



STATE OF ILLINOIS
OFFICE OF THE GOVERNOR
SPRINGFIELD 62706

JIM EDGAR
GOVERNOR

November 6, 1998

The Honorable Donna E. Shalala, Secretary
United States Department of
Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Madam Secretary:

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

Phase I of Illinois' Title XXI implementation began on January 5, 1998, through an expansion of our Medicaid program. A single Medicaid income standard of 133% of the FPL for children under age 19 was established at that time. This resulted in providing benefits to over 23,000 children. The standard for pregnant women and infants was simultaneously increased to 200% of the FPL under a Title XIX State Plan Amendment.

Effective August 12, 1998, Illinois began enrolling children under Phase II of its Children's Health Insurance Program. Illinois has expanded health benefits to children under 19 years of age with family incomes above 133% and at, or below, 185% of the FPL. With this amendment of Illinois' Title XXI State Plan, as well as the plans already approved under Title XXI and Title XIX, Illinois has created a continuum of insurance plans with varying degrees of family financial responsibility. Collectively, these programs are now known as Kidcare.

Staff from the Department of Public Aid have submitted draft versions of this State Plan Amendment to the Center for Medicaid and State Operations and have modified the document based on their recommendations. We believe the attached document meets all necessary requirements.

This document is being submitted electronically, on diskette, and in hard copy. In addition to our electronic transmission to the central and regional office, one diskette and three hard copies have been 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.

We continue to be excited by the opportunities afforded by Title XXI. I look forward to your approval of Phase II of our plan.

Sincerely,

Jim Edgar
GOVERNOR

JE:gc

cc: Dorthy Collins

Enclosure

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,

Jim Edgar, Governor, State of Illinois

Date: November 6, 1998

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 Titles 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.

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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.

**HCFA DRAFT TEMPLATE
Title XXI Plan Amendment**

ILLINOIS

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).**

Addendum to 2.1

Effective August 12, 1998, Illinois began enrolling children under Phase II of its Children's Health Insurance Program. Phase II expands the new children's health insurance program, KidCare, under Title XXI for children under 19 years of age with family incomes above 133% FPL and at or below 185% FPL.

With the implementation of KidCare, the State has created a continuum of insurance plans with varying degrees of family financial responsibility. In an effort to reduce the stigma of being on Medicaid and to create health plans that resemble the private sector, KidCare includes five plans. These include:

- 1) KidCare Assist - Children with family income at or below 133% of the FPL enroll and receive services through the State's Medicaid Program under Title XIX or through the Medicaid Phase I expansion under Title XXI. This program is publicly known as KidCare Assist. No monthly copayments or premiums are charged under KidCare Assist. This plan is currently in place under the State's approved State Plan.
- 2) KidCare Moms and Babies - Pregnant women and their babies up to age one with family income at 200% of the FPL or less, receive benefits with no monthly premiums or copayments. This program is publicly known as KidCare Moms and Babies. This plan is currently in place under the State's approved Medicaid State Plan.
- 3) KidCare Share - KidCare Share provides benefits for children with family income over 133% through 150% of the FPL, who are not covered by KidCare Moms and Babies. Under KidCare Share, no monthly premiums are imposed,

but modest copayments for prescriptions, office visits and non-emergency visits to the emergency room are required.

- 4) KidCare Premium - KidCare Premium provides benefits for children with family income above 150% up to 185% of the FPL, who are not covered by KidCare Moms and Babies. KidCare Premium imposes modest premiums and copayments.
- 5) KidCare Rebate - KidCare Rebate is the fifth plan and is not included under this State Plan. KidCare Rebate is available to those with family income above 133% up to 185% of the FPL whose children are insured. KidCare Rebate reimburses part of the cost of private health insurance for children.

The KidCare Share and KidCare Premium plans provide benefits that mirror the benefits provided for children under the State's approved plan under Title XIX of the Social Security Act. KidCare Share and KidCare Premium utilize the same provider networks, including essential community providers. KidCare Share, KidCare Premium and KidCare Rebate are not considered to be an entitlement.

KidCare Rebate is further encouraging coverage of children from working families by providing an insurance rebate to families who have enrolled their children in employer sponsored or private insurance. The rebate is capped at the average Medicaid payment minus the average KidCare premium. This rebate serves as an "anti-crowd-out" strategy to discourage employees from dropping current coverage to take advantage of other KidCare plans. This rebate plan is NOT included in this Title XXI State Plan and the following sections of this State Plan will address only KidCare Share and KidCare Premium. At a later date, the State may amend this plan to seek federal financial participation for portions of KidCare Rebate.

KidCare Moms and Babies is currently operating under Illinois' approved Title XIX State Plan. KidCare Assist is currently operating under the approved Medicaid State Plan and under the approved Phase I State Plan for Title XXI. More detailed descriptions of copayments, premiums and other requirements for the KidCare Share and KidCare Premium are described in this Title XXI State Plan Amendment.

The Department's original submission of this State Plan estimated that 61,200 children with family income above 133% and at or below 185% of the FPL had no health insurance and would be potentially eligible for benefits under Phase II. The census data provided in the initial Title XXI State Plan may be under-counting the number of

uninsured children in Illinois. Around 100,000 children could qualify under Phase II. Because of the unreliability of these estimates, the Illinois *Children's Health Insurance Program Act*, which implemented KidCare, requires the Department to commission a population study to establish regional estimates of the number of children:

- 1) with and without health insurance coverage;
- 2) who are eligible for Medicaid;
- 3) who are eligible for Medicaid and enrolled;
- 4) with access to dependent coverage through an employer; and,
- 5) with access to dependent coverage through an employer and enrolled.

The study shall also attempt to determine, for the population of children potentially eligible for coverage under KidCare:

- 1) the extent of access to dependent coverage;
- 2) the extent to which children are enrolled in private coverage; and
- 3) the amount of cost sharing related to such coverage.

Upon completion of this study, more accurate estimates will be available.

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)

As a Medicaid look-alike, KidCare Share and KidCare Premium deliver child health assistance through fee-for-service and prepaid providers included in the current Illinois Title XIX State Plan and any future approved amendments. Prepaid providers include Health Maintenance Organizations, Prepaid Health Plans, and Managed Care Community Networks.

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

KidCare Share and KidCare Premium employ all utilization controls from the Title XIX program, including prior approval controls, peer reviews, Medical Management Information System edits, and all existing post-audit and review procedures. Section 7.1 provides a more detailed explanation of these utilization controls.

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:** The Plan will be statewide.

4.1.2. **Age:** Under 19 years of age.

4.1.3. **Income:** The child's family income is above 133% and at or below 185% of the federal poverty level. Family income considers all persons living in the household, including those that are not applying for benefits. Certain income that is exempt under Title XIX is exempt under Title XXI. This includes the exemption of certain employment related costs, child care costs, and earned income of children who are not minor parents.

4.1.4. **Resources (including any standards relating to spend downs and disposition of resources):** No asset limitation is applied. Met spend-down cases are not eligible for KidCare Share or KidCare Premium.

4.1.5. **Residency:** The child must be a resident of the State of Illinois and a U.S. citizen or qualified legal immigrant. Qualified legal immigrants are non-citizens who meet one of the following categories;

- 1) Unmarried dependent children of a United States Veteran honorably discharged or a person on active military duty,
- 2) Refugees under Section 207 of the Immigration and Nationality Act,
- 3) Asylees under Section 208 of the Immigration and Nationality Act,
- 4) Persons for whom deportation has been withheld under Section 243(h) of the Immigration and Nationality Act,
- 5) Persons granted conditional entry under Section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1,

- 1980,
- 6) Persons lawfully admitted for permanent residence under the Immigration and Nationality Act, or
 - 7) Parolees, for at least one year, under Section 212(d)(5) of the Immigration and Nationality Act.

A child in categories (6) or (7) above, who enters the United States on or after August 22, 1996, is not eligible for five years beginning on the date of entry into the United States.

- 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:** Eligibility for benefits requires that:
- 1) The child is not a member of a family that is eligible for health benefits covered under the State of Illinois health benefits plan on the basis of a member's employment with a public agency;
 - 2) The child has not been covered by private insurance, including employer sponsored insurance, in the three calendar months prior to month of application. This three month limitation does not apply if the applicant lost their insurance through no fault of their own. The phrase "through no fault of their own" means that the insurance coverage was not voluntarily dropped by the family. Examples of losing insurance through no fault of their own include a person being laid off or an employer who drops coverage for its employees; and
 - 3) The child is not found to be eligible for Medicaid under Title XIX.
- 4.1.8. **Duration of eligibility:** The duration of eligibility is for 12 months unless terminated for one of the reasons described below. The twelve months of eligibility commences when the first child in a household is determined to be eligible, not when an additional child is added. Eligibility is redetermined at least every 12 months. Eligibility is terminated if;
1. The child loses his or her Illinois residency,
 2. The child attains 19 years of age,
 3. The child becomes eligible for and is enrolled in Medicaid under Title XIX,
 4. The child becomes an inmate of a correctional facility or a

patient in a mental institution,

5. The child's family becomes eligible for health benefits coverage under a State of Illinois health benefits plan on the basis of a member's employment with a public agency,
6. The child is found to have other significant health benefits,
7. Applicable premium payments are not made, or
8. The child's parent or adult who is legally responsible for the child's health care makes a written request to terminate coverage.

4.1.9. **Other standards (identify and describe):** At the time of application; a) the child is not a patient in an institution for mental diseases, or b) the child is not an inmate of a public institution. In addition, program eligibility is limited by amounts appropriated for KidCare Share and KidCare Premium. If the plans' enrollment reaches levels that indicate that fiscal year costs for those currently enrolled are approaching the appropriation, the State will stop taking new applications. The State will again take applications once enrollment levels are reduced or funding becomes available.

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))

A combined application is used for all KidCare plans as described in Section 2.1. Through a single application, children are reviewed for eligibility under all of the five plans and placed into the appropriate plan. If the review finds a child to be eligible under Title XIX, that child is enrolled in a Title XIX funded plan. Applications are

reviewed by both local offices and a central processing unit. Face-to-face interviews are not required under any of the KidCare plans.

To determine eligibility for KidCare Share and KidCare Premium under Title XXI, the total gross income of the family is counted, less allowable deductions and exemptions as defined in the Title XIX State Plan. For KidCare Share and KidCare Premium, the Department defines a family as the child applying for the program and the following persons who live with the child:

- 1) The child's parent(s).
- 2) The spouse of the child's parent(s).
- 3) Children under age 19 of the parent(s) or the parent's spouse.
- 4) The spouse of the child.
- 5) The children of the child.

The number of persons in the family determines the applicable income standard.

If the monthly countable income of a child is above 133 percent and at or below 150 percent of the Federal Poverty Level for the applicable income standard, the child is enrolled in KidCare Share. If the monthly countable income of a child is above 150 percent and at or below 185 percent of the Federal Poverty Level for the number of persons in the income standard, the child is enrolled in KidCare Premium.

All applicants are notified, in writing, regarding the outcome of their eligibility determination.

Eligibility determinations made by the fifteenth day of the month are effective the first day of the following month. Eligibility determinations made after the fifteenth day of the month are effective no later than the first day of the second month following that determination.

Monthly identification cards are issued for each family with a child enrolled under KidCare Share and KidCare Premium.

The duration of financial eligibility for KidCare Share and KidCare Premium is 12 months. The 12 months of financial eligibility commences when the first child in a family is covered under a plan. Children added to a plan after the eligibility period begins are eligible for the balance of the 12 month eligibility period. Before any 12 month period of eligibility ends, families are allowed to reapply to determine eligibility for another 12 months.

4.4. Describe the procedures that assure:

- 4.4.1. Through intake and follow-up 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))**

The single application enrollment process described above only allows those not eligible for Medicaid or those not having other creditable coverage to be enrolled into KidCare Share or KidCare Premium plans.

- 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))**

The single application process described above assures that all children applying for KidCare are considered for eligibility under Title XIX. Where they are found to be eligible for Medicaid, they are enrolled in KidCare Assist under Title XIX or Title XXI as appropriate. A child who is pregnant at the time of application for KidCare or an infant whose mother is eligible under Title XIX at the time of birth is enrolled in KidCare Moms and Babies.

If a child enrolled in KidCare Share or KidCare Premium becomes pregnant, she is terminated from either plan and enrolled under KidCare Moms and Babies (Title XIX funded) under the following circumstances: 1) upon the request of the pregnant child or her family she is reviewed for Title XIX eligibility, and if found eligible, is enrolled in KidCare Moms and Babies; 2) upon reapplication for KidCare Share or KidCare Premium, a pregnant child is enrolled in KidCare Moms and Babies when the 12 month eligibility period for KidCare Share or KidCare Premium ends; or 3) upon the family seeking to enroll the infant in KidCare, the State reviews the mother's status and if determined to be eligible under Title XIX, both mother and infant are enrolled in KidCare Moms and Babies.

- 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))**

As a deterrent to families dropping existing coverage to apply for KidCare Share or KidCare Premium, Illinois requires that they be uninsured for three

consecutive months prior to the month of application of plan coverage. Families who lose health benefits coverage through no fault of their own, or families who were receiving Medicaid before becoming eligible for KidCare Share or KidCare Premium, are not subject to this three month requirement.

The State is also implementing the State funded KidCare Rebate to subsidize employer-sponsored or private insurance. The KidCare Rebate serves as a significant "anti-crowd-out" strategy. This plan was designed to bring fairness to families who would be otherwise eligible for KidCare Share or KidCare Premium, but who, because they made the effort to insure their children, would be ineligible for coverage under the Children's Health Insurance Program. By providing these families with a subsidy to offset the costs of health insurance for their children, the rebate encourages families to retain their private coverage. The rebate also encourages employers to continue offering coverage to their employees' dependents.

In addition, under KidCare Share and KidCare Premium the State utilizes the same methods used under Title XIX to identify any third party payers.

The State will monitor the effect of KidCare on private insurers and modify the program if it appears that, because of availability of KidCare Share and KidCare Premium, persons or employers are inappropriately dropping privately funded coverage.

- 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))**

Not applicable in Illinois.

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

Coordination with public programs is attained through the single application process for all plans, as described above. The dual approach of providing eligible children with either KidCare Share and KidCare Premium, or KidCare Rebate assures coordination with private sector programs. Coordination between public and private entities is also discussed in Section 5.1 below.

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))**

Addendum to 5.1

In addition to the tasks already described under 5.1, Illinois is conducting an outreach campaign to increase public awareness of the State's health care programs for children. The campaign has been developed with the assistance of the Outreach Advisory Committee. This committee includes representatives from social services agencies, churches, schools, provider groups, community groups, fraternal organizations, local government, employer groups, unions, HCFA, and State agency personnel.

This outreach campaign is designed to reach eligible children in KidCare Share, KidCare Assist, KidCare Premium, KidCare Moms and Babies, and KidCare Rebate. Outreach to all of these plans will be accomplished by 1) identifying targeted populations; 2) publicizing the available benefits; 3) motivating families to take advantage of available plans; and 3) providing applications and assisting people with the application process. The enrollment process itself is more accessible and streamlined by expanding the number of offsite enrollment locations, using a combined application for all plans, and through the use of mail-in applications. Through this coordinated approach, all outreach efforts target all children potentially eligible under both Titles XIX and XXI.

Other specific outreach activities that are being implemented include the following:

1. Distribute informational brochures and implement a toll-free number for interested parties to learn more about the plans and receive assistance in completing and submitting applications;
2. Develop a media campaign to promote public awareness of the plans. The campaign will include, radio, print, and promotional advertising. The State is investing considerable resources into making materials attractive, interesting, and easy to follow;

**HCFA DRAFT TEMPLATE
Title XXI Plan Amendment**

ILLINOIS

3. Educate employers, unions, and trade associations about the plans;
4. Establish strong community outreach through churches, immigrant organizations, and community based organizations. Medical providers, including doctor's offices, local health departments, emergency rooms, Federally Qualified Health Centers, and Rural Health Clinics are also being enlisted. To assist community providers, the Department has developed an income screening tool that persons in the community can use to determine whether families appear to be eligible for the KidCare and for which plan they may be eligible;
5. Complete an electronic cross-match of participants in the WIC, school lunch, and child care programs to identify families who meet the income criteria for KidCare, but have not enrolled. Families in an unmet spend-down status are invited to apply;
6. Pilot the use of eligibility for the free lunch program as a determination of presumptive eligibility for KidCare Assist;
7. Establish educational partnerships to assist the State in promoting public awareness of KidCare. Such partnerships will include Americorp and VISTA programs, Headstart programs, Project Success (a program that coordinates social services through local schools), and coordination with the Illinois Departments of Human Services, Commerce and Community Affairs, Aging, Natural Resources, Revenue, and the State offices of Secretary of State, Attorney General and Comptroller, as well as through legislative offices.
8. The Department recognizes that certain populations will be hard to reach. Therefore, the Department may release a Request for Proposals to contract with multiple entities to identify and implement creative outreach strategies to locate and enroll identified hard-to-reach populations that may be eligible for KidCare and Medicaid. If implemented, the Department will provide multiple small grants for this project and has committed up to \$500,000 in total spending. Hard-to-reach populations that may be targeted through these grants include:
 - a) Children in families with limited English proficiency and other language barriers such as illiteracy;
 - b) Children with special needs. This includes children who are visually impaired, hearing impaired, and children with other chronic conditions such as emotionally, physically, or developmentally challenged children;

**HCFA DRAFT TEMPLATE
Title XXI Plan Amendment**

ILLINOIS

- c) Families who are difficult to reach because of various cultural barriers;
- d) Families who have multiple jobs;
- e) Families whose members are healthy and are, therefore, not motivated to apply for health insurance coverage;
- f) Families residing in rural areas of the State where medical provider services are limited or non-existent;
- g) Migrant children;
- h) Homeless children, and:
- i) Other hard-to-reach populations that may be defined by the contractors.

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))

KidCare Share and KidCare Premium mirrors the benefits of the Medicaid program in terms of the amount, duration and scope of services covered, except as noted below. The only exceptions are that home and community-based waiver services that are provided to Medicaid eligible persons as an alternative to institutionalization are not a part of KidCare Share or KidCare Premium, and no abortion services are included. KidCare Share and KidCare Premium include the following services in all primary, preventive, acute and chronic circumstances:

- 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))**

All services available under the State's Title XIX State Plan that are provided to participants of home and community based waivers are included under KidCare Share and KidCare Premium. Only the specialized services unique to these waivers are excluded from these plans. The waiver programs themselves have been specifically excluded for the following reasons:

- 1) KidCare Share and KidCare Premium are designed to be broadly applicable and are not intended to focus on the unique circumstances addressed through the home and community-based waivers;
 - 2) Each of the waiver programs have specialized eligibility objectives, several of which include income standards above those allowed under KidCare Share and KidCare Premium; and
 - 3) All of the waiver programs have enrollment caps.
- 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))**

No abortion services are covered by KidCare Share and KidCare Premium. A child who is pregnant when she applies is not enrolled in these plans but instead enrolled under Title XIX. If a child who becomes pregnant while she is enrolled under KidCare Share or KidCare Premium chooses to have an abortion, she must enroll under Title XIX to have abortion services covered. Abortion service limitations are defined in the Illinois Medicaid State Plan.

- 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))
Limited to children diagnosed with mental illness and children under the age of three who are receiving early intervention services.
- 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))

Home health care services
Audiology services
Optometric services
Family planning services
All EPSDT services
Services of Intermediate Care Facilities for the Mentally Retarded, skilled pediatric nursing facility services
Early Intervention services, including case management, for children who meet eligibility requirements established in the State's approved plan pursuant to Part C of the Individuals with Disabilities Education Act
- 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))**

The Department will submit a separate amendment regarding family coverage. Any questions related to family coverage will be addressed in that amendment.

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))**

Not applicable at this time.

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))**

The Department has established access to quality care, and the appropriateness of care, as performance measures for KidCare Share and KidCare Premium. These performance goals and methods of assuring their attainment are more fully described in Section 9. Methods to measure quality and appropriateness of care include the following:

Managed Care

For clients enrolled in managed care, the Department establishes and provides monitoring and oversight to ensure that quality control requirements are met. Managed Care Entities (MCEs) are required to have a quality assurance system in place that focuses on quality improvement. System activities include:

- Collecting systematic data on performance and patient results;
- Monitoring health care services through medical records review, clinical studies, physician peer review, and monitoring of health outcomes
- Developing and monitoring health education and outreach for clients;
- Establishing and monitoring member services to handle client issues;
- Establishing mechanisms for preauthorization and review of denials;
- Monitoring access standards;
- Monitoring fraud and abuse;
- Establishing and monitoring a client grievance and complaint resolution system;
- Evaluating client satisfaction;
- Providing information to providers, evaluating provider satisfaction and resolving provider concerns; and
- Establishing procedures for ongoing quality improvement with written procedures for taking appropriate remedial action and correcting deficiencies.

The Department has established quality control mechanisms for managed care which include ongoing monitoring of contract compliance, including the areas of covered services; service delivery; access standards; health education and outreach; pharmacy

formulary; linkages to other services; records requirements; care standards; encounter reporting; on encounters and quality assurance/improvement activities; marketing; member services; health outcomes, including measuring HEDIS indicators; minimum required performance standards; and financial stability. The Department contracts with a Quality Assurance Organization to assist in the oversight of managed care under both Title XIX and Title XXI. The Contractor's responsibilities include but are not limited to, medical records review, technical assistance, health outcome analysis and quality assurance monitoring of each managed care entity.

Fee-For-Service

Quality assurance mechanisms in the fee-for-service Medicaid system are listed below. These are employed under fee-for-service for KidCare Share and KidCare Premium. Through these mechanisms, quality problems are identified and addressed. Providers found to have quality problems are asked to prepare quality improvement plans.

1. Staff from the Division of Medical Programs are constantly looking for provider abuses of the Medicaid system. Such abuses are referred to the Bureau of Medical Quality Assurance (BMQA) for review.
2. BMQA has many tasks to assure medical quality.
 - a. Face-to-face client surveys regarding quality of care and access to care.
 - b. Investigations of referrals from within DPA; the Department of State Police; the Department of Public Health; and from the state's peer review organization.
 - c. Audits of providers who fall outside accepted norms for claims activity.
 - d. Peer review coordination of medical necessity and over-utilization issues.
3. The state's Medical Management Information System (MMIS) includes many edits to prevent abuse and excessive billings. New ones are created regularly.
4. DPA operates a toll-free hotline for clients to report any problems or concerns they may have.
5. The Department's peer review organization, conducts prepay and postpay medical records reviews on certain hospital inpatient and outpatient claims.
6. Special reviews are conducted on pharmacy claims to identify duplicate therapy, refill-too-soon, potential drug interactions, and abnormal dosages. Prior approval is required for high risk medication and drugs likely to be abused.
7. Prior approval is required for durable medical equipment and many medical supply items.

**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

The Department has established quality control mechanisms, including the monitoring of contract compliance, covered services, service delivery, access standards, health education and outreach, coordination with other services, and quality assurance and improvement activities. Specific goals for maintaining quality standards and measures of their attainment are described in Section 9.

7.1.2. Performance measurement

Performance measures include improving the health status of children by reducing infant mortality, lead poisoning, and school absenteeism; extending health coverage to more Illinois children; and assuring appropriateness, of and access to, necessary health care. These performance measurements and specific criteria for assessing their attainment are more fully described in Section 9.

7.1.3. Information strategies

The Department is expanding its client health care hotline and promoting the hotline as a place for families to call with concerns and questions. The Department is also incorporating a satisfaction survey for families participating in KidCare. Under both of these efforts, information is being collected and used to directly monitor and improve health care access and quality.

7.1.4. Quality improvement strategies

The Department is establishing procedures for ongoing quality improvement with written procedures for taking appropriate remedial action and correcting deficiencies.

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

The Department maintains a toll-free telephone hotline that allows recipients to identify any problems, including accessing health services and emergency room services. The Department also uses surveys to identify patterns that may be indicative of problems in accessing necessary medical services.

**HCFA DRAFT TEMPLATE
Title XXI Plan Amendment**

ILLINOIS

The Department believes the State's current Medicaid network is adequate to add an additional 100,000 children. However, to increase access even further, the Department has significantly reformed its payment methodology for outpatient and physician services, effective, July 1, 1998. To more accurately reflect the resources used in outpatient services, the Department increased from four to 12 the number of reimbursement groupings. Along with the increase in reimbursement groups, total reimbursement rates on outpatient services were increased by 42%. The Department has also significantly increased physician reimbursement rates. Overall, the Department increased physician rates by 10%, with certain basic procedures receiving increases as high as 61%. Dental rates have also been increased an average of 50%.

The Department is closely monitoring provider capacity in order to assure appropriate access.

The following table displays estimates of average payments that are made by the State KidCare Share and KidCare Premium:

**Department of Public Aid
Sample of Average Weighted Payments per Service
For Children 0-18 (Adjusted to FY99 Dollars)**

	<u>Liability</u>	<u>Services</u>	<u>Avg. Payment</u>
Physicians	\$ 1,375,679	58,190	\$ 23.64
Other Practitioners	50,750	3,046	16.66
Hospital Inpatient	16,592,020	3,256	5,095.83
Hospital Outpatient	125,385	4,850	25.85
Prescribed Drugs	3,293,634	149,441	22.04
Com. Hlth Centers	953,423	26,799	35.58
Home Health Care	1,373,824	4,528	303.41
TOTAL	\$ 23,764,715	250,110	\$ 95.02

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:** A family with a family income above 133% and at or below 150% of the FPL (KidCare Share) has no premium requirements, as required by federal law. A family with an income above 150% through 185% of the FPL (KidCare Premium) is charged a premium of \$15 per month for one child, \$25 per month for two children, and \$30 per month for three or more children.

8.2.2. **Deductibles:** None.

8.2.3. **Coinsurance:** None.

8.2.4. **Other:** Copayment requirements under KidCare comply with federal regulations. A family with a family income above 133% and below 150% of the FPL (KidCare Share) has a \$2 copayment for medical visits and prescriptions, including nonemergency use of the emergency room. A family with an income above 150% through 185% of the FPL (KidCare Premium) has a \$5 copayment for medical visits, a \$3 copayment for generic and \$5 copayment for name brand prescriptions, and a \$25 copayment for nonemergency use of the emergency room. All families have a \$100 annual cap on copayments. No copayments are charged for well-baby, well-child, or immunization services in any plan. In addition, no copayments are charged for visits to health care professionals or hospitals solely for lab or radiology services.

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income: Potential enrollees are notified of the cost sharing requirements during the enrollment process and through outreach efforts. The combined application

describes cost sharing requirements and requires applicants to attest that they understand and will comply with the requirements.

Cost sharing has already been described and debated through the legislative process and through public advisory committee meetings. It is described in brochures, during public hearings, through the State's administrative rule writing process (which provides for public comments and requires a public hearing) and through this State Plan process.

- 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))

With a maximum premium of thirty dollars per month, or \$360 per year, and a copayment cap of \$100 per year, the maximum cost sharing that can ever be imposed equals \$460 per year. The \$460 limit does not mathematically approach 5% of an eligible family's income under KidCare. This can be illustrated by applying the maximum total cost sharing against the minimum income possible under KidCare Share.

The minimum annual income for a child qualifying under KidCare Share is \$10,708 (1998 FPL for a family of one (\$8050) multiplied by 133% plus \$1). The \$460 maximum cost sharing represents 4.3% of the person's income. This example is used only as an illustration, since no premiums would be imposed at this income level.

The State's \$100 annual cap on family copayments is tracked by each family. Once a family has paid \$100 in copayments within a year, the family submits receipts to the State. The State then confirms the cap was reached by tallying the receipts submitted and immediately generates a written notice to the family. Such a designation is made on a client data system and the family's next monthly medical card indicates that they have reached the copayment cap. The Department's Recipient Eligibility Verification system is also updated to reflect that the copayment cap has been reached. Families that make a copayment before they receive notification from the Department may recover their copayment from the provider.

- 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: _____**

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

Addendum to 9.2

By January 1, 2000, it is the State's goal to enroll in KidCare at least 50 percent of the children whose family income is at or below 185% of the FPL. The actual number of children represented within this goal will be determined upon the completion of the population study described in Section 2.1.

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.

Addendum to 9.9

In addition to the advisory committees already described, the Department held public hearings on this proposed State Plan in both Chicago and Springfield. The Department submitted state administrative rules to implement the program. Prior to the adoption of any state administrative rule, state law requires a public notice process, the consideration of any comments, and a public hearing. The Outreach Advisory Committee will continue to assist the Department in implementing KidCare.

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.

Addendum to 9.10

The following table details estimated KidCare direct service budgets for State Fiscal Years (July 1 through June 30) 1999, 2000, and 2001. The following table provides a breakdown of estimated administrative expenses. Both tables include both State and federal funds. As can be seen from the second table, outreach represents the largest single administrative line.