



STATE OF ILLINOIS  
OFFICE OF THE GOVERNOR  
SPRINGFIELD 62706

December 31, 1997

JIM EDGAR  
GOVERNOR

The Honorable Donna E. Shalala, Secretary  
The United States Department of Health and Human Services

Dear Madam Secretary:

I am pleased to submit Illinois' plan for expanding services to uninsured children under Title XXI of the Social Security Act.

Illinois has elected to implement Title XXI at this time through an expansion of our Medicaid program. Effective January 5, 1998, Illinois will establish a single Medicaid income standard of 133 percent of the federal poverty level (FPL) for children from birth through age 18. Illinois will simultaneously increase to 200 percent of the FPL the income standard for pregnant women. Title XIX plan amendments required to effect these changes will be submitted under separate cover.

This is only the first stage of the Illinois Child Health Initiative to be implemented under Title XXI. Later in 1998, I will submit amendments to the enclosed plan to expand coverage further. The design of additional stage(s) of Illinois' program is currently under development. A legislative task force has been established to make recommendations for expansion of health benefits coverage for targeted low income children up to 200 percent of FPL.

These documents are being submitted electronically, on diskette, and in hard copy as directed in Sally Richardson's letter of December 2, 1997. In addition to our electronic transmissions to the central and regional office, one diskette and three hard copies are directed to central office and one of each to the HCFA Region V office.

A. George Hovanec, Administrator of the Division of Medical Programs, Illinois Department of Public Aid, will serve as our contact to HCFA concerning the review of this plan. He may be contacted at 217/782-2570.

Illinois is excited by the opportunities Title XXI offers in expanding health care coverage to our uninsured children. I look forward to your review and approval of our plan.

Sincerely,

Jim Edgar  
GOVERNOR

MODEL APPLICATION TEMPLATE FOR  
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: ILLINOIS  
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

December 31, 1997

Jim Edgar, Governor, State of Illinois

Date:

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Proposed Effective Date: 1/5/98

Template Version 9/12/97

**Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)**

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1.  Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2.  Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.3.  A combination of both of the above.

**Section 2. General Background and Description of State Approach to Child Health Coverage**  
(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

Illinois has chosen to target children who are under the age of 19 and who are from families with incomes at or below 133 percent of the federal poverty level (FPL). Health benefits coverage will be provided to these children through a Medicaid expansion that will cover children who are between ages 0 and 19 and who are from families with incomes above the March 31, 1997 Medicaid eligibility standard and at or below 133 percent of the FPL. The expansion will serve an additional 40,400 children. Illinois will implement this expansion on January 5, 1998.

Estimated Number of Optional Targeted Low Income Children and Estimated Number of Potentially Medicaid-Eligible Children By Age and Family Income Relative to the Federal Poverty Level: Illinois, 1993 - 1996 Average				
POVERTY LEVEL	AGE			TOTAL
	0 - 5	6 - 13	14 - 17	
186 - 200	2,800	5,400	3,700	11,900
151 - 185	13,300	17,100	11,200	41,600
134 - 150	6,300	8,000	5,300	19,600
100 - 133		17,500	10,600	28,100
50 - 99			12,300	12,300
< 50	(52,500)	(40,400)	(12,300)	
TOTAL				113,500

Illinois did not identify a reason to further target children by race, ethnicity or geography. In addition, an estimated 105,200 children are potentially eligible for Medicaid (under the income standards in effect March 31, 1997) and will be targeted for enrollment in the Medicaid program through intensive community-based outreach efforts.

These estimates were derived by aggregating the 1993 through 1996 Current Population Surveys and cross-tabulating age (in single years) by income relative to the federal poverty level, controlling for insurance status. Insurance status was determined by an algorithm that combined the responses to several survey items in order to determine that the child was uninsured.

**2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)**

**2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):**

Outreach to low income children and pregnant women for the Medicaid program is conducted by the State's Maternal and Child Health (Title V) program in the Illinois Department of Human Services. The *Family Case Management* program conducts outreach and case management activities for low-income families that include a pregnant woman, infant or young child. Medicaid matching funds are claimed for outreach activities and for case management activities conducted with Medicaid-eligible families for Medicaid-covered services. The program has been operating since 1986 and has been a Medicaid-MCH partnership since 1990. The program's current budget is \$45.7 million, of which \$4.1 million is used for outreach activities.

Family Case Management activities are carried out by local agencies: local health departments, community health centers, other FQHCs and other community-based organizations. "Outreach" activities include any activity to find and inform potential program participants of the health services available through the Medicaid program. Outreach, therefore,

can include community campaigns as diverse as door-to-door canvassing, production and distribution of handbills, design and publication of newspaper announcements, and production and broadcast of public service announcements or paid advertising on radio or television. Projects also target outreach activities to employers that do not offer health insurance coverage for their employees. Presentations are made to church groups, service clubs, and other community groups. Local agencies develop networks of community health care providers, hospitals, clinics, emergency rooms, pharmacies and other agencies to distribute information on the Medicaid program. The primary objective of outreach activities is to inform potential program participants of available services, eligibility criteria and methods of accessing services (for example, the name, address and phone number of the provider). This is not to preclude the use of nontraditional methods of outreach.

Once identified through outreach activities, The Family Case Management program then helps eligible families to enroll in Medicaid. Many of the local provider agencies are also qualified to conduct Medicaid Presumptive Eligibility determinations for pregnant women. The Family Case Management providers either are WIC providers or have a linkage with the WIC Program. WIC identifies potentially eligible Medicaid clients and refers them for eligibility determination. Local providers have also established good working relationships with the eligibility determination staff at local DHS offices and can assist families in making appointments for eligibility interviews and in providing or arranging transportation and child care if necessary.

The Family Case Management program serves about 140,000 families each year. This total includes currently Medicaid-eligible families as well as targeted low income children who will become eligible through the Medicaid expansion under Title XXI.

Health care services — The Maternal and Child Health program pays for primary health care services to Medicaid-ineligible targeted low income children through two programs: Family Case Management, and a “Maternal and Child Health Mini-Block Grant” to the Chicago Department of Health.

A portion of the grant funds awarded to each Family Case Management agency is earmarked for primary care services. These funds may be used to purchase health care for either pregnant women or children. To use these funds, the family must be ineligible for Medicaid and not have insurance that will cover primary care services. The Chicago Department of Health uses its "Mini-Block" grant to pay for primary health care services provided through its community-based clinics to uninsured women of reproductive age (for family planning services), pregnant women (for prenatal care) and children (for pediatric primary care). All of these funds are used only for ambulatory, preventive and primary care; they are not used for specialty or inpatient care. During SFY'97, these programs used \$1.6 million to pay for approximately 85,200 pediatric encounters.

In Illinois, 106 FQHC site locations provide medical services to families with little or no income. The FQHC staff identify potentially eligible Medicaid clients and assist them in completing the eligibility process. In 1991, the Department of Public Aid implemented procedures for Medicaid eligibility application processing for pregnant and post partum women and children under age 19 at designated locations other than the local DHS offices. Those locations include FQHCs and disproportionate share hospitals.

In Illinois' continuing effort to improve the health status of school-aged children, the Project Success Program coordinates social and health services with parental involvement in approximately 200 designated school sites throughout the State. Project Success sites refer potentially eligible Medicaid children for eligibility determination. Additionally, sixteen school based/linked clinics provide services to school-aged children, their siblings and preschool aged children in the district. The clinics are required to assess income levels and refer those children who appear to be Medicaid eligible for eligibility determination while at the same time providing needed medical services.

**2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:**

The State of Illinois is not directly involved in a public-private partnership concerning health insurance for children. A local public-private partnership, however, operates in suburban Cook County. The Suburban Primary Health Care Council operates the Access to Care Program in suburban Cook County. This public-private partnership includes the Community and Economic Development Association of Cook County, Inc.; the Cook County Department of Public Health; the Northwest Suburban Health Care Council; and the Park Forest Health Department. Approximately 4,500 uninsured or under-insured children from suburban Cook County (outside of Chicago) will be served during 1997.

- 2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered:**

**(Section 2102)(a)(3)**

Illinois' Title XXI program will be fully integrated with the State's Medicaid program. Procedures currently employed in the Illinois Medicaid program will be used for the identification of third party coverage for optional targeted low income children.

Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4))

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)

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3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

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**Section 4. Eligibility Standards and Methodology.** (Section 2102(b))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A))

- 4.1.1.  Geographic area served by the Plan: \_\_\_\_\_
- 4.1.2.  Age: \_\_\_\_\_
- 4.1.3.  Income: \_\_\_\_\_
- 4.1.4.  Resources (including any standards relating to spend downs and disposition of resources): \_\_\_\_\_
- 4.1.5.  Residency: \_\_\_\_\_
- 4.1.6.  Disability Status (so long as any standard relating to disability status does not restrict eligibility): \_\_\_\_\_
- 4.1.7.  Access to or coverage under other health coverage: \_\_\_\_\_
- 4.1.8.  Duration of eligibility \_\_\_\_\_
- 4.1.9.  Other standards (identify and describe):  
\_\_\_\_\_

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B))

- 4.2.1.  These standards do not discriminate on the basis of diagnosis.
- 4.2.2.  Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3.  These standards do not deny eligibility based on a child having a pre-existing medical condition.

- 4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2))
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- 4.4. Describe the procedures that assure:

- 4.4.1. Through intake and followup screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))
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- 4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))
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- 4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))
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- 4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))
- 

- 4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))
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**Section 5. Outreach and Coordination (Section 2102(c))**

**Describe the procedures used by the state to accomplish:**

**5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))**

Illinois will conduct an outreach campaign and target an enrollment strategy to children throughout the State who are likely to be eligible either for Medicaid under Title XIX or for expanded Medicaid under Title XXI. This strategy will encourage these children to enroll, utilize and stay in the health care system. This will be achieved in the following manner:

- 1) IDPA will review its automated records and notify the families of eligible children who are currently in the Medicaid system as unmet spenddown of their eligibility under the new income thresholds and will enroll the children.
- 2) IDPA will develop a new simplified application process and the procedures to support widespread offsite enrollment.
- 3) MPE and MCH offsite enrollment sites including FQHCs, disproportionate share hospitals, local health departments and WIC sites will be utilized to conduct offsite enrollment of uninsured children into the new program.
- 4) County health departments, Family Case Management and WIC sites will be asked to utilize existing records on the Cornerstone system of the Department of Human Services to review their records and identify children who are in their programs and likely to be eligible for health benefits coverage.
- 5) The Department of Public Aid will send a notice to all non-assistance Child Support families informing them of the program and of locations where the family could enroll the child.

- 6) Outreach will be coordinated with the Illinois child care resource and referral networks and larger child care or Head Start providers.
- 7) School districts will be recruited for identifying children likely to be eligible for health benefits coverage and, wherever possible, offsite enrollment, according to the school census of the number of children receiving free and reduced cost lunch. This will be coordinated with Project Success and School Attendance Initiative sites.
- 8) Special efforts will be made to identify eligible:
  - a) migrant children through community agencies such as the Illinois Migrant Council or migrant health clinics;
  - b) homeless children through community-based organizations such as those who provide shelter or emergency food services, and clinics which target these populations;
  - c) children with special health care needs through the Division of Specialized Care for Children and through children's hospitals; and,
  - d) children in rural areas through the efforts of county health departments, rural health clinics and FQHCs.
- 9) Community-based organizations will be asked to disseminate information about the program and the referral process to potentially eligible families. These organizations include, but are not limited to:
  - Project SUCCESS sites;
  - Places of worship;
  - Day care facilities, Child Care Resource and Referral Networks;
  - Early Intervention sites;
  - Head Start, Early Head Start sites;
  - Community-based organizations (YWCA, etc.); and
  - DPA's Neighborhood Education Contractors

10) Other efforts to promote the program will include a program fact sheet and a provider notice explaining the new eligibility levels and a listing of enrollment sites.

**5.2. Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))**

Coordination of the administration of this program with other public and private health insurance programs (section 2102(c)(2)) will be achieved by enrolling the children through a simplified application process that is similar to the MCH enrollment process for offsite enrollment. Otherwise all application and eligibility decisions will be made by DHS for Title XXI expanded Medicaid the same as for Title XIX.

**Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)**

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.**

6.1. The state elects to provide the following forms of coverage to children:  
(Check all that apply.)

6.1.1.  Benchmark coverage; (Section 2103(a)(1))

6.1.1.1.  FEHBP-equivalent coverage; (Section 2103(b)(1))  
(If checked, attach copy of the plan.)

6.1.1.2.  State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3.  HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.) \_\_\_\_\_

6.1.2.  Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). **See instructions.**

6.1.3.  Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."

6.1.4.  Secretary-Approved Coverage. (Section 2103(a)(4)) \_\_\_\_\_

- 6.2. The state elects to provide the following forms of coverage to children:  
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a))
- 6.2.1.  Inpatient services (Section 2110(a)(1))
  - 6.2.2.  Outpatient services (Section 2110(a)(2))
  - 6.2.3.  Physician services (Section 2110(a)(3))
  - 6.2.4.  Surgical services (Section 2110(a)(4))
  - 6.2.5.  Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
  - 6.2.6.  Prescription drugs (Section 2110(a)(6))
  - 6.2.7.  Over-the-counter medications (Section 2110(a)(7))
  - 6.2.8.  Laboratory and radiological services (Section 2110(a)(8))
  - 6.2.9.  Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))
  - 6.2.10.  Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
  - 6.2.11.  Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
  - 6.2.12.  Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
  - 6.2.13.  Disposable medical supplies (Section 2110(a)(13))
  - 6.2.14.  Home and community-based health care services (See instructions) (Section 2110(a)(14))
  - 6.2.15.  Nursing care services (See instructions) (Section 2110(a)(15))
  - 6.2.16.  Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))

- 6.2.17.  Dental services (Section 2110(a)(17))
- 6.2.18.  Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19.  Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20.  Case management services (Section 2110(a)(20))
- 6.2.21.  Care coordination services (Section 2110(a)(21))
- 6.2.22.  Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23.  Hospice care (Section 2110(a)(23))
- 6.2.24.  Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25.  Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26.  Medical transportation (Section 2110(a)(26))
- 6.2.27.  Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28.  Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

6.3. **Waivers - Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and(3))

6.3.1.  **Cost Effective Alternatives.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** (Section 2105(c)(2)(B)(i))

6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii))

6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** (Section 2105(c)(2)(B)(iii))

- 6.3.2.  **Purchase of Family Coverage.** Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3))
- 6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** (Section 2105(c)(3)(A))
- 6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B))

**Section 7. Quality and Appropriateness of Care**

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.**

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A))

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Will the state utilize any of the following tools to assure quality?  
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1.  Quality standards  
7.1.2.  Performance measurement  
7.1.3.  Information strategies  
7.1.4.  Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))

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**Section 8. Cost Sharing and Payment** (Section 2103(e))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.**

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1.  YES

8.1.2.  NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:  
(Section 2103(e)(1)(A))

8.2.1. Premiums: \_\_\_\_\_

8.2.2. Deductibles: \_\_\_\_\_

8.2.3. Coinsurance: \_\_\_\_\_

8.2.4. Other: \_\_\_\_\_

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income: \_\_\_\_\_

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))

8.4.1.  Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))

8.4.2.  No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))

8.4.3.  No child in a family with income less than 133% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4.  No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))

8.4.5.  No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))

8.4.6.  No funds under this title will be used for coverage if a private insurer

would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.

(Section 2105(c)(6)(A))

- 8.4.7.  Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1))
- 8.4.8.  No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B))
- 8.4.9.  No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A))

- 8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: (Section 2103(e)(3)(B))
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- 8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

- 8.6.1.  The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**
- 8.6.2.  The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:
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**Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)**

**9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children:  
(Section 2107(a)(2))**

Illinois has established five strategic objectives:

1. Improve the health status of Illinois' children;
2. Extend health benefits coverage to optional targeted, low income children;
3. Improve access to quality health care for optional targeted low income children enrolled in the Title XXI program;
4. Assure appropriate health care utilization by optional targeted low income children enrolled in the Title XXI program; and
5. Implement a statewide outreach and public awareness campaign regarding the importance of preventive and primary care for well-children and the availability of health benefits coverage through Title XXI.

**9.2. Specify one or more performance goals for each strategic objective identified:  
(Section 2107(a)(3))**

1. Improve the health status of Illinois' children.
  - 1.1 Reduce the infant mortality rate.
  - 1.2 Reduce the prevalence of childhood lead poisoning exceeding 25mg/dL.
  - 1.3 Reduce school absenteeism in grades K-8.
2. Extend health benefits coverage for optional targeted low income children.
  - 2.1 By January 1, 2000, increase the percentage of children enrolled in the program who are eligible at the Medicaid standard in effect on March 31, 1997. Illinois will conduct a baseline survey. For this calculation, an unduplicated count of children enrolled at any time during calendar year 1999 will be compared to the number enrolled during the baseline year. The performance goal will be to enroll one-third of the number of children identified by the survey as

- eligible but not enrolled.
- 2.2 By January 1, 2000, enroll in Title XXI at least 50 percent of the estimated 40,400 optional targeted low income children with family income above the Medicaid standard in effect on March 31, 1997, but at or below 133 percent of the FPL.
  3. Improve access to quality health care for optional targeted low income children enrolled in the Title XXI program.
    - 3.1 By January 1, 2000, 60 percent of the enrollees will have an identified primary health care provider (medical home).
    - 3.2 By January 1, 2000, increase by 5 percent the rate at which primary and preventive health care (EPSDT) providers participate in the program.
  4. Assure appropriate health care utilization by optional targeted, low income children enrolled in the Title XXI program.
    - 4.1 By January 1, 2000, 80 percent of enrolled children will be appropriately immunized at age two.
    - 4.2 By January 1, 2000, 80 percent of enrolled children will participate in EPSDT and receive a well-child visit, as measured by the HCFA 416 participation ratio.
    - 4.3 By January 1, 2000, reduce the rate per year of hospitalizations of enrolled children for the ambulatory care sensitive conditions of childhood asthma and dehydration/non-infectious gastroenteritis as compared to the baseline population.
    - 4.4 By January 1, 2000, reduce the rate of enrolled pregnant teens who deliver a very low birthweight baby as compared to the baseline population.

5. Implement a statewide outreach and public awareness campaign regarding the importance of preventive and primary care for well-children and the availability of health benefits coverage through Title XXI.

5.1 Launch a statewide outreach campaign through the coordinated efforts of the Illinois Departments of Public Aid and Human Services.

5.2 Increase the number of community-based sites certified by DPA to accept eligibility applications for forwarding to and eligibility determination by the local DHS office.

**9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:**

(Section 2107(a)(4)(A),(B))

Illinois will measure performance by establishing a baseline for each performance goal through various methods including: conducting a baseline population-based survey; using State vital records, hospital discharge and claims information; and using other Medicaid and non-Medicaid data bases that provide relevant information. For each performance goal, the method of measurement will be established and reports will be generated to monitor, on an ongoing basis, Illinois' progress toward meeting the goal.

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

9.3.1.  The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2.  The reduction in the percentage of uninsured children.

9.3.3.  The increase in the percentage of children with a usual source of care.

9.3.4.  The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5.  HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6.  **Other child appropriate measurement set. List or describe the set used.**

See response to 9.3.7

9.3.7.  If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1.  Immunizations

9.3.7.2.  Well child care

9.3.7.3.  Adolescent well visits

9.3.7.4.  Satisfaction with care

9.3.7.5.  Mental health

9.3.7.6.  Dental care

9.3.7.7.  **Other, please list:** \_\_\_\_\_

Infant mortality

Childhood lead poisoning

School absenteeism

Hospitalization of enrolled children for ambulatory sensitive conditions of gastroenteritis/dehydration and asthma.

Very low birthweight babies born to adolescents

9.3.8.  **Performance measures for special targeted populations.**

- 9.4.  The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1))
- 9.5.  **The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))**

In the first year of the program, Illinois will finalize the overall design and plan for the required annual assessment of the effectiveness of the elements of the State plan. Illinois will focus first upon further refining what is known about the demographic characteristics of children in families whose income is below 200 percent of poverty. The State will seek to collect sufficient baseline data to complete the chart for the State's annual report as proposed in this draft Title XXI plan.

Illinois will also establish the baseline levels for all performance measures established in Section 9 of the Plan. Most performance measures selected by the State are related to established data reporting systems. The data for establishing baseline levels will be drawn from existing data sources such as vital records, Medicaid claims records, hospital discharge data and school attendance records among others. Where necessary, Illinois will supplement existing data sources by conducting a population based survey.

The first year's annual assessment will report the results of efforts made to establish baseline levels for all measures and will report the State's progress in providing health benefits coverage to optional targeted low income children. In subsequent years, the annual assessment will provide updated information on performance on all measures. State staff will complete each year's annual assessment and will monitor ongoing progress toward meeting all performance goals.

In the first year of the program, the State will develop specifications for an evaluation of the program. The results of the evaluation will be submitted to the Secretary of DHHS by March 31, 2000. The evaluation will include an assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage. This evaluation will

include a comprehensive examination of the characteristics of children receiving health benefits coverage under the plan and will encompass such factors as ages of children, family income, and the children's health insurance status after their eligibility for the Title XXI program ends.

Through analysis of the patterns of utilization of service under the plan and the effectiveness of the plan as demonstrated through the performance measures established in Section 9, the evaluation will assess the overall quality and outcome of health benefits coverage provided under the plan. The provision of services, as an expansion of Medicaid, will be fully encompassed by all quality control mechanisms in place in Illinois' Medical Assistance program.

The evaluation will also include a complete description of the policy and processes established by the State for the Title XXI program. This will include the amount and level of assistance provided by the State and the mechanisms by which such assistance was provided; the service area; any time limits for coverage; the State's choice of health benefits coverage and other methods used for providing child health assistance; and the sources of non-Federal funding used for the program.

The State's plan will be considered effective if it achieves the performance goals established in Sections 9.2.1 and 9.2.2.

- 9.6.  The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))
- 9.7.  The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.
- 9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e))
  - 9.8.1.  Section 1902(a)(4)(C) (relating to conflict of interest standards)

- 9.8.2.  Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3.  Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4.  Section 1115 (relating to waiver authority)
- 9.8.5.  Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
- 9.8.6.  Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7.  Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8.  Section 1128A (relating to civil monetary penalties)
- 9.8.9.  Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10.  Section 1132 (relating to periods within which claims must be filed)

- 9.9. **Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement.** (Section 2107(c))

State staff have conducted an exhaustive set of discussions with a wide variety of interested parties concerning the implementation of Title XXI. These efforts have occurred in four principle forums as described below. All recommendations received through these avenues were considered in the development of Illinois' Title XXI plan.

Governor's Office

In September and October 1997, staff of the Office of the Governor, Directors of the Departments of Public Aid and Public Health and the Secretary of the Department of Human Services held a lengthy series of meetings with a wide variety of consumer advocacy and provider groups to discuss how Illinois should implement Title XXI. The organizations which participated in the meetings include:

Advocacy Groups

Voices for Illinois Children  
Maternal and Child Health Coalition  
Don Moss & Associates (United Cerebral Palsy)  
Campaign for Better Health Care  
Southside Health Consortium  
Chicago Hispanic Health Coalition  
Rural Health Association  
Illinois Public Health Association

Government Groups

Chicago Department of Health  
Cook County Bureau of Health Services  
DuPage County Health Department  
Will County Health Department  
Illinois Association of Public Health Administrators

Health Care Provider Groups

Illinois State Medical Society  
Illinois Hospital and Health Systems Association  
Illinois Primary Health Care Association  
Illinois Association of Health Maintenance Associations  
Children's Memorial Hospital  
Blue Cross/Blue Shield of Illinois  
St. Louis Children's Hospital  
Cardinal Glennon Hospital  
LaRabida Hospital  
Wylers Children's Hospital  
Rush Presbyterian St. Luke's Children's Hospital  
Lutheran General Children's Hospital  
Christ Hospital  
Human Resource Development Institute  
Lawndale Christian Health Center  
Metropolitan Chicago Healthcare Council  
Illinois Alcoholism and Drug Dependence Association  
Rush Prudential HMO

Others

Head Start Collaboration Project  
Project Success  
Chicago Public Schools  
National Association of Social Workers  
Children's Home and Aid Society of Illinois  
Illinois State Chamber of Commerce  
Illinois Retail Merchants Association  
Federation of Independent Business  
Illinois Manufacturers Association  
Shattuck and Associates

Illinois General Assembly

On October 29, 1997, the Illinois House of Representatives Children and Youth Committee, held a public hearing to hear testimony concerning Title XXI. The Departments of Public Aid and Human Services participated both in presenting testimony and witnessing the testimony of other interested parties.

A special legislative task force has been formed to consider Title XXI program options. The Children's Health Insurance Task Force includes four members of the Illinois Senate, four members of the Illinois House of Representatives, representatives of the Office of the Governor, advocates and members of the medical community. At the task force's first meeting on December 17, 1997, the details of this plan were discussed. The task force will continue to meet to discuss options for further expansion of child health insurance under Title XXI.

Health and Medicine Policy Research Group Seminar

On September 11, 1997, the Medicaid Administrator and the Assistant Secretary of the Department of Human Services participated in a half-day seminar hosted in Chicago by the Health and Medicine Policy Research Group, an independent organization generally concerned with issues of access to health care by low income individuals. The seminar was widely advertised throughout Chicago and well over a hundred individuals participated. The seminar included a lengthy audience participation period during which participants were able both to comment to and question the State's representatives concerning Illinois' opportunities for implementing the children's health insurance program.

Medicaid Advisory Committees

Title XXI was the subject of lengthy discussions by two of the Department of Public Aid's Medical Assistance Advisory groups. All meetings of both groups are open to the public. On September 19, 1997 as a result of lengthy discussion, the Medicaid Advisory Committee resolved in part that "...the MAC recommends to the Director of IDPA that he support the earliest feasible expansion of Medicaid eligibility to take full advantage of the immediate availability of federal funds at a 35% (state) match."

Title XXI was also discussed at three meetings of the Managed Care Subcommittee of the MAC on September 2, 1997, October 7, 1997, and November 4, 1997. These meetings were each attended by approximately 50 interested parties in addition to committee members. At each meeting, the Department presented updated

information concerning the opportunities presented by the new law and the possibilities for program design. Committee members as well as interested parties asked questions and made comments concerning the direction they thought the state should take in program design.

- 9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))**

**A financial form for the budget is being developed, with input from all interested parties, for states to utilize.**

(See attached).

**Title XXI State Children's Health Insurance Program  
Multi-Year Budget**

Federal Fiscal Year Budget

	<u>FFY98</u>	<u>FFY99</u>	<u>FFY00</u>
Medical Costs	\$28,392,721	\$38,388,999	\$38,958,223
State Liability	\$ 9,937,452	\$13,436,150	\$13,635,378
Federal Participation	\$18,455,269	\$24,952,849	\$25,322,845

State Fiscal Year Budget

	<u>SFY98</u>	<u>SFY99</u>	<u>SFY00</u>
Medical Costs	\$17,698,811	\$39,577,211	\$38,958,223
State Liability	\$ 6,194,584	\$13,852,024	\$13,635,378
Federal Participation	\$11,504,227	\$25,725,187	\$25,322,845

The state General Revenue Fund will be the source of state funds for this program.

**Section 10. Annual Reports and Evaluations (Section 2108)**

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2))

10.1.1.  The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.1.2.  Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

**HCFA DRAFT TEMPLATE  
Title XXI**

**ILLINOIS PLAN**

Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

<u>Attributes of Population</u>	<u>Number of Children with Creditable Coverage</u>		<b>TOTAL</b>
	<u>XIX</u>	<u>OTHER CHIP</u>	
<b>Income Level:</b>			
< 100%			
≤ 133%			
≤ 185%			
≤ 200%			
> 200%			
<u>Age</u>			
0 - 1			
1 - 5			
6 - 12			
13 - 18			
<u>Race and Ethnicity</u>			
American Indian or Alaskan Native			
Asian or Pacific Islander			
Black, not of Hispanic origin			
Hispanic			
White, not of Hispanic origin			
<u>Location</u>			
MSA			
Non-MSA			

- 10.2.  State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: **(Section 2108(b)(A)-(H))**
- 10.2.1.  An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.
- 10.2.2.  A description and analysis of the effectiveness of elements of the state plan, including:
- 10.2.2.1.  The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;
- 10.2.2.2.  The quality of health coverage provided including the types of benefits provided;
- 10.2.2.3.  The amount and level (including payment of part or all of any premium) of assistance provided by the state;
- 10.2.2.4.  The service area of the state plan;
- 10.2.2.5.  The time limits for coverage of a child under the state plan;
- 10.2.2.6.  The state's choice of health benefits coverage and other methods used for providing child health assistance, and
- 10.2.2.7.  The sources of non-Federal funding used in the state plan.
- 10.2.3.  An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

- 10.2.4.  A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5.  An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6.  A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7.  Recommendations for improving the program under this Title.
- 10.2.8.  Any other matters the state and the Secretary consider appropriate.
- 10.3.  The state assures it will comply with future reporting requirements as they are developed.
- 10.4.  The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.