

State Decision	**October**	**November**	**December**	**3 Month Total**	**FY17**	**FY17 Percent**
Continue	23,723	20,477	22,046	66,246	139,292	41%
Change	5,814	5,112	5,068	15,994	35,279	10%
Cancel	27,013	23,999	29,955	80,967	163,847	48%
Reason for Cancellation						
% Lack of Response	80%	79%	80%		80%	
% Other	20%	21%	20%		20%	
TOTAL	**56,550**	**49,588**	**57,069**	**163,207**	**338,418**	

II. Summary Case Level Activity for all Redeterminations

	October	**November**	**December**	**3 Month Total**	**FY17**
Total W/ Maximus Involvement	56,550	49,588	57,069	163,207	338,418
Continuation/Change	29,537	25,589	27,114	82,240	174,571
Initial Cancellations	27,013	23,999	29,955	80,967	163,847
Total W/o Maximus Involvement	80,444	81,884	93,425	255,753	523,349
Continuation/Change	65,797	67,480	78,043	211,320	423,129
Initial Cancellations	14,647	14,404	15,382	44,433	100,220
Continuation/Change Language Preference	**October**	**November**	**December**	**3 Month Total**	**FY17**
English	83,071	80,888	91,943	255,902	429,793
Spanish	9,725	9,681	11,111	30,517	60,214
Unknown	2,538	2,500	2,103	7,141	16,202
TOTAL	95,334	93,069	105,157	293,560	506,209
Cancellation Language Preference	**October**	**November**	**December**	**3 Month Total**	**FY17**
English	38,138	34,753	40,883	113,774	239,563
Spanish	2,968	3,042	3,472	9,482	20,280
Unknown	554	608	982	2,144	4,224
TOTAL	41,660	38,403	45,337	125,400	264,067

III. Individual Level Cancellation Data

	October	**November**	**December**	**FY17**
Total Initial Cancellations	66,709	61,890	70,876	418,693
Return from Cancellation	12,606	9,409	6,372	83,680
Net Cancellations	54,103	52,481	64,504	335,013
% persistent after 1 month	88%	90%	91%	
% persistent after 2 months	85%	85%	---	
% persistent after 3 months	81%	---	---	

NOTES:

Maximus system data based on January 3, 2017 data extract; EDW data based on January 5, 2017 extract.

Data covers fiscal year 2017 of IMRP, which started in July, 2016. Attribution to a month reflects the month in which a decision was made, not necessarily the month in which the decision was effective. Notes on individual sections follow:

I. Case level data from Maximus system

a. There are small fluctuations in determinations completed for previous months due to determinations completed retroactively.

II. Case level data from both Maximus system for those cases in which Maximus was involved (primarily cases without benefits in addition to Medicaid) and from EDW for those in which Maximus was not involved (cases with other benefits in addition to Medicaid). Lower cancellation rate for clients who have additional benefits (primarily SNAP) reflects the fact these clients return information more promptly because the loss of food support is much more immediate. Medicaid tends to be regarded as a benefit accessed when needed. (For the same reason, the more a client uses Medicaid, the more likely information will be returned promptly.)

III. Data is at individual level from EDW. Table shows that a significant number of clients return to the rolls, some of them fairly immediately when they present required information.

January 2017

To: The Honorable Bruce Rauner, Governor and Members of the General Assembly

Please find attached three reports concerning the Illinois Medicaid Redetermination Project (IMRP) undertaken by the Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) pursuant to PA 97-0689 (also known as the SMART Act). These reports summarize the work that has been done in Quarter 2 of Fiscal Year (FY) 2017. Included are:

- A report of overall activity in Quarter 2 of Fiscal Year 2017;
- A report of agreement of the State with Maximus recommendations during Quarter 2 of Fiscal Year 2017; and
- A report on the reason for State disagreement with Maximus recommendations during Quarter 2 of Fiscal Year 2017.

Summary

- Since beginning in February 2013, IMRP has reviewed almost 2.37M cases for redeterminations of eligibility.
- For Quarter 2 Fiscal Year 2017, IMRP initiated reviews on about 65,000 cases each month.
- About 41% of clients responded and were found eligible for the same medical coverage.
- About 10% of clients responded and were found eligible for a different medical program or for a different number of people in the household.
- About 48% of clients were cancelled, mostly for failing to respond to the redetermination request.
- Of the total clients initially cancelled, approximately 15% cooperated within three months and were reinstated. This equated to an overall cancellation rate of approximately 30% for all cases reviewed.
- The State decision agreed with the Maximus electronic determination about 85% of the time for cases that cooperated with the review.
- When clients responded, about 55% of disagreements with the Maximus recommendation were due to the State verifying other income, not available to Maximus, which affected the client's eligibility.

Background

The goal of the IMRP is to process the backlog of cases that under federal law require redeterminations of eligibility and to ensure that redeterminations are processed in a timely manner so that Medicaid eligibility is verified on an annual basis. The IMRP is improving Medicaid program integrity by validating that clients who qualify for medical benefits receive them, while those who do not qualify are disenrolled. This is particularly important as the State of Illinois has transitioned most clients into managed care and generates monthly capitation payments based on

enrollment as opposed to processing payment for claims for specific services used by each client.

Phase One

The contract with Maximus was signed in September 2012. Implementation, while experiencing some start-up difficulties, proceeded and Maximus was conducting case reviews in early 2013, the same time DHS began bringing on additional caseworkers to focus solely on Medicaid redeterminations.

Due to the backlog in annual redeterminations, HFS and DHS prioritized identification of cases with clients who had the greatest likelihood of being ineligible for the Medicaid program or enrolled in the wrong medical benefit group. Accordingly, Maximus ran the entire database and applied high-level filters to identify and prioritize those cases requiring immediate attention, regardless of the client's annual redetermination date.

Maximus would review a case using evidence from high-level filters and assess what issues needed to be resolved before the client's eligibility could be determined. It then attempted to use additional databases to obtain other information and, in some cases, would contact clients when more information was necessary. At the end of the response period, Maximus would pull together all the available data, including documentation from the client, and post a recommendation on a secure Internet site for State caseworkers. The assigned caseworkers would then review the assembled information and make a final determination as to whether the client was eligible or ineligible for the Medicaid program and enter the redetermination accordingly into the State system.

In 2013, an external arbitrator, responding to an AFSCME-filed grievance, ruled that the contract with Maximus violated the State's Collective Bargaining Agreement. To avoid disruption, HFS amended the contract with Maximus in December 2013 to conform to the ruling and streamline the redetermination process while maintaining some of Maximus' most positive performance aspects.

Altogether, Phase One of the IMRP resulted in the review of 360,741 cases by State caseworkers that Maximus had previously reviewed and the cancellation of 148,283 (41%) of these cases. However, about 20% (27,769) were reinstated within three months leaving a net cancellation rate of 33% of all cases reviewed.

Phase Two

Under the amended contract and in conformance with the SMART Act, Maximus continues to provide electronic review of all cases to make a preliminary recommendation on the likelihood of a client's eligibility. The amended contract has resulted in a substantial reduction in the monthly cost of the contract, dropping from an average of $3.2M per month under the original contract, to an estimated FY16 average of $1.2M per month. Maximus provides the underlying software used for data matching, process management and reporting. Maximus also continues to provide call center and mail room capabilities until the State's new eligibility system is fully implemented and staffed.

DHS maintains two redetermination centers that handle redeterminations for Medicaid clients who do not participate in the Supplemental Nutritional Assistance Program (SNAP) or receive cash assistance.

Medicaid redeterminations for clients participating in SNAP or cash assistance will continue to be conducted as part of their SNAP or cash redeterminations. HFS also has casework units that process redeterminations for specified medical benefit groups.

Attachment 1 contains a report on Phase Two of the IMRP during Fiscal Year 2017, with particular focus on the quarter ending December 30, 2016. These results show:

- A continued high level of cancellations for cases without SNAP (48%), a level consistent with previous quarters;
- Most of the cancellations (87% for the quarter) are because the client failed to return information; and
- The percentage of cases cancelled for clients with SNAP is 17% in in Quarter 2 of Fiscal Year 2017.

HFS believes the reason for the difference in the two cancellation rates is that clients receiving SNAP have a stronger incentive to timely return information, as failure to do so results in immediate termination of a benefit needed for day-to-day survival. A comparison of medical use rates for those clients who cooperate and are reinstated supports this finding. Clients who cooperate within three months used, on average, $2,458 in medical services in the prior six months; whereas, clients who remain canceled after three months averaged less than half the same usage, only $1,176 in medical services over the prior six months.

Data has shown that the effective cancellation rate will be lower than the initial cancellation rate reported because as clients realize they have been cancelled, many will return required information. During FY17, 20% of clients initially cancelled following review returned within three months after cancellation. HFS continues to work with Maximus and community advocates to find ways of getting more clients to return information in a timely way to avoid unnecessary churn. HFS has also developed a procedure to identify individuals residing in long-term care facilities, enrolled in managed care and receiving Department of Aging (DoA) services who are coming up for redetermination. By working with the facilities, managed care organizations and DoA to assist recipients with completing the redetermination process, HFS hopes to reduce churning.

It should also be noted that the rate of cases reviewed in Phase Two continues at a high level. In Quarter 2 of Fiscal Year 2017, IMRP reviewed 163,207 cases. Maximus currently initiates reviews on approximately 65,000 cases per month.

Reasons for Disagreement

Agreement with Maximus recommendations remains relatively high for those cases where the client actually responds to the redetermination form. The recommendation by Maximus is developed entirely from electronic sources and does not take into account whether the client will return necessary information. As HFS has improved the number of electronic sources available to Maximus, the number of cases for which Maximus makes an electronic recommendation has increased to encompass most of

the cases being reviewed (99.9%). If the client does not return the required information, however, the client is cancelled for non-cooperation. A very large percentage of cancellations are due to client non-response.

For Quarter 2 of Fiscal Year 2017, the ultimate outcome agreed with the Maximus recommendation for cancellation about 85% of the time when cases cancelled for non-response are excluded. Attachment 3 illustrates that when this recommendation is not implemented, it is usually because income has not been applied correctly. This is due to the State verifying other income, from the client or other sources not available to Maximus, that affects the client's eligibility. Certainly, at least some percentage of clients who did not respond did so because their circumstances were such that they were indeed not eligible. The people who are more likely to respond are those who are eligible.

HFS also knows, from the high level of reinstatements, that many clients who do not respond are eligible but for a variety of reasons are late to return the required information. In only about 18% of cases where the client responds, are the individuals found to be ineligible (Attachment 2.1). In 7% of cases disagreeing with the Maximus recommendation (Attachment 3), the State caseworker was able to identify other income not available to Maximus. In total, where Maximus recommended continuation and the client responded, the State caseworker confirmed this and the case was continued 96% of the time.

Conclusion

The volume of redeterminations of Medicaid eligibility is stable. Processing capacity is driven by the capacity of state caseworkers and is expected to remain stable as long as support from Maximus continues until Phase 2 of IES is deployed.

HFS will continue to report regularly on the progress of the IMRP and a rolling summary of redeterminations for the three previous months can be found at http://www.illinois.gov/hfs/MedicalClients/medrede/Pages/default.aspx. Other information on IMRP can also be found on the HFS website.

Attachment 1

Medicaid Redetermination Activity, Redeterminations finalized by Maximus and HFS/DHS

(October - December, 2016)

I. Case Level Maximus Related Redetermination Activity Summary
(reflects month in which action was taken)

State Decision	**October**	**November**	**December**	**3 Month Total**	**FY17**	**FY17 Percent**
Continue	23,723	20,477	22,046	66,246	139,292	41%
Change	5,814	5,112	5,068	15,994	35,279	10%
Cancel	27,013	23,999	29,955	80,967	163,847	48%
Reason for Cancellation						
% Lack of Response	80%	79%	80%		80%	
% Other	20%	21%	20%		20%	
TOTAL	**56,550**	**49,588**	**57,069**	**163,207**	**338,418**	

II. Summary Case Level Activity for all Redeterminations

	October	**November**	**December**	**3 Month Total**	**FY17**
Total W/ Maximus Involvement	56,550	49,588	57,069	163,207	338,418
Continuation/Change	29,537	25,589	27,114	82,240	174,571
Initial Cancellations	27,013	23,999	29,955	80,967	163,847
Total W/o Maximus Involvement	80,444	81,884	93,425	255,753	523,349
Continuation/Change	65,797	67,480	78,043	211,320	423,129
Initial Cancellations	14,647	14,404	15,382	44,433	100,220
Continuation/Change Language Preference	**October**	**November**	**December**	**3 Month Total**	**FY17**
English	83,071	80,888	91,943	255,902	429,793
Spanish	9,725	9,681	11,111	30,517	60,214
Unknown	2,538	2,500	2,103	7,141	16,202
TOTAL	95,334	93,069	105,157	293,560	506,209
Cancellation Language Preference	**October**	**November**	**December**	**3 Month Total**	**FY17**
English	38,138	34,753	40,883	113,774	239,563
Spanish	2,968	3,042	3,472	9,482	20,280
Unknown	554	608	982	2,144	4,224
TOTAL	41,660	38,403	45,337	125,400	264,067

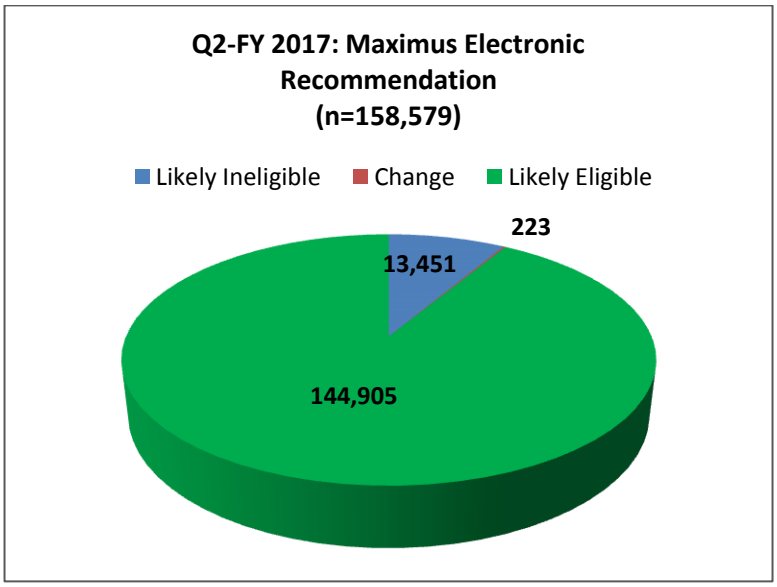
III. Individual Level Cancellation Data

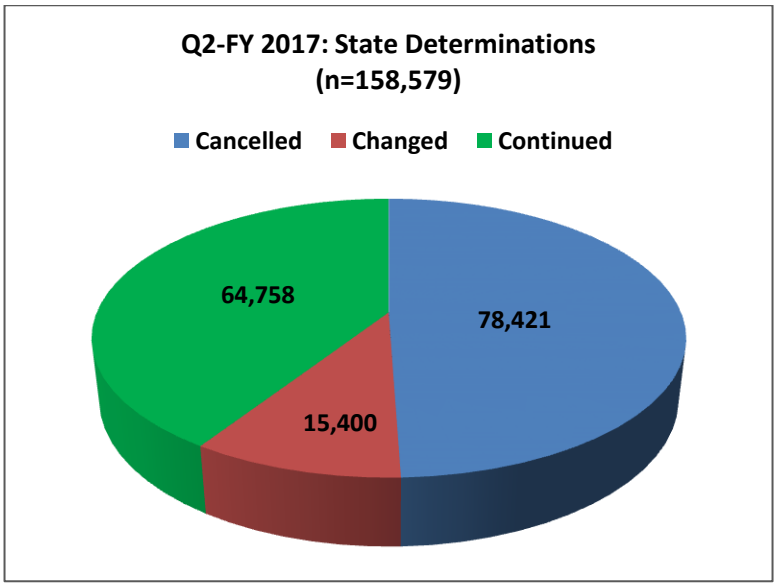
	October	**November**	**December**	**FY17**
Total Initial Cancellations	66,709	61,890	70,876	418,693
Return from Cancellation	12,606	9,409	6,372	83,680
Net Cancellations	54,103	52,481	64,504	335,013
% persistent after 1 month	88%	90%	91%	
% persistent after 2 months	85%	85%	---	
% persistent after 3 months	81%	---	---	

Attachment 2
State Agreement with Max-IL Electronic Recommendations
(October - December, 2016)

State Determination Agreement with Maximus Electronic Recommendation

Reporting Period: Q2-FY 2017 State Determination	State Agreements by MAXIMUS Electronic Recommendation					
	LIKELY INELIGIBLE	CHANGE	LIKELY ELIGIBLE	Grand Total	% AGREE	% DISAGREE
CANCELLED	10,517	133	67,771	78,421	13.41%	86.59%
CHANGED	583	33	14,784	15,400	96.21%	3.79%
CONTINUED	2,351	57	62,350	64,758	96.28%	3.72%
Grand Total	**13,451**	**223**	**144,905**	**158,579**		

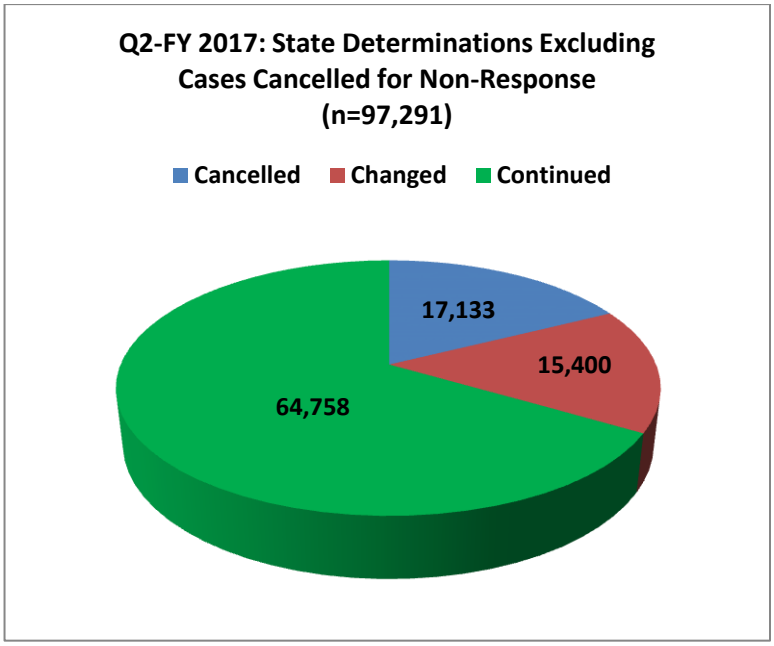




NOTES:

1. The electronic matching by Maximus occurs each month after the cohort of cases subject to redetermination is selected. Approximately 65,000 medical only cases are pulled for redetermination each month. Maximus runs electronic data matches to verify the continued eligibility of clients in the household. The results are compiled and an electronic recommendation of the likelihood of continued eligibility is made.
2. Most cases receive a recommendation of eligible, ineligible or change in some key eligibility factor on the case. When Maximus can find no electronic information sufficient to verify income, the case receives an electronic recommendation of insufficient information. There were no cases with insufficient data in Q2-FY 2017. When Maximus is unable to conduct any match of case information against any electronic data, no recommendation is made and the case is marked unable to match.
3. At approximately the same time that Maximus runs data matching, the vendor mails redetermination forms to each household in the monthly cohort. Upon receiving a response from the customer, Maximus' mail room staff scans the information provided into the case's electronic file.
4. State caseworkers review the recommendation and documents provided by Maximus to make a final determination of ongoing eligibility. Caseworkers use the State's eligibility system to process the redetermination and enter results in the State's system of record.
5. Customers who fail to provide information about current eligibility are cancelled for non-cooperation and have three months to provide the information to be reinstated, as required by federal law. After three months, the customer must reapply to begin medical assistance.

Attachment 2.1
State Action Excluding Cases Where Client Fails to Respond
(October - December, 2016)



Reporting Period: Q2-FY17	# State Determinations	Percent of State Determinations
CANCELLED	17,133	17.6%
CHANGED	15,400	15.8%
CONTINUED	64,758	66.6%
Grand Total	**97,291**	**100.0%**

NOTES:

6. State actions are more congruent with Maximus electronic recommendations when excluding cases where the client failed to cooperate with redetermination efforts. The percentage of remaining cases determined by the State to have continued eligibility comprises two-thirds (67%) of total determinations, compared to Maximus' electronic recommendations of 'Likely Eligible' for 96% of cases (Attachment 2).

7. This difference is most striking when examining cases the State cancels; only 13% (n=10,517) of Maximus electronic recommendations are deemed 'Likely Ineligible' (Attachment 2). When removing those cancelled for failure to comply, the percentage of cases cancelled by State action increases to 18% (n=17,133) versus nearly half of all State actions when including cancellations where the client does not return information (Attachment 2.1).

Attachment 3
Reasons for State Disagreement with Max-IL Electronic Recommendations
(October - December, 2016)

MAXIMUS Electronic Recommendation					
Reporting Period: 2Q-2017	**CHANGE**	**LIKELY ELIGIBLE**	**LIKELY INELIGIBLE**	**Grand Total**	**% of Total**
HOH Failed to Cooperate	**124**	**61165**	**161**	**61450**	**87%**
Oct	50	20258	47	20355	29%
Nov	36	18258	52	18346	26%
Dec	38	22649	62	22749	32%
Income Not Correctly Applied	**31**	**3441**	**1495**	**4967**	**7%**
Oct	10	1209	512	1731	2%
Nov	6	1018	412	1436	2%
Dec	15	1214	571	1800	3%
Post Recommendation Information on Income Presented	**5**	**1309**	**361**	**1675**	**2%**
Oct	4	489	135	628	1%
Nov	0	419	99	518	1%
Dec	1	401	127	529	1%
Post Recommendation Member Change	**9**	**824**	**130**	**963**	**1%**
Oct	5	376	78	459	1%
Nov	2	233	23	258	0%
Dec	2	215	29	246	0%
Household Composition Not Correctly Included	**3**	**768**	**57**	**828**	**1%**
Oct	0	274	22	296	0%
Nov	0	250	14	264	0%
Dec	3	244	21	268	0%
Post Recommendation Change in Residency Verification	**18**	**257**	**206**	**481**	**1%**
Oct	3	88	81	172	0%
Nov	7	62	64	133	0%
Dec	8	107	61	176	0%
Post Recommendation Citizenship, Immigration Proof	**0**	**7**	**0**	**7**	**0%**
Oct	0	1	0	1	0%
Nov	0	1	0	1	0%
Dec	0	5	0	5	0%
Grand Total	**190**	**67771**	**2407**	**70371**	**100%**

Form **1095-B**
Department of the Treasury
Internal Revenue Service

Health Coverage

2016-003594-003888889

☐ VOID
☐ CORRECTED

OMB No. 1545-2252

2016

Do not attach to your tax return. Keep for your records.
Information about Form 1095-B and its separate instructions is at www.irs.gov/form 1095b

Part I Responsible Individual

Lines 4-7: address shown below

[redacted]

1 [redacted]
2 Social Security Number (SSN): [redacted]
3 Date of Birth (if SSN is not available):

8 Origin of the Health Coverage: C

9 Reserved

You are getting this form because the people listed below got minimum essential coverage through the Illinois Medicaid or All Kids program for the months listed below. Individuals listed will need to use this information for their 2016 federal income tax return. If there are some months with no minimum essential coverage from any source, individuals should see if they qualify for a health coverage exemption (go to www.healthcare.gov/taxes)

Part II Information about Certain Employer Sponsored Coverage

10 11 12 13 14 15

Part III Issuer or Other Coverage Provider (see instructions)

16 Illinois Healthcare and Family Services
17 EIN: 37-1320188
18 Phone Number: 1-800-843-6154
19 P.O. Box 19122
TTY: 1-800-447-6404
20 Springfield
21 IL
22 62794-9122

Part IV Covered Individuals

(a) Name of Covered Individuals	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage (if column d is blank)											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 [redacted]	xxx-xx[redacted]			X				X	X	X	X	X	X	X	X
24 [redacted]	xxx-xx[redacted]		X												
25															
26															
27															
28															

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse (if you file a joint return), and individuals you claim as dependents had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who do not have minimum essential coverage and do not qualify for an exemption from this requirement may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage. For more information on the requirement to have minimum essential coverage and what is minimum essential coverage, see www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision.

TIP *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

Part I. Responsible Individual, lines 1-9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN). For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

Caution! *If you don't provide your SSN or other TIN and the SSNs or other TINs of all covered individuals to the sponsor of the coverage, the IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.*

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- **A.** Small Business Health Options Program (SHOP)
- **B.** Employer-sponsored coverage
- **C.** Government-sponsored program
- **D.** Individual market insurance
- **E.** Multiemployer plan
- **F.** Other designated minimum essential coverage

TIP *If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see* https://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-about-Health-Care-Information-Forms-for-Individuals.

Line 9. Reserved.

Part II. Information about Certain Employer-Sponsored Coverage, lines 10-15. If you had employer-sponsored coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

Part III. Issuer or Other Coverage Provider, Line 16-22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

Part IV. Covered Individuals, lines 23-28. This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in Column (c) only if an SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered.

Spenddown Note If you received Medicaid for at least one month of the year through spenddown, you may apply for an exemption from the individual shared responsibility payment. Fill out and send in an Application for a Health Coverage Exemption. (Form 8965-Health Coverage Exemptions) found at www.healthcare.gov/taxes. The type of Exemption you would apply for is "Certain Medicaid Programs that are Not Minimum Essential Coverage."

Subcommittee Public Education Subcommittee Charge

The Public Education Subcommittee is established to advise the Medicaid Advisory Committee concerning materials and methods for informing individuals about health benefits available under the Department of Healthcare and Family Service's medical programs.

The subcommittee, comprised of a diverse group of stakeholders, will:

- Review and provide advice on brochures, pamphlets and other written materials prepared by the department;
- Review and provide advice on HFS website content directed towards Medicaid beneficiaries and the general public;
- Review projects designed to inform the general public about medical programs;
- Serve as a conduit for informing the Medicaid Advisory Committee and the department concerning gaps in public understanding of the medical programs;
- Propose additional means of communicating information about medical programs;
- Review and provide advice on program eligibility changes, customer service delivery, and eligibility processing systems; and
- Make necessary recommendations to the Medicaid Advisory Committee.