ILLINOIS DEPARTMENT OF Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
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Medicaid Advisory Committee
Public Education Subcommittee Meeting

Thursday, August 25, 2011
10:00 a.m. to 12:00 p.m.

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

Agenda

1. Introductions

2. Approval of the Meeting Minutes from June 23, 2011

3. Address Change Process / HFS Health Benefits Hotline

4. State Medicaid Reform Implementation (2 documents attached)

5. Updates:
   - Web Redetermination
   - July 21, 2011 AKAA Alert http://www.allkids.com/assets/072111n.pdf
   - Policy Change – Stepparent Income / MPE July 29, 2011 http://dhsinfonet/onenet/page.aspx?item=55882
   - Eligibility System for Health Care Reform (IES attached)

6. Announcements:
   - Pending rulemaking
   - Rules codifying changes required by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 – Illinois Register July 15, 2011, Vol. 35, Issue 29 pp. 11094-11125, Changes made to 89 Ill Adm Code 102, 110, 120
   - Rules codifying changes to All Kids required by PA 96-1501, Medicaid Reform – pending publication August 26, 2011, Changes made to 89 Ill Adm Code 123

7. Revised 2011 Meeting Schedule – October 20th and December 8th

8. Open Discussion

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

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

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

Illinois Department of Healthcare and Family Services
Public Education Subcommittee Meeting
June 23, 2011.

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

Committee Members Present
Kathy Chan, IMCHC
Susan Vega, Alivio Medical Center
Suzanna Gonzalez, Mac Neal Hospital (via phone)
Margaret Stapleton, Shriver Center (for John Bouman)
Henry Taylor, Mile Square Health Center (via phone)
Terri Gendel, Age Options (via phone)

Committee Members Absent
Courtney Hedderman, AARP
Judy King, Consumer Advocate
Tamela Milan, Westside Health Start
Hardy Ware, East Side Health District
Robyn Scott, CDPH

Interested Parties
Brittany Ward, Beacon Therapeutic
Jessica Williams, CPS
Jacqueline Gonzalez, CHHC
Margaret Dunne, Beacon Therapeutic
Deborah Mathews, DSCC
Diane Montanez, Alivio Medical Center
Lucero Cervantes, ICIRR
Daisy Velazquez, ICIRR
Nelson Soltman, Legal Assistance Foundation
Maria Shabanova, Maximus (Health Services, Eastern Division)

HFS Staff
Jacqui Ellinger
Donna Drew
Amy Wallace
Veronica Archundia

DHS Staff
Jennifer Hrycyna

Illinois Department of Healthcare and Family Services
Public Education Subcommittee Meeting
June 23, 2011.

The MAC Public Education Subcommittee was called to order at 1:06 p.m.

1. **Introductions.** Kathy Chan chaired the meeting. Attendees in Chicago and Springfield introduced themselves.

2. **Review of Minutes.** Margaret Dunne, from Beacon Therapeutic, recommended a change under the CHIPRA updates by revising the number of applications produced by her agency to 175. Under the same section, Jessica Williams, from Chicago Public Schools, recommended replacing the CFBU with the ECHO program. Following these changes, the May 12, 2011 minutes were approved.

3. **All Kids Income Cap**
   Jacqui Ellinger, Deputy Administrator of the Medical Programs, indicated that the income cap of 300% FPL for the All Kids program will be implemented on July 1, 2011. The Department of Healthcare and Family Services (HFS) is working on a general notice to remind families whose children are currently enrolled at any of the Premium Levels 3 through 8 that they will be able to continue receiving benefits until 7/01/2012, at which time the All Kids insurance for children under these levels will end.

   Sue Vega, from Alivio Medical Center, suggested that the department provide data regarding how many children will be affected, and their geographic distribution. Jacqui estimated that there may be fewer than 5,000 children affected by this policy. She indicated that, after August, 2011, HFS staff may be able to provide an estimate of this population at an upcoming meeting.

   Margaret Stapleton, from the Shriver Center of Poverty Law, recommended for children denied All Kids coverage due to family's income above 300% FPL that the denial notice should advise them that insurance companies cannot deny them coverage. The notice should inform them to contact the Department of Insurance if they are refused coverage. Ms. Stapleton added the denial notice should include information regarding the Pre-Existing Condition Insurance Plan (IPXP).

4. **Residency and Income Verification**
   Jacqui Ellinger stated that HFS has been informally notified by CMS, the Federal Agency which governs Medicaid, that the provisions of residency and income verifications, as indicated in the Medicaid Reform will be a violation of Maintenance of Effort (MOE) provisions as stipulated within the Affordable Care Act (ACA). Ms. Ellinger noted that HFS is anxiously waiting for the written letter which is expected to arrive soon. HFS is still hopeful that, within the next few months, it will be possible to start electronically verifying Illinois residency through the Secretary of State driver's license and state I.D. system. HFS would put some checks in place for those individuals whose residency cannot be verified electronically, so we could dispel the notion that there are no controls over entry into the program. She added that feedback from the federal government has not been received regarding the renewal process scheduled to be implemented beginning October 1st, 2011,

which may require active redetermination of all cases. This means that, if approved by the federal government, Illinois will eliminate passive redetermination.

5. Update on Eligibility Verification Enrollment Process (EVE)

Jacqui Ellinger indicated that Health Management Associates (HMA) is the vendor assisting HFS with the Illinois Health Insurance Exchange and the Eligibility Verification Enrollment (EVE) process. HMA recently made a presentation on the project to MAC, as follow up. Kathy Chan (IMCHC) and Andrea Kovach (Shriver Center) produced a summary of comments and suggestions generated during the meeting. Jacqui noted that the first phase of EVE development is expected to provide a very high level view and broad ideas regarding how to move forward. This work serves as a basis for HFS to request federal money to develop both the Health Benefits Exchange and a new electronic system to handle eligibility under healthcare reform.

On a related note, the Framework request for proposal was posted to the Illinois Procurement Bulletin. Ms. Ellinger noted the Framework is "an integrated enterprise benefits determination eligibility system that involves seven state agencies." This reflects a major step toward integrating eligibility and service delivery for public benefits offered by the state. It is expected also to result in a robust system for care management. The Framework will facilitate the coordination of access, process, and delivery of community services without the need to apply to different agencies in order to receive an array of public benefits.

Susan Vega noted that a recent announcement on National Public Radio indicated that the Department of Human Services in Illinois was recognized for achieving high performance improvement. Jennifer Hrycyna, DHS, stated that Illinois was ranked as being the fourth best in SNAP payment accuracy, and third most improved in the country. She added that this accomplishment was possible as a result of strong staff commitment, training, and a control policy, for which Illinois was awarded $3.4 million.

6. Meeting Schedule

Kathy Chan made a motion to meet every other month during the remainder of the year. It was agreed that these should be on 8/25/11 and 12/08/11 from 10:00 a.m. to 12:00 p.m. A third meeting will take place in October, the date will be determined based on availability. The motion was voted and approved.

7. Open to the Committee

Jacqueline Gonzalez, from the CHHC, asked for an update on the durable medical card. Jacqui Ellinger stated that this project is in the procurement process. HFS posted an invitation for the request for proposals, and several bids have been received. HFS staff is reviewing the proposals. Once a vendor is chosen, it is expected that the implementation of the durable medical card will begin in January of 2012.

Jennifer Hrycyna, DHS, shared that the 2012 budget is pending for the governor's signature, which is expected to impact several programs.

Illinois Department of Healthcare and Family Services
Public Education Subcommittee Meeting
June 23, 2011.

- The General Assistance (GA) or Transitional Assistance program will discontinue the payment grant beginning July 2011. The limited medical card will continue, but recipients will no longer receive the $100 per month grant.
- The Funeral/Burial expenses program will end beginning July 1st, 2011.
- The P3 Medical Assistance will no longer provide cash assistance beginning July 1, 2011.

Jacqui Ellinger provided a report on the following topics:

All Kids Alert: HFS will send a revised alert to AKAAs to address concerns raised by a previous alert sent in April, 2011, that was related to documentation requirements for noncitizens applying for the family health plans. She emphasized that the documentation requirements for noncitizens have not changed. The intent of the alert was to remind AKAAs of existing requirements that have long been in place for individuals using passports or visas to document their legal status. Ms. Ellinger added that the documentation of immigration status is required for the state to receive federal matching funds whenever possible.

Undocumented Children: As a result of audit findings and a clarification of state law, HFS anticipates a change in the way income is counted for all undocumented children when a stepparent with income lives in the home. A manual release will be issued to advise that regardless of where the family applies, if there is a stepparent in the home, his or her income will be counted in order to determine the child's eligibility.

Customer Services: The HFS customer hotline will assist the Department of Human Services in processing requests to update changes of address and phone numbers. Ms. Ellinger added that clients will continue to report changes of address to their case workers at the Family Community Resource Center (FCRC). The intent of this measure is to improve customer service and improve the accuracy of address information.

Rulemaking: HFS is in the process of reviewing several rules which govern eligibility for family health plans. There is a variety of reasons why these rules need to be changed, such as: the change in the name of the program from KidCare to All Kids, elimination of the three month penalty period for families whose children lose benefits due to the lack of premium payment, the cap limit of the All Kids program, the department's decision to keep operational consistency among all the family health plans to facilitate the process. HFS staff will make these rules revisions as a package.

Web Redetermination: HFS in conjunction with DHS has been working on a project to offer the completion of redeterminations on the Internet for most HFS and DHS cases. This new procedure will operate in a manner that is similar to the phone stamps redetermination. Clients will receive a notice with a pass code. The notice would indicate that there is a certain period of time that the clients will have to complete their redetermination though the Internet. The notice will give directions regarding how many days they have to provide the necessary

documentation, when applicable. More details on this project will be provided during upcoming meetings.

Civil Unions: There is a new law recently approved in Illinois that authorize same sex and opposite sex couples to enter into a civil union. HFS staff is reviewing the implications of the new law since the partnership of a civil union is not recognized under federal Medicaid policy in accord with the federal Defense of Marriage Act (DOMA). New developments regarding these issues will be reported on during future meetings.

8. Next meeting/adjournment

The next meeting is scheduled for August 25, 2011, from 10:00 a.m. to 12:00 p.m. The June 23, 2011 session was adjourned at 3:08 p.m.

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April 29, 2011

Cindy Mann, Deputy Administrator/Director
Center for Medicaid, CHIP and Survey and Certification
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Dear Ms. Mann:

As you know from our discussion a few weeks ago, Illinois enacted a Medicaid reform law that mandates certain procedural changes in the Illinois Medicaid and CHIP programs. These changes include enhancing income and residency verification requirements and eliminating "passive" annual redetermination of eligibility. As I stated in our meeting, it is the state's intention to ensure program integrity, not to make it more difficult to become eligible for the programs. However, the State is mindful of the Maintenance of Effort (MOE) requirements of the Affordable Care Act and this letter is to seek federal guidance.

These changes in Illinois law were not enacted as a means to reduce enrollment but rather to assure that all applicants and recipients are treated equitably and comply with existing eligibility requirements. These changes will also implement procedures that are consistent with new requirements of the Affordable Care Act after 2014, with respect to both income verification and annual redetermination of eligibility. I believe that implementing these procedural changes has become politically imperative for maintaining legislative support for Illinois' generous eligibility standards.

The following excerpt from the law explains the context of my request:

> ...eligibility shall be determined in a manner that ensures program integrity and complies with federal laws and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and **unless the Department receives written denial from the federal government, this Section shall be implemented.** [Emphasis added.]

Attachment 1 contains a table laying out the relevant requirements of the law and the options we have explored for implementation. It also provides space for CMS to provide an explicit

denial, should you determine any change to be unacceptable. We have structured the table to receive responses at a sufficiently refined level to permit us to distinguish between various alternatives unambiguously. Attachment 2 provides more detail relevant to residency verification requirements referenced in Attachment 1. Attachment 3 contains a longer excerpt of the relevant sections of the new law.

I would very much appreciate receiving your quick response as the law includes specific and challenging timeframes. If necessary, we stand ready to discuss our plans at your earliest convenience.

Sincerely,

Julie Hamos

cc: Verlon Johnson, Hye Sun Lee, Michelle Baldi, CMS ROV

Attachments

Attachment 1

Eligibility Verification Under Illinois' Medicaid Reform Law		
A. Income Verification on New Applications		
Medicaid Reform Law Provisions	[HFS shall] require verification of, at a minimum, one months' income from all sources required for determining the eligibility of applicants ... Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically . . . [Applications for which income cannot be verified shall be denied.]	
Current Procedures	Illinois requires AFDC related eligibility groups (family cases) to provide just one document for all sources of income received in a month. That is, if an applicant is paid twice a month, one pay stub is sufficient. Business records of any kind kept by self-employed persons are accepted. AABD related eligibility groups must provide documents of all income other than that which Illinois currently verifies electronically. Medicare Savings Program participants' income may be declared; no documentation is required.	
Change Options		**CMS Approval/Denial**
1. Require applicants to provide documentation to verify all income payments received in a month other than those currently verified through data matches for SSA benefits, UIB and child support. This includes requiring self-employed persons who keep their own business records to provide their most recent federal tax return in addition to current income and expense records. Failure to comply will result in denial of the application.		
2. For family cases, in addition to current income document requirements, require applicants to provide documentation to verify any income payments that the state cannot reasonably verify electronically using less precise data such as quarterly wage verification income or whatever earnings are reported to a commercial service such as the Work Number or state tax records if they are available. Self-employed persons must provide their most recent income tax return in addition to current income and expense records. Failure to comply will result in denial of the application.		
3. Use electronic data matches with the state's employment security wage verification system and possibly state income tax data as available to confirm the validity of monthly income declared on applications and evidenced by one document per source of income. If data matches identify possible errors in income reported, applicants may be asked to document all income, including tax returns from self-employed persons in addition to current income and expense records. Failure to validate income with data matches will not automatically result in denial of applications.		

Eligibility Verification Under Illinois' Medicaid Reform Law		
B. Residency Verification on New Applications		
Medicaid Reform Law Provision	[HFS shall] require verification of Illinois residency. . . [Applications for which residency cannot be verified shall be denied.]	
Current Procedure	Illinois accepts applicants' declaration of Illinois residence unless questionable.	
Change Options		**CMS Approval/Denial**
1. Require applicants to provide documentation (see SNAP procedures attached) to verify they are Illinois residents. All adult requestors must document Illinois residency. Residency of children (younger than age 19) will be deemed verified if the adult responsible for their case documents their own residency. Children living independently must document Illinois residency except that children in foster care or subsidized adoption/guardianship relationships shall be deemed residents by virtue of their connection to the child welfare system. Failure to comply will result in denial of the application.		
2. Require only those applicants for whom the state cannot verify residency through other means to provide documentation (see SNAP procedures attached). Other means includes matching against Illinois Secretary of State (ISoS) motor vehicle driver's license and state identification databases to confirm Illinois residence. Illinois residency of all adult requestors must be verified. Residency of children (younger than age 19) will be deemed verified if the adult responsible for their case is verified. Residency of children living independently must be documented except that children in foster care or subsidized adoption or guardianship relationships shall be deemed residents by virtue of their connection to the child welfare system. Failure to comply will result in denial of the application.		
3. Illinois will conduct electronic data matches with ISoS and other sources as available to verify Illinois residency. If Illinois residence is questionable despite electronic matches, applicants may be asked to prove they reside in Illinois (using SNAP procedures.)		

Attachment 1

Eligibility Verification Under Illinois' Medicaid Reform Law		
C. Administrative/Passive Redeterminations		
Medicaid Reform Law Provisions	[HFS shall] send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice a notice of cancellation shall be issued to the recipient and coverage shall end on the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the month following the last date of coverage. Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.	
Current Procedures	Illinois conducts administrative ex parte redeterminations for AABD recipients receiving SSI benefits and individuals in cases receiving SNAP or TANF benefits as well as medical benefits. Active renewals by mail or phone are required for all other adults, family cases known to the state to have increased income, who are enrolled with income in excess of 200% FPL. Passive redeterminations and renewals are used for children whose only benefit is medical coverage. A form is sent to the family pre-populated with the information currently of record in the data system. Often, the information is that which was reported and verified by the family at application. The family is not required to respond unless there has been a change in their circumstances. If no response is received, the child's coverage is automatically renewed for another year.	
Change Options		**CMS Approval/Denial**
1. Require individuals and families to respond to renewal/redetermination notices by at least signing and returning a pre-populated form to confirm receipt of the notice and the accuracy of the information it contains. Eligibility is cancelled for those who fail to respond timely although reinstatement is possible if recipients respond within the month following the last day of coverage. No change for individuals enrolled as AABD or those whose eligibility for medical benefits is redetermined/renewed as part of SNAP or TANF recertification.		
2. Require individuals and families to respond in one of three ways: signing and returning a paper notice, completing an automated redetermination interview by telephone, or completing a redetermination interview online. Eligibility is cancelled for those who fail to respond timely although reinstatement is possible if recipients respond within the month following the last day of coverage. No change for individuals enrolled as AABD or those whose eligibility for medical benefits is redetermined/renewed as part		

Eligibility Verification Under Illinois' Medicaid Reform Law	
of SNAP or TANF recertification.	
3. Restrict passive redetermination for children to those for whom an electronic data match against available earnings records (SSA, Employment Security, income tax records) reveals no evidence that income may have increased above the relevant income eligibility level. In cases where evidence of relevant change exists, require an active redetermination in which families must document income. Eligibility is cancelled for those who fail to respond timely although reinstatement is possible if recipients respond within the month following the last day of coverage. No change for individuals enrolled as AABD or those whose eligibility for medical benefits is redetermined/renewed as part of SNAP or TANF recertification.	

Attachment 1

Eligibility Verification Under Illinois' Medicaid Reform Law		
D. Income Verification at Renewal/Redetermination		
Medicaid Reform Law Provisions	[HFS shall] require verification of, at a minimum, one months' income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility. . . Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically. [Cases for which income cannot be verified shall be cancelled.]	
Current Procedures	At annual redetermination or renewal, parents and caretaker relatives as well as children who are not eligible for passive redetermination (see item C) must provide just one document for all sources of income received in a month. That is, if an applicant is paid twice a month, one pay stub is sufficient. Business records of any kind kept by self-employed persons are accepted with the exception that in Illinois' Health Benefits for Workers with Disabilities Program (Title XIX coverage under the Ticket to Work and Work Incentives Improvement Act) a tax document is required of self employed persons. AABD related eligibility groups must provide documents of all payments other than those that Illinois currently verifies electronically. Medicare Savings Program participants' income may be declared; no documentation is required.	
Change Options		**CMS Approval/Denial**
1. Require all family cases to provide documentation to verify all income payments of any kind received in a month. This includes requiring self-employed persons who keep their own business records to provide their most recent federal tax return in addition to current income and expense records. No change for AABD recipients or Medicare Savings Program participants.		
2. No change in income documentation requirements for families for whom the state can reasonably verify total monthly income through electronic means such as SSA and UIB and including 1/12 of gross income reported on last Illinois tax return or 1/3 of income reported for the last quarter available from the Dept of Employment Security or the Work Number or similar sources, if available. Families whose income cannot reasonably be verified by the state electronically must provide documentation of all income received in a month and self-employed persons must provide their most recent income tax return in addition to current income and expense records. No change for AABD recipients or Medicare Savings Program participants.		

SNAP Residency Verification Policy

WAG 03-02-00: Residence

PM 03-02-00.

Persons must be residents of Illinois to receive Cash, MANG, or Food Stamps.

For Cash and MANG cases, accept the client's statement claiming residence in Illinois unless there is reason to question the claim. If the client's claim is questionable, verify residence.

For Food Stamps, verify residence at initial application and whenever the client's residence is questionable.

Use one of the following sources to verify residence:

Rent Receipts

Leases

Mortgage Books

Utility Bills

Contact with landlord

Employment Records

Voter's Registration Card

Driver's License

Medical Records and Clinic Card

Contact with family or relatives

Observation of the client in stated residence

PM 03-02-03-a: Proof of Residence

WAG 03-02-03-a

Get proof of Illinois residence before approving SNAP benefits unless the persons:

- are homeless, or
- are migrant farmworkers, or
- are new arrivals in the area.

After approval, only get proof of the client's address when there is conflicting information.

➡

A SNAP unit that cannot be located does not qualify for SNAP benefits. ➡ When mail is returned to the office as undeliverable, send a request for contact and allow 10 days for the customer to respond before canceling the case.

WAG 03-02-03-a: Proof of Residence

PM 03-02-03-a

When the FCRC learns that an FS Unit has moved out of Illinois, cancel the case, sending the Form 157C to the unit at the out of state address if known or the last address on record.

➡ When mail is returned as undeliverable, send a Form 1721 to the last known address (if there is forwarding information on the returned envelope, send to the forwarding address) before canceling the case, see **WAG 18-04-03**.

(305 ILCS 5/11-5.1 new)

Sec. 11-5.1. Eligibility verification. Notwithstanding any other provision of this Code, with respect to applications for medical assistance provided under Article V of this Code, eligibility shall be determined in a manner that ensures program integrity and complies with federal laws and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

(a) The Department of Healthcare and Family Services or its designees shall:

(1) By no later than July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants for medical assistance under this Code. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section.

(2) By no later than October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility for medical assistance under this Code. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. The Department shall send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice a notice of cancellation shall be issued to the recipient and coverage shall end on the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the month following the last date of coverage. Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

(3) By no later than July 1, 2011, require verification of Illinois residency.

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data shall be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

(215 ILCS 106/7 new)

Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that complies with federal law and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

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(2) By no later than October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility under the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. The Department shall send a notice to the recipient at least 60 days prior to the end of the period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice, a notice of cancellation shall be issued to the recipient and coverage shall end on the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the month following the last date of coverage. Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

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(215 ILCS 170/7 new)

Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that complies with federal law and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Center for Medicaid, CHIP and Survey & Certification

JUN 2 4 2011

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

Dear Ms. Hamos:

I am writing to reply to your letter, dated April 29, 2011, in which you asked for Federal guidance on the Maintenance of Eligibility (MOE) requirements in section 2001(b) of the Affordable Care Act (adding sections 1902(a)(74) and 1902(gg) to the Social Security Act). Specifically, your letter indicates that "unless the Illinois Department of Healthcare and Family Services receives a written denial from the Federal Government [a new section of the State's Medicaid reform law] will be implemented." Your letter stated that these new provisions would change Medicaid eligibility determination procedures in a "manner that ensures program integrity and complies with Federal laws and regulations while minimizing unnecessary barriers to enrollment." Please be assured that the Centers for Medicare & Medicaid Services (CMS) used this same goal -- safeguarding program integrity and at the same time ensuring appropriate access to health coverage for eligible individuals and compliance with the law-- to guide our evaluation of the options presented in your letter.

Following receipt of your letter, staff from CMS and our Region V Office conferred with members of your staff to gain clarity about the specifics of the changes to eligibility determination procedures, which primarily entail new verification requirements. We also discussed the alternative options you proposed for implementation and how such procedures would differ from current practice. While your letter raised four issues, this response addresses the first two, for which we understand there is a July 1 implementation date: (A) income verification on new applications and (B) residency verification on new applications. (There is an October 1 implementation date for the remaining procedural changes described in your letter and we will respond to those issues separately.)

This letter discusses the following questions:

- Do the provisions of the Illinois Medicaid reform law, regarding income verification for new applications and residency verification for new applications, constitute a violation of the MOE provision of the Affordable Care Act?
- Do any of the proposed implementation options allow for more rigorous verification while remaining in compliance with the MOE requirements?

The MOE provision of the Affordable Care Act states that with certain exceptions, as a condition of receiving Federal Medicaid funding, States must maintain Medicaid "eligibility standards, methodologies, and procedures" that are no more restrictive than those in effect on March 23, 2010. There is extensive evidence that eligibility procedures are strong determinants of whether eligible people can actually gain coverage. According to your letter, the new State law would require applicants to submit more documentation of both income and residency than is required under current

Illinois law, procedures which would be more restrictive than those in effect on March 23, 2010. Thus, such procedural changes would constitute a violation of the MOE provision of the Affordable Care Act. In addition, some of the implementation options proposed in your letter also call for applicants to submit more paper documentation than they do now under Illinois policies in effect as of March 23, 2010, and as such, would also violate the MOE provision.

Your letter did, however, include proposed implementation options that seek to improve program integrity procedures already in place by employing new electronic data matches during initial eligibility. It appears that such approaches would verify information through available sources and safeguard program integrity without creating any additional burden on applicants. As a result, we do not believe that these electronic data matches would trigger MOE violations.

Our assessment of the various options you present for addressing the first two issues discussed in your letter has led us to the following conclusions:

A. **Your options for changing the procedure you use to electronically verify income at application could be adopted without triggering an MOE violation.** Specifically, the use of additional databases, such as the "Work Number," or other options that may provide more recent data than quarterly wage reports, would not violate MOE.

B. **Your options for changing how Illinois verifies residency information include methods that would not constitute an MOE violation.** Currently, applicants are allowed to attest that they are Illinois residents and further explanation is requested only when the applicant's statement is questionable, for example, when mail is returned. You stated that a "Secretary of State database" will soon become available for your use and that this database would enable you to compare the applicants' attestation of residency with drivers' license and State identification card information. The Secretary of State database could be considered a verification tool that refines the current process and it can be applied without triggering and MOE violation.

If you decide to move forward with the approaches to verification outlined above please submit a plan for our review in which you explain the problem that has been identified and detail how your solution addresses the problem in ways that ensure compliance with the MOE provisions while maintaining and strengthening program integrity. For example, for cases in which electronic verification is not feasible, we recommend that a sampling procedure be used to limit the number of applicants asked to submit more rigorous paper documentation (e.g. income/expense statements, recent tax returns). In determining whether a current procedure needs to be improved, program audits, such as PERM and MEQC reviews, can help detect specific problems and lead to solutions that explicitly address the problems.

I hope this response clarifies how the MOE provisions of the Affordable Care Act relate to the particular options that Illinois has proposed and that our suggestions prove helpful. If you have any additional questions, or would like to further discuss best practices for conducting electronic verification while ensuring compliance with MOE provisions, please feel free to contact me. We remain committed to assisting you and my staff remains available to help you formulate plans for moving forward.

Sincerely,

Cindy Mann
Director

Illinois Integrated Eligibility System Update

MAC Public Education Subcommittee

Illinois Department of Healthcare and Family Services

August 25, 2011

Organizational Environment

- Structure:
  - DHS – eligibility determination for Medicaid, SNAP, TANF and other human services programs
  - DHFS – administers Medical programs for Illinois (MMIS)
  - DOI – implementation of the HIX (until Exchange governance is established)
- Eligibility determination
  - Takes place at DHS local offices distributed throughout the state
  - Partial online web access – 2 apps - HFS and DHS

System Environment

- Current systems are highly integrated but antiquated
- Years of resource privation have depleted human capital in profound ways
- Local offices already severely overloaded

Additional Challenges

- Other major State initiatives underway
  - Replacing 30+ year old MMIS
  - Struggling to coordinate systems across human service agencies that are siloed with systems that don't communicate
- Dynamic state of national action
  - Federal rulemaking proceeding slowly
  - Uncertainty on what "Early Innovators" will actually have…and when

Governance

- Created strong user group
  - Included business and technology owners from all impacted agencies from the beginning
  - Sharing tasks and governance across departments has so far worked well
  - Starting to think of this as a “virtual department of eligibility”
- But biggest challenges still ahead

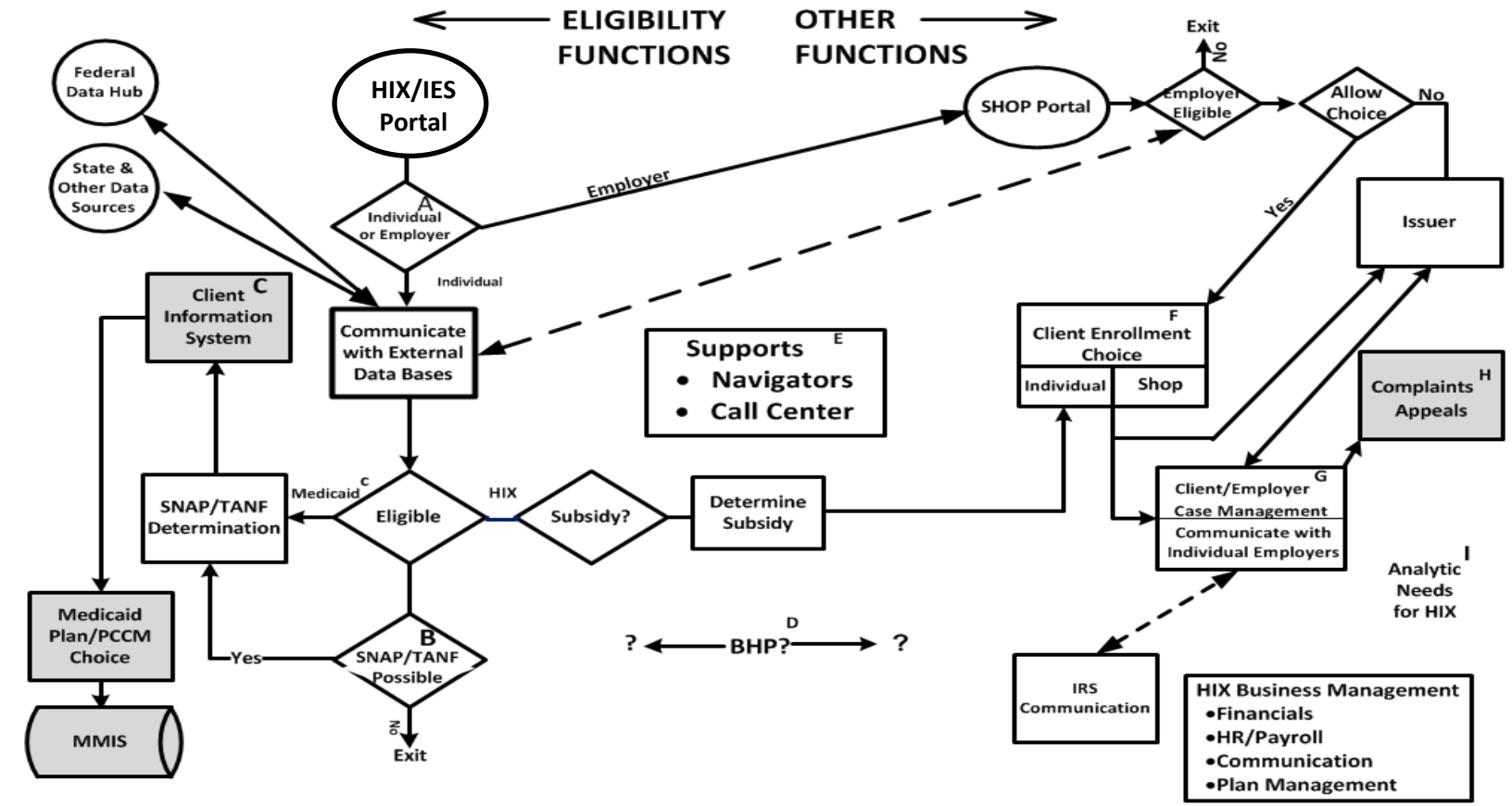
Strategy Elements

- Striving to retain degree of current integration—i.e. include SNAP and TANF—and, if possible, use as base for broader system integration
- Need complete (and compelling) solution to maximize automated online eligibility
- Keep closely integrated with HIX operating systems
- For developmental purposes, keep enough separate that development of the Eligibility System doesn’t wait until Exchange established

Technology Approach

- Cannot do everything we want to do by October 2013
- Therefore, use a two-step approach
  - By 2013 have internet front end that connects to national and local data sources and routes relevant information through a rules engine to HIX or existing DHS eligibility system as appropriate
  - By 2015, replace existing eligibility system with a completely modular set of applications, relating to MMIS and other human service data bases as appropriate and in sync with Framework project

Process Schematic



NOTES
A. Many doors possible
B. Unlikely
C. Not sure where "type" Medicaid decided
D. BHP to be decided later

E. Shared functions to some degree
F. May be one or two choice sites
G. Probably two separate functions
H. Probably more routes to complaints & appeals
I. Presumably some kind of data warehouse

Grey = Existing Systems

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