ILLINOIS DEPARTMENT OF
HFS Healthcare and
Family Services

Rod R. Blagojevich, Governor
Barry S. Maram, Director

201 South Grand Ave., East

217/557-4677

To: Honorable Members of the Special Investigative Committee

From: Illinois Department of Healthcare and Family Services

Date: December 29, 2008

Re: Additional information requested by the Special Investigative Committee

Pursuant to the Special Investigative Committee's formal request to Ms. Tamara Hoffman to produce notes of meetings or emails regarding who made or was involved in conversations regarding (1) the decision to expand the FamilyCare Program from 185% to 400% of the Federal Poverty Level by regulation or (2) the decision to simultaneously expand the program and to transfer the population formerly covered under the SCHIP waiver to Medicaid by means of a single rulemaking, Ms. Tamara Hoffman has conducted an extensive review of her files, both in Springfield and in Chicago, and found the enclosed responsive documents. In addition, Ms. Hoffman found a communication responsive to inquiry number two above between herself and Mr. Pat Hughes, the General Counsel for the Office of the Governor, which is being withheld on grounds of Attorney-Client Privilege. If subsequent to this production, Ms. Hoffman finds any additional responsive documents, which she may have inadvertently missed, she will promptly produce them to the Committee.

In addition to the attached documents and persons named previously, Ms. Hoffman would like to identify the following persons as being involved in the inquiries above:

Internal HFS Department Staff:
Jacquetta Ellinger
Susan Moorchead
Michael Moss
Emily Coultas
Theresa Eagleson
Matthew Werner
Joe Holler

Persons external to HFS:
Milliman Inc. – Rob Damler and staff
Navigant Consulting – Gwen Volk and staff
Barnes and Thornburg, LLP – Larry Blust and Kascia Dygas
Director Michael McRaith, Department of Insurance
Shannon Lightner and staff, Department of Public Health
Marva Arnold and staff, Department of Human Services

Office of the Governor:

Matthew Summy
Anne Marie Murphy
Pat Hughes
Andrew Stolfi
Theresa Kurtenbach
Abby Ottenhoff
John Filan

Committee Exhibit 67

From: Krista Donahue
To: Eagleson, Theresa; Ellinger, Jackie; Hoffman, Tamara; Moorehead, Susan; Werner, Matthew
Date: Mon, Aug 13, 2007 10:52 AM
Subject: New summary document

attached is a draft of the new summary document.

DRAFT

Affordable Healthcare Initiatives

ILLINOIS COVERED ASSIST

Access to care for low-income, uninsured adults

- Provide access to a medical home with consistent primary care, a prescription drug benefit, hospital services, and disease management to uninsured Illinoisans with very low incomes—under 100% of the federal poverty level (FPL) (currently a single person who makes less than $10,210 annually, or a couple making less than $13,690 annually).

FAMILYCARE EXPANSION

Access to insurance for uninsured parents up to 400% FPL

- Illinoisans with children under the age of 19, who have been uninsured for 12 months and are under 400% of FPL ($80,000 for a family of four) will have access to the FamilyCare program.

EXPANSION OF COVERAGE FOR ILLINOISANS WITH DISABILITIES

Expanded access for working disabled Illinoisans

- Expand the Health Benefits for Workers with Disabilities program, which allows disabled Illinoisans to go back to work without losing their health benefits, from 200% to 350% FPL.

EXPANSION OF COVERAGE FOR YOUNG ILLINOISANS

Coverage for sick kids 19-21 who age off of All Kids

- Governor will direct the Director of the Department of insurance who is the Chairman of the Board of the Comprehensive Health Insurance Program (CHIP) to develop a bridge for children with pre-existing conditions who age off of All Kids and have no access to insurance. If eligible, premiums to these young adults will be subsidized to the age of 21.

PREMIUM ASSISTANCE FOR MIDDLE CLASS FAMILIES

Help for families struggling with the high cost of insurance

- Provide annual premium subsidy up to 20% of the cost of health insurance premiums to families at or below 300% of FPL ($60,000 for a family of four). Premium subsidies not to exceed $1,000.

BREAST AND CERVICAL CANCER SCREENING AND TREATMENT

Screening and treatment for all uninsured Illinoisans

- Expand the Illinois Breast and Cervical Cancer Program to provide free or lower-cost mammograms, breast exams, pelvic exams and Pap tests all uninsured Illinoisans. The program currently serves low- income, uninsured women and has provided screenings for more than 66,000 women.
- If diagnosed with cancer upon screening, program participants will have access to coverage for treatment under the Medicaid program.

From: JACQUETTA ELLINGER
To: JACQUETTA.ELLINGER@illinois.gov,Michael.P.Casey@illinois.gov,Michael.Moss@illinois.gov,Gia.Shelton@illinois.gov,Joe.Holler@illinois.gov
Date: Fri, Oct 12, 2007 2:42 PM
Subject: Re: FamilyCare to 400% FPL - rule draft

Gia and Finance Guys,

I goofed again by not attaching the draft - but that was good because we probably do need two slightly versions of this rule.

If we go with regular rulemaking to take FamilyCare to 400% FPL, then the first draft attached should work.

If we're filing FamilyCare as an emergency AND we have to have someone covered immediately and we proceed before any system changes can be made, then the second version - rapid start - should work. I've marked in blue highlighting the language we need for a quick start.

My head is spinning. Jacqui

Jacquetta Ellinger
Deputy Administrator
Division of Medical Programs
Illinois Department of Healthcare and Family Services
312-793-1984
>>> JACQUETTA ELLINGER 10/12/07 1:08 PM >>>
Gia and Finance Guys:

This version takes FamilyCare to 400% FPL. It may be filed as an emergency or maybe regular rulemaking - I don't think we know which yet - but we will need to be ready either way.

The budget impact here needs to match whatever has been said for the Gov's initiatives - and if we decide moving parents off SCHIP is not zero impact for the other version - that amount would have to be added here as well. That's because this version makes the change for parents up to 185% fpl as well as expanding up to 200% FPL.

You can ignore the yellow highlighting. That's just there in case we need it to show AMM and others the changes we've made since they last saw this.

Jacqui

Jacquetta Ellinger
Deputy Administrator
Division of Medical Programs
Illinois Department of Healthcare and Family Services
312-793-1984

CC: Theresa.Eagleson@illinois.gov,James.M.Parker@illinois.gov,Debbie.Watkins@illinois.gov,Lynne.Thomas@illinois.gov,Susan.Moorehead@illinois.gov,Nancy.Shalowitz@illinois.gov,Tamara.Hoffman@illinois.gov,Krista.Donahue@illinois.gov,Laura.Zaremba@illinois.gov

DRAFT

Amendment to 89 Ill. Adm. Code Part 120

SUBPART B: ASSISTANCE STANDARDS

Section 120.32 ~~KidCare Parent Coverage Waiver~~FamilyCare Eligibility and Income Standard

a) A caretaker relative (see Section 120.390) who is 19 years of age or older qualifies for medical assistance when countable income is at or below the appropriate income standard and all MANG(C) eligibility requirements in this Part, with the exception of Sections 120.320 through 120.323, are met.

b) The appropriate income standard is 133 per cent of the Federal Poverty Income Guidelines, as published annually in the Federal Register, for the appropriate family size.

c) If income is greater than this amount, it is compared to the MANG(C) Income Standard in Section 120.30 to determine the spenddown amount.

Section 120.33 FamilyCare Expansion Demonstration Eligibility

a) A caretaker relative (see Section 120.390), including a pregnant woman or her spouse if living together, who is 19 years of age or older qualifies for medical assistance under Section 120.32 if all of the following are met:

1) The individual is not otherwise eligible under this Part, Part 123 or Part 125.200;

2) All MANG(C) eligibility requirements in this Part, with the exception of Sections 120.320 through 120.323, are met, and

3) The individual meets one of the following:

A. Upon initial determination of eligibility:

i. The individual has been without health insurance for at least 12 months prior to the date of application unless the individual is a pregnant woman in which case the individual was without health insurance when her pregnancy was medically confirmed; ~~*do we want to further amend this to enroll pregnant women if their insurance does not provide maternity care?*~~

ii. The individual lost employer-sponsored health insurance when their job or their spouse's job ended;

iii. The individual has exhausted the life-time benefit limit of his or her health insurance;

iv. The individual's health insurance is purchased under the provisions of Consolidated Omnibus Budget Reconciliation Act (COBRA);

v. The individual was disenrolled for medical assistance under the Public Aid Code or benefits, including rebates, under the Children's Health Insurance Program Act or the Covering ALL KIDS Health Insurance Act within one year prior to applying under this Section unless the individual has state-sponsored health insurance;

vi. **The individual aged out of coverage under a parent's health insurance;** or

vii. The individual's income, as determined for establishing the appropriate premium payment under paragraph (g) below, is at or below 200 percent of poverty.

B. Upon redetermination of eligibility:

i. The individual's income, as determined for establishing the appropriate premium payment under paragraph (g) below, is at or below 200 percent of poverty;

ii. The individual was initially enrolled under subsection (a)(3)(A)(i), (v) or (vi) of this Section; or

iii. Affordable health insurance is not available to the individual. For the purpose of this Section, affordable health insurance for the individual does not exceed four percent of the family's monthly countable income. For the purposes of this determination, the amount of income disregarded under paragraph (b) below shall not be disregarded.

iv. For the purposes of this subsection (a)(3)(B), health insurance shall be considered unavailable to the individual if subsection (a)(3)(A)(iii) or (iv) apply.

b) For the purpose of determining eligibility under this Section, the department shall disregard income in an amount equal to the difference between 133 percent and 400 percent of the Federal Poverty Level Guidelines for the appropriate family size.

c) If after the application of paragraph (b) the caretaker relative is not eligible, total countable income is compared to the MANG(C) Income Standard in Section 120.30 to determine the spenddown amount.

d) Eligibility shall commence as follows:

1) Eligibility **determinations for the program made by the 15th day of the month will be effective the first day of the following month. Eligibility determinations for the program made after the 15th day of the month will** be effective no later than the first day of the second month following that determination.

2) Individuals with income at or below 200 percent of the Federal Poverty Level Guidelines found eligible under this section may obtain coverage for a period prior to the date of application for the program subject to the following:

i. The individual must request prior coverage within six months following the initial date of coverage.
ii. The prior coverage shall be individual specific and will only be available the first time the individual is enrolled under this Section.
iii. The prior coverage shall begin with services rendered during the two weeks prior to the date the individual's application was filed and will continue until th eindividuals coverage under paragraph (d)(1) is effective. ~~In no case may eligibility be effective earlier than.~~

e) **Eligibility shall be reviewed annually.**

fe) Caretaker relatives enrolled under this section must pay monthly premiums as follows:

1) Individuals who are not American Indians or Alaska Natives in families with countable income above 150 percent and at or below 200 percent of poverty shall pay premiums as set forth in Section 125.320(b).

2) Individuals in families with countable income above 200 percent but at or below 300 percent of the Federal Poverty Level Guidelines shall pay premiums of $80 per person per month.

3) **Individuals in families with countable income above 300 percent but at or below 400 percent of the Federal Poverty Level Guidelines shall pay premiums of $140 per person per month.**

gh) Individuals who are American Indians or Alaska Natives shall have no co-pays if their family income is at or below 200 percent of the Federal Poverty Level Guidelines.

h) The amount of income disregarded under paragraph (b) above shall not be disregarded in determining premium levels, or co-payments or eligibility for prior coverage or rebates.

i) **Premiums are billed by and payable to the department or its authorized agent, on a monthly basis.**

j) **The premium due date is the last day of the month preceding the month of coverage.**

k) **Individuals will have a grace period through the month of coverage to pay the premium.**

l) Failure to pay the full monthly premium by the last day of the grace period will result in termination of coverage.

m) Partial premium payments will not be refunded.

n) When termination of coverage is recorded by the 15th day of the month, it will be effective the first day of the following month. When termination of coverage is recorded after the 15th day of the month, it will be effective no later than the first day of the second month following that determination.

o) Following termination of an individual's coverage under this Section, the following action is required before the individual can be re-enrolled:

1) A new application must be completed and the individual must be determined otherwise eligible;

2) There must be full payment of premiums due under this Part or 89 Ill. Adm. Code 123 or 125, for periods in which a premium was owed and not paid for the individual;

3) If the termination was the result of non-payment of premiums, the individual must be out of the program for three months before re-enrollment; and

4) The first month's premium must be paid if there was an unpaid premium on the date the individual's previous coverage was canceled.

p) Individuals eligible under this Section who have health insurance and who have income under 200 percent of the Federal Poverty Level Guidelines may choose to receive a rebate instead of direct coverage by the department. The department shall apply the provisions of Part 125 Subpart D regarding rebates for persons eligible under this Section..

q) For the purposes of this Section, "Health Insurance" means any health insurance coverage as defined in 215 ILCS 105/2.

DRAFT – FamilyCare to 400% with Rapid Start

Amendment to 89 Ill. Adm. Code Part 120

SUBPART B: ASSISTANCE STANDARDS

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3) The individual meets one of the following:

A. Upon initial determination of eligibility:

i. The individual has been without health insurance for at least 12 months prior to the date of application unless the individual is a pregnant woman in which case the individual was without health insurance when her pregnancy was medically confirmed; ~~*do we want to further amend this to enroll pregnant women if their insurance does not provide maternity care?*~~

ii. The individual lost employer-sponsored health insurance when their job or their spouse's job ended;

iii. The individual has exhausted the life-time benefit limit of his or her health insurance;

iv. The individual's health insurance is purchased under the provisions of Consolidated Omnibus Budget Reconciliation Act (COBRA);

v. The individual was disenrolled for medical assistance under the Public Aid Code or benefits, including rebates, under the Children's Health Insurance Program Act or the Covering ALL KIDS Health Insurance Act within one year prior to applying under this Section unless the individual has state-sponsored health insurance;

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[redacted]

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i. The individual must request prior coverage within six months following the initial date of coverage.

ii. The prior coverage shall be individual specific and will only be available the first time the individual is enrolled under this Section.

iii. The prior coverage shall begin with services rendered during the two weeks prior to the date the individual's application was filed and will continue until th eindividuals coverage under paragraph (d)(1) is effective. ~~In no case may eligibility be effective earlier than.~~

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2) Individuals in families with countable income above 200 percent but at or below 300 percent of the Federal Poverty Level Guidelines shall pay premiums of $80 per person per month.

3) ~~2)~~ Individuals in families with countable income above 300 percent but at or below 400 percent of the Federal Poverty Level Guidelines shall pay premiums of $140 per person per month.

[redacted]

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p) Individuals eligible under this Section who have health insurance and who have income under 200 percent of the Federal Poverty Level Guidelines may choose to receive a rebate instead of direct coverage by the department. The department shall apply the provisions of Part 125 Subpart D regarding rebates for persons eligible under this Section..

q) For the purposes of this Section, "Health Insurance" means any health insurance coverage as defined in 215 ILCS 105/2.

From: JACQUETTA ELLINGER
To: Hoffman, Tamara
Date: Fri, Oct 19, 2007 2:04 PM
Subject: updated FamilyCare Plan

Tami,

I changed a couple small errors. So here it is if you want to send it to Pat or AMM or Andrew prior to the 3:30. I'll be heading over to JRTC shortly.

JE

CC: Donahue, Krista; Eagleson, Theresa; McCutchan, Christina; PARKER, James; Schafer, Lynette; Zaremba, Laura

DRAFT **FamilyCare Expansion Implementation Plan** *DRAFT*
October 19, 2007

Interim Implementation Effective: One Month from Decision to Proceed

Policy/Process Requirements During the Interim Period:

1. No change in the application. Parents at all levels can apply using the existing All Kids/FamilyCare/Moms & Babies application. They can also apply online.

2. The All Kids Hotline will handle requests for paper applications or general program information.

3. Expansion parents will have only one premium level encompassing the income range 186-400% FPL. We propose to charge them $80/person/month.

4. Expansion parents' co-pays will be the same as FamilyCare Assist (less than or equal to133% FPL.)

5. We will require that parents not have had insurance for 12 months, with exceptions like All Kids. We would not apply the uninsurance period to parents with income under 200% FPL to match what we do with kids.

6. Only HFS's All Kids unit will process eligibility for parents over 185% FPL. DHS's local FCRCs will take applications and begin processing them but they will transfer cases including parents with excess income to HFS's central All Kids unit for final disposition.

7. Cases processed by DHS will get a notice at the point the DHS staff finishes their work on a case. This is necessary to satisfy application-processing time limits. Instead of the existing denial notice, however, we will change the language in the automatically generated denial notice to:

   The adults on your application do not qualify for FamilyCare Assist, Share or Premium Level 1. However, they may qualify for a new program. We will send you a separate notice to tell you if the adults qualify for the FamilyCare expansion.

8. Parents over 185% FPL will be set up on separate cases. They will not appear on their kids' cases. A couple will be placed on the same case.

9. These parents will get a white monthly medical card with no change in any of the messages on the card. Their kids will continue to get yellow cards.

10. Eligibility will always be prospective. (Prior coverage will be available only to parents under 200% FPL.) The first day of coverage will be the same as All Kids Premium cases – and will depend on whether the disposition occurs at the beginning or end of each month.

11. Eligibility will have to be determined manually (as only minimum system changes are being made for interim period). Central automated notices will be suppressed and manual disposition notices will have to be used instead. This will require more staff time per case as the All Kids unit will have to manually track the cases for premium billing, case coordination and cancellations. The likelihood for increased backlog / waiting period for application processing is high.

12. Until such time as they cancel their coverage, parents will have to keep their premium payments current as well as their children's to preserve the children's coverage. Any payment received will be applied to the oldest debt of record per state accounting policy. This is similar to private credit card company practice.

Minimum data system requirements

DHS's system must create a new code (MANG P value) to pass to HFS's MMIS to identify these parents to allow proper claims payment and to make certain their costs are not included in the federal claim.

The centrally generated denial notices must be changed to account for the All Kids unit's review for parents with income over 185% FPL.

MMIS must be modified to recognize the new code identifying these cases and to handle claims processing and reporting correctly.

HFS's accounting system (PAAS) will have to be modified to receive premium obligation information run manually by the Bureau of All Kids and combine it with the automatically generated information about kids' premiums coming from DHS to generate accurate premium invoices and statements.

Staffing Requirements:

HFS needs a total of 106 new staff. These must be added to FY08 budgeted headcount. Most of these would be application processors or customer service positions but we will need other key positions added in Medical and other supporting units.

HFS will also need assistance to release pending PAR's to permit filling positions that will support this effort.

Caveats to this approach:

1. HFS must file emergency rules to maintain coverage of parents with income from 133% to 185% of poverty due to the Congress's failure to override the President's veto of the SCHIP reauthorization yesterday. We will also need a rule for the expansion from 186%-400% of poverty. JCAR has said they will call an emergency session and vote a suspension of any emergency rule dealing with eligibility.

An alternative to this would be to file emergency peremptory rulemaking, based on Congress's failure to override the President's veto of the SCHIP reauthorization, to move coverage of parents up to 185% FPL under the authority of the Public Aid Code. This is likely to put JCAR in a very tough position because failure to accept this action would mean denying benefits to about 130,000 people currently enrolled. Once this rulemaking survives the committee, we would have laid the legal basis for expanding eligibility for parents, by regular rulemaking under the Public Aid Code. If JCAR ignores the law and suspends or prohibits a peremptory rule of this nature, the state would arguably be in a good position to challenge JCAR's authority. This theory should be reviewed by Governor's legal counsel or outside counsel.

2. During the interim period, the lowest income parents (186-200% FPL) will be paying considerably more than we had originally planned to charge them. ($80/month compared to a max of $15/month). Parents with income 300-400% FPL will be paying considerably less. ($80 compared to $140)

3. Manual work will also increase the possibility of errors. For example, kids may be cancelled for non-payment of premiums while their parents continue on the program.

4. Parent's renewal dates may vary from that of their kids.

5. There may be a lot of clean up required down the road when the system catches up.

6. We will need to file rules twice. When we have a firm start date for the system changes, we would revise the rules to adopt the original proposed premium structure:

185% - 200% FPL	Parents pay the same as kids - $15-$40 per family
201% - 300% FPL	Parents pay $80 per person per month
301% - 400% FPL	Parents pay $140 per person per month

DRAFT **FamilyCare Expansion Implementation Plan** *DRAFT*
October 19, 2007

Full Automation Effective: April - July 2008

Objective:

Create a rules based data system interface for the FamilyCare expansion that will allow policy makers maximum flexibility to define and maintain program requirements while allowing the IT organizations in both HFS and DHS to concentrate on creating a permanent flexible data system infrastructure.

Phase I – 4 weeks

1. Procurement - Obtain contractors
   1.1. Business analysts to determine the parameters needed by policy
   1.2. Technical analysts to investigate existing technical structure at HFS & DHS
   1.3. Rules specialists that can help us select a rules engine and implement rules based processing
   1.4. Need high-level support to move procurements through CMS expeditiously.

Phase II – 8 weeks

2. Business analysts meet with policy offices in both HFS & DHS to determine the types of parameters needed and what repositories contain the base data.
3. Rules specialists meet with IT staff and directors to determine the rules engine requirements
4. IT team procures (through the best available mechanism) a rules engine
5. IT team creates a project plan to complete this project (building interfaces to DHS (eligibility) and HFS (claims).

Phase III – The remainder

IT team (including contractors) implements the rules engine and interfaces. Rules are developed and tested by the IT team and finally the policy side.

Phase IV – Roll-Out

System is put into production. Further refinements & maintenance continues

Cost Estimates

Type	Number	Rate	Hours	Cost
Business Analyst	4	150	3000	$1,800,000
Technical Analysts	6	150	3000	$2,700,000
Project Manager	1	200	3000	$600,000
Programmers	6	150	2160	$1,944,000
Hardware				$100,000
PCs, Phones, Desks, etc.				$25,000
Total				$7,169,000