Medicaid

An Introduction and Overview

prepared by

CHICAGO DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

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Last Revised on July 30, 2007

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Medicaid

MEDICAID

In 1965, President Lyndon B. Johnson signed into law a bill that, in addition to establishing Medicare for the elderly, created a categorical entitlement program,[1] called Medicaid, with open-ended federal matching under Title XIX of the *Social Security Act.*

Medicaid originally established a linkage between Medicaid eligibility and receipt of cash assistance. With the *Personal Responsibility and Work Opportunity Reconciliation Act of 1996,* the linkage between eligibility for cash assistance and for Medicaid was severed and Aid to Families with Dependent Children (AFDC) was repealed and replaced with a block grant-like allotment to states under Temporary Assistance for Needy Families (TANF). In addition, this Act barred Medicaid coverage for 5 years for certain categories of individuals who entered the U.S. after August 22, 1996. Coverage after the five-year ban, however, is allowed as a state option. States always have the option of providing medical services to otherwise-eligible immigrants using state funds.

The State Children's Health Insurance Program (SCHIP), a block grant to states for coverage of uninsured low-income children whose family incomes exceed Medicaid limits, was established under the *Balanced Budget Act* (BBA) of 1997. The BBA also allowed states to cover working people with disabilities and individuals with incomes up to 250 percent of the federal poverty level (FPL) that lose their Social Security Income (SSI) eligibility due to earnings. In addition, states are allowed to require most Medicaid enrollees to enroll in managed care organizations (MCOs) without obtaining a section 1915(b) "freedom of choice" waiver.

Program Description

Medicaid financed health care for over 55 million low-income individuals in 2003, making Medicaid the second largest health insurance program in the United States. Medicaid covers approximately 25 percent of the nation's children and is the largest single purchaser of nursing home services and other long-term care in addition to maternity coverage for prenatal, delivery, and post-partum care.

Medicaid is a categorical federal-state entitlement program. The statutory scheme of Medicaid requires states to provide certain services and protections to certain populations who qualify for the program. Those who meet program eligibility are entitled to have payment made on their behalf for covered services. Medicaid only entitles certain categories of individuals that meet federal and/or state eligibility criteria to services. Medicaid does not generally cover poor adults without disabilities who have no children or dependents.

Medicaid is the largest federal grant-in-aid to states. State participation in Medicaid is voluntary and all states have elected to participate. Medicaid makes federal matching funds available to states for the costs of paying for covered services. The amount of

[1] Medicaid requires states to provide certain services and protections to certain populations; thus, Medicaid is called an "entitlement" for those who qualify for the program.

money a state receives from the federal government is called the Federal Financial Participation (FFP). Each state's FFP is determined by a formula based on the state's per capita income and the amount of medical services the state chooses to provide to needy people within the state. The Federal government pays a minimum of at least half the cost of Medicaid's total program cost in every state. The range of payment varies from 50 to 76.29 percent in FFY 2008. There are no caps on spending.

Although 53.8 percent of those enrolled in Medicaid in FFY 2003 were children ages 21 and younger, 63.6 percent of all Medicaid funds that year were spent on services for the elderly and people with disabilities. Services to children ages 21 and younger in FFY 2004 represent only 16.8 percent of all Medicaid spending.

Medicaid provides a unique, counter-cyclical, positive stimulus during downturn and has a greater economic impact than other state spending increases because it is not a transfer of state funds but an infusion of new funds from federal match into the state economy. In Illinois, for each $1 million invested in Medicaid spending, $2.38 million is gained in business activity, 20.21 jobs are gained and $839 million in employee wages is gained[2]. Every $37 million that the federal government contributes to All Kids results in $87.6 million in business activity and $30.7 million in wages in Illinois.[3]

Deficit Reduction Act of 2005 (DRA)

The Deficit Reduction Act of 2005 (DRA) requires that most Medicaid applicants and recipients who are citizens document their citizenship in order to receive Medicaid. Citizens need to show a birth certificate or U.S. passport to enroll or remain in Medicaid. Other proof of citizenship and identity may be accepted in lieu of these primary documents. Medicare beneficiaries, SSI enrollees, and foster children are not required to provide proof of citizenship.

Naturalized citizens must show their Certificate of Naturalization or Certificate of U.S. Citizenship. Foreign-born citizens (those born overseas to U.S. parents) must show a certification or report of birth abroad.

Legal immigrants and undocumented immigrants are not affected by this change and do not need to provide any citizenship documentation.

Administration

The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for administering and financing Medicaid, SCHIP, and other related health programs.

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[2] Families USA. *Medicaid: Good Medicine for State Economies 2004 Update*. Washington, DC. May 2004. p. 7.

[3] Families USA. *Good for the Kids, Good for the Economy: Health Coverage for All Kids in Illinois*. Washington, D.C. 2005. p.4.

The state Medicaid and SCHIP agency for Illinois is the Illinois Department of Healthcare and Family Services (HFS).

Federal Waiver Services

The federal Department of Health and Human Services (HHS) can waive certain requirements of federal law and regulation in order to encourage innovation and provide states with greater flexibility in their SCHIP and Medicaid programs. These waivers can enable states to better tailor their programs to meet local needs and allow states to experiment with new approaches to providing health care services to Medicaid and SCHIP recipients.

Waiver programs range from comprehensive health care reform projects and other fundamentally new approaches (Section 1115 demonstration projects) to narrower changes (Section 1915 program waivers) aimed specifically at allowing use of managed care and alternatives to nursing home care. Health Insurance Flexibility and Accountability Initiative (HIFA) waivers expand the use of SCHIP funds to offer health coverage to uninsured adults.

Costs

Medicaid spending is affected by a variety of factors but is largely shaped by state decisions.

The federal Congressional Budget Office (CBO) estimated that the federal share of Medicaid spending would increase from $129.8 billion in FFY 2001 to $295.4 billion in FFY 2011, an average annual rate of growth of 8.6 percent. These figures reflect all components of Medicaid spending that in 2005 consisted of: acute care services (59.8 percent), long-term care services (34.6 percent), and disproportionate share hospital payments (DSH) (5.6 percent). CBO attributed Medicaid spending growth to a number of factors including upper payment limit (UPL)[4] mechanisms, enrollment increases, growth in underlying medical costs and wages, and the increasing use and rising costs of prescription drugs. About 60 percent of what Medicaid spends on services pays for hospitals, physicians, and other acute care costs. The remaining 40 percent of Medicaid service dollars is spent on nursing home and other long-term care.

Medicaid spending per enrollee varies considerably by eligibility category. In 2003, Medicaid spent an average of $4,702 per enrollee throughout the year. While spending on each child and adult enrollee was only $1,467 and $1,872 respectively, Medicaid spent $10,799 for each elderly enrollee and $12,265 for each disabled enrollee. As a result,

[4] Upper Payment Limit (UPL) is a financing mechanism under which state Medicaid programs generate additional federal matching payments by paying certain local public hospitals or public nursing facilities at rates substantially in excess of the costs of providing care to Medicaid enrollees. Excess payments are transferred through Intergovernmental Transfers (IGTs) by local public facilities back to the state Medicaid program or the state general treasury. The federal match on these transferred funds may be retained, in whole or in part, by the state or transferred back to the local public entity that initially transferred funds.

although 50 percent of all Medicaid enrollees are children, they accounted for only 17 percent of program spending in 2003. Payments for services to the elderly and to people with disabilities, while only 25 percent of enrollees, accounted for 87 percent of all Medicaid spending in 2003. Individuals age 65 and older comprise 10.5 percent of persons served by Medicaid, yet they account for nearly 56 percent of expenditures in 2005. This is due, in part, to higher service utilization and use of long-term care by these enrollees.

The principal factors driving Medicaid spending include:

- the number of eligible individuals who enroll;
- the price of the medical and long-term care services that Medicaid buys;
- the use of covered services by those enrolled;
- state decisions as to whether to cover optional eligibility groups or optional services;
- other factors such as the effectiveness of managed care in achieving savings; and
- state use of DSH, UPL, and IGT (Intergovernmental Transfer) mechanisms.

State Medicaid costs vary substantially from year to year and state to state. Because state Medicaid programs vary so greatly in eligibility, benefits, and payments to providers, individual states will experience growth rates that differ from the national average.

Cost Sharing

Medicaid is funded jointly by the federal government and participating states. Medicaid is the single largest source of federal funding to states and accounts for roughly 40 percent of all federal grants-in-aid. The federal government matches state Medicaid spending for covered services on behalf of eligible individuals. Some states also require their localities to contribute toward the state share.

State participation in the Medicaid program is optional. Since 1982, all states have chosen to participate and are entitled to receive federal medical assistance percentages (FMAP) for spending on covered services to eligible individuals on an open-ended basis.

On average, the federal share pays more than half of the costs of the Medicaid program. Federal share of the cost is a minimum of 50 percent but can be considerably higher since the funding formula is based on a state's per capita income. The federal government determines FMAP by comparing the average per capita income for each state to the national average per capita income. Thus, relatively poorer states receive a higher FMAP while relatively wealthy states are matched at the minimum FMAP. The FMAP is revised annually.

As a condition of participating in Medicaid, states are required by federal law to cover certain populations. States may also cover populations and services that are optional, not mandatory, and for which federal matching funds help pay for the cost of this coverage. About half of all Medicaid spending is for populations and/or services that states are not

required to cover. On average, states spent 17.9 percent of their own general fund dollars on Medicaid in 2003.

Eligibility

Medicaid covers three federally defined categories of low-income U.S. citizens: the elderly, people with disabilities, and parents and their children. These categorically needy individuals must meet certain financial criteria based on income and resources such as savings and other assets. This financial criterion is determined by each state within federal guidelines, so they may vary from state to state. Millions of poor U.S. citizens, including childless couples and single adults who are not aged or people with disabilities, are not eligible to receive Medicaid unless their states have obtained federal demonstration waivers that cover them. Individuals must, in general, be U.S. citizens to qualify for Medicaid. Documented immigrants who entered the U.S. before August 22, 1996, may, at state option, qualify for full Medicaid coverage. Federally funded Medicaid covers undocumented immigrants, or legal immigrants whose status makes them ineligible for coverage, only for emergency care including prenatal, delivery, and postpartum care.

States have the option of covering other categorically related groups.

DRA Eligibility Requirement

The Deficit Reduction Act of 2005 (DRA) requires that most Medicaid applicants and recipients document their citizenship to receive Medicaid. National born citizens need to show a birth certificate or U.S. passport to enroll or remain in Medicaid. Other proof of citizenship and identity may be accepted in lieu of primary documentation. Medicare beneficiaries, SSI enrollees, and foster children are not required to provide proof of citizenship. Naturalized citizens must show their Certificate of Naturalization or Certificate of U.S. Citizenship. Foreign-born citizens (those born overseas to U.S. parents) must show a certification or report of birth abroad.

Legal immigrants and undocumented immigrants are not affected by this change and do not need to provide any citizenship documentation.

Income Requirements

States must provide Medicaid services to those categorically needy individuals meeting the following criteria:

- individuals who met the requirements of Aid to Families with Dependent Children (AFDC) or more liberal state options in effect on July 16, 1996;
- children under age six with family incomes at or below 133 percent FPL;
- children 6-18 years old born after September 30, 1983, with family incomes at or below 100 percent FPL;

- pregnant women whose family income is below 133 percent FPL for services relating to prenatal, delivery, and postpartum care;
- fetuses that require more than prenatal, delivery, and postpartum care provided to pregnant women whose family income is below 133 percent FPL and who are covered by federal provisions for pregnant women or emergency care;
- recipients of Social Security Income (SSI);
- Medicare enrollees with income that qualifies them as dual eligibles; and
- recipients of adoption or foster care assistance under Title IX of the *Social Security Act*.

In situations where there is a "well spouse", or a spouse that is considered healthy, federal Medicaid law permits states to "deem" the income and resources of the well spouse as available to the sick spouse. The extent of this "deeming" depends on whether the sick spouse is at home or institutionalized. States also vary in how they apply these deeming rules. When there is a community spouse, or a spouse living at home, and an institutionalized spouse, there are federal guidelines regarding how income and assets are considered.

Eligibility is redetermined at least annually and recipients may not be terminated automatically from Medicaid when their financial or family situation changes. State agencies must continue to provide Medicaid to eligible individuals until they are found to be ineligible through an *ex parte* redetermination. The term "*ex parte* redetermination" refers to a redetermination made by one party, in this case the state, without the involvement of any other party such as the recipient. Thus, an *ex parte* redetermination is based to the maximum extent possible on information contained in the individual's Medicaid file including information available through the federal SDX or BENDEX systems[5] that the state believes is accurate. If the state is able to make a decision that the individual continues to be eligible for Medicaid, the beneficiary should be notified.

States have the option to use presumptive eligibility (PE) to facilitate the prompt enrollment and immediate access of services for children under age 19, pregnant women, and/or women with breast or cervical cancer, before there has been a full Medicaid eligibility determination. Presumptive eligibility allows states to enroll those eligible for a limited period of time before full Medicaid applications are filed and processed based on a determination by a Medicaid provider of likely Medicaid eligibility. States may also accept self-declaration of family income for initial eligibility. After initial eligibility is established, states must meet the requirement for an income and eligibility verification

[5] SDX is an automated system available to states under written agreements with the Social Security Administration (SSA). SDX provides title XVI (SSI) data to states for implementing agreements between the Secretary of HHS and state welfare agencies. The states use the data for administering SSI optional and mandatory state supplemental payments and the Medicaid (Title XIX) program, including fraud investigation and prosecution. The SDX provides information relevant to determining eligibility for State assistance programs, such as a recipient's name, SSN, DOB, address, relationship, income and resources. BENDEX is a centralized SSA computer process available to states under written agreements with SSA. BENDEX can verify or provide Title II information about payment status, benefit amounts, entitlement and termination dates, health insurance data, and other information relevant to eligibility for state assistance programs.

system (IEVS). Under IEVS, the state must request information from other federal and state agencies to verify the applicant's income and resources. A state may apply for a federal waiver to allow self-declaration of income.

Dual Eligibility

In addition to expanding children's health insurance programs, the *Balanced Budget Act of 1997* expands coverage for dually eligible individuals that qualify for both Medicare and Medicaid. To receive Medicare an individual must meet the following criteria: 65 years or older or between 18 and 65 and have a disability or a permanent renal failure; and the individual or the individual's spouse must have paid Social Security for 10 years. Individuals who fall into any one of these categories may need additional assistance if they cannot afford their medical expenses and may qualify for Medicaid benefits if they meet Medicaid eligibility requirements. Beginning in FFY06, the *Medicare Prescription Drug Improvement and Modernization Act* (MMA) provides Medicare prescription drug coverage for dually eligible individuals. States are required to make a monthly payment to the federal government according to a "take back" factor. The take back factor begins at 90 percent in FFY06 and phases to 75 percent in FFY15 and beyond.

- **Qualified Medicare Beneficiaries (QMBs)** are entitled to Medicare Part A and have an income up to 100 percent FPL. Medicaid pays their Medicare Part A premiums, Part B premiums, if any, and Medicare deductibles and coinsurance for Medicare services rendered by Medicare providers. These individuals may or may not already receive full Medicaid benefits.

- **Specified Low-Income Medicare Beneficiaries (SLMBs)** are entitled to Medicare Part A, and have an income between 100 percent and 120 percent FPL. Medicaid pays their Medicare Part B premiums only. These individuals may or may not already receive full Medicaid benefits.

- **Qualified Disabled and Working Individuals (QDWIs)** have lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have an income up to 200 percent FPL, and they are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only. (This was in the original version.)

- **Qualifying Individuals (1) (QI-1)** are entitled to Medicare Part A, have an income between 120 percent and 135 percent FPL, and are not otherwise eligible for Medicaid. Medicaid pays for their Medicare Part B premiums only. There is an annual cap on the amount of money available, which may limit the number of individuals in the group. This benefit is effective through FFY07.

- **Medicaid Only Dual Eligibles** are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as QMB,

SLMB, or QDWI. Typically, these medically needy individuals need to spend down[6] to bring them into income eligibility that qualifies them for Medicaid. Medicaid provides full Medicaid benefits and pays for Medicaid services, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare. Payment by Medicaid of Medicare Part B premiums is a state option. Nonetheless, states may not receive full federal participation for Medicaid services also covered by Medicare Part B for individuals who could have been covered under Medicare Part B had they been enrolled.

Medicaid Buy-In

The *Balanced Budget Act of 1997* (BBA) created a new optional categorically needy eligibility group that allows states to provide Medicaid coverage to working people with disabilities who, because of earnings, do not qualify for Medicaid under other provisions. Although eligibility is confined to those with family income below 250 percent FPL, many states implemented more liberal income and resource methodologies than federal Supplemental Security Income (SSI) and have premium payments or other cost-sharing charges on a sliding scale based on income.

The *Ticket to Work and Work Incentives Improvement Act of 1999* (TWWIIA) created two new optional categorically needy Medicaid eligibility groups: the Basic Coverage Group and the Medical Improvement Group. The Basic Coverage group is similar to the BBA group with two exceptions. The Basic Coverage group is limited to people at least 16 years old but no more than 64 years old, and there is no family income limit. The Medical Improvement Group covers any individual who lost eligibility under the Basic Coverage Group because the medical condition has improved so that it no longer qualifies the individual under SSI disability criteria.

Under the TWWIIA groups, states are free to have no income and resource standards or to establish state standards. If states establish standards, SSI income and resource methodologies are used to determine eligibility. Among state options under TWWIIA are: allowing more liberal income and resource methodologies than federal SSI standards, permitting more restrictive eligibility criteria than SSI, and requiring payment of premiums.

Services Covered

Title XIX of the *Social Security Act* requires that certain basic services in any state program must be offered to the categorically needy population in order to receive federal

[6] For most Medicaid eligibility categories, having countable income above a specified amount will disqualify an individual from Medicaid. Those who are medically needy may qualify for Medicaid coverage even though their countable incomes are higher than the specified income standard by spending down through payment of medical expenses until their income meets Medicaid eligibility criteria. Under this process, the medical expenses that an individual incurs during a specified period are deducted from the individual's income during that period. When the individual's incurred medical expenses have been subtracted from his or her income, and the difference is at or below the state-specified income standard, the individual qualifies for Medicaid benefits for the remainder of the period.

matching funds. States may, at their option, cover additional types of services and receive federal matching funds for the costs of those services. Because states have flexibility to design their own benefits packages, subject to federal minimum requirements, the benefit packages vary significantly from state to state. Although states cover a broad spectrum of services to meet a wide range of beneficiary needs, not all Medicaid enrollees use all services.

Medicaid services must be offered throughout a state. States may not vary the amount, duration, or scope of a covered service "solely on the basis of an individual's diagnosis, types of illness, or condition." Services must be "sufficient in amount, duration, and scope to reasonably achieve its purpose." States have discretion to vary these services, but services must meet federal standards of adequacy.

The DRA also gives states the authority to replace Medicaid benefits with a "benchmark" package for most children and certain other groups. States using benchmark coverage must provide EPSDT (Early and Periodic Screening, Diagnostic, and Treatment Services) as a wrap-around for children. Most groups**,** including mandatory pregnant women and parents, individuals with disabilities or special medical needs, people who receive both Medicare and Medicaid, and people with long-term health care needs, cannot be required to enroll in benchmark coverage, but states can offer voluntary enrollment.

States cannot offer benchmark coverage to any "expansion" groups to whom eligibility was extended after the DRA was enacted.

States must cover the following mandatory services:

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under age 21:
    - EPSDT services are Medicaid's comprehensive and preventive child health program for individuals under 21;
    - includes periodic screening, vision, dental and hearing services;
    - section 1905 (r)(5) of the *Social Security Act* requires that any medically necessary health care service listed at section 1905 (a) of the Act be provided to an EPSDT recipient even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population;
    - EPSDT benefit, in accordance with section 1905(r) of the Act, must include the following services:
        - screening services, which include:
            - comprehensive health and developmental history;
            - comprehensive unclothed physical exam;
            - appropriate immunizations;
            - laboratory tests;
            - health education;
            - vision services;
            - dental services;
            - hearing services;

        - other necessary health care services;
        - diagnosis;
        - treatment; and
        - lead poisoning prevention;
    - State Medicaid agency required activities:
        - inform all Medicaid-eligible persons under age 21 that EPSDT services are available;
        - set distinct periodicity schedules for screening, dental, vision, and hearing services; and
        - report EPSDT performance information annually;
- periodicity schedules for periodic screening, vision, and hearing services must be provided at intervals that meet reasonable standards of medical practice;
- dental services must be provided at intervals determined to meet reasonable standards of dental practice;
- inpatient and outpatient hospital care;
- home health care services for persons eligible for nursing facility services;
- nursing facility (NF) services for individuals aged 21 or older;
- physician services;
- laboratory and x-ray services;
- family planning services and supplies;
- federally qualified health center and federally qualified health center look-alike (FQHC and FQHCLA) and rural health clinic (RHC) services;
- nurse midwife services;
- pediatric and family nurse practitioner services; and
- medical and surgical dental services.

States also have the flexibility to offer other optional services without applying for a waiver. Optional services include:

- clinic services;
- optometrist services;
- eyeglasses;
- chiropractors services;
- psychologists services;
- medical social worker services;
- nurse anesthetists services;
- private duty nursing;
- physical therapy;
- occupational therapy;
- prosthetic devices;
- speech, hearing and language therapies;
- TB-related services;
- diagnostic services;
- screening services;
- preventive services;

- rehabilitative services;
- dental services;
- dentures;
- prescription drugs;
- intermediate care facilities/mentally-retarded services (ICF/MR)
- inpatient psychiatric services for under age 21;
- inpatient and nursing facility (NF) services for people 65 years or older in Institutions for Mental Diseases (IMDs);
- Christian Science nurses;
- Christian Science sanatoriums;
- NF services for under age 21;
- personal care services;
- transportation services;
- case management services;
- hospice care services;
- respiratory care services; and
- emergency hospital services.

States may also be approved for home and community-based care waiver services to certain classes of individuals who are eligible for Medicaid. The services to be provided to these persons may include: case management, personal care services, respite care services, adult day health services, homemaker/home health aide, habilitation, and other services requested by the state and approved by CMS.

The *Breast and Cervical Cancer Prevention and Treatment Act of 2000* gives states the option to provide medical services to certain women who have been found to have breast or cervical cancer or precancerous conditions. States may receive enhanced funding for this option.

States may choose to include the medically needy as an optional Medicaid population. The medically needy population refers to persons who would qualify for Medicaid categorically, but whose incomes are above Medicaid income eligibility requirements. These individuals can spend down to the Medicaid level by deducting incurred medical expenses. Federal law allows a state to provide less comprehensive benefits to the medically needy[7]. If a State chooses to include the medically needy population, the state plan must provide, as a minimum, the following services:

- prenatal care and delivery services for pregnant women;
- ambulatory services to individuals under age 19 and individuals entitled to institutional services;
- home health care services to individuals entitled to nursing facility services; and
- if the State plan includes services either in institutions for mental diseases or in intermediate care facilities for the mentally retarded (ICF/MRs), it must offer either

[7] Illinois has historically provided the same package to all Medicaid eligible individuals.

of the following to each of the medically needy groups: the services contained in 42 CFR sections 440.10 through 440.50 and 440.165 to the extent that nurse-midwives are authorized to practice under state law or regulations, or the services contained in any seven of the sections in 42 CFR 440.10 through 440.165.

State Children's Health Insurance Plan (SCHIP)

STATE CHILDREN'S HEALTH INSURANCE PLAN (SCHIP)

The State Children's Health Insurance Plan (SCHIP) was established as part of the *Balanced Budget Act of 1997* under Title XXI of the *Social Security Act* and became law in August 1997. The intent of the legislation was to bridge the gap for low income, uninsured families who earn too much to qualify for Medicaid but cannot afford to pay for health insurance coverage on their own or through an employer. SCHIP funds cover the cost of insurance, outreach services, and administrative costs. Funds must be used to cover the uninsured and not to replace existing public or private coverage. SCHIP's passage marked a historic national commitment to expanding health care coverage for children.

SCHIP is a voluntary program for states with flexibility in tailoring programs to meet state need. States may set eligibility criteria regarding age, income, resources, residency, and duration of coverage within broad federal guidance. Federal requirements for SCHIP mandate that participating states provide services to pregnant women and infants who are either at or below 133 percent of the FPL. Legislation allows states to choose one of three ways to spend SCHIP allotments. States can expand Medicaid, create or expand a state health insurance program, or a combination of both approaches. States may spend up to 10 percent of their funds to provide coverage through a community-based health delivery system or by purchasing family coverage. Although the law limits the amount by 10 percent that states can spend on direct purchase of services, administration, and outreach, the Secretary of the federal Department of Health and Human Services can grant waivers to states wishing to spend more on these areas. Non-mandatory federal requirements allow states with separate SCHIP programs to expand Medicaid presumptive eligibility and accept a self-declaration of income for initial services.

States may implement cost sharing initiatives by imposing premiums, deductibles, or fees for some services and for some groups. No co-payments are allowed for pediatric preventive care, including immunizations, at any income level. Current regulations on cost sharing for adults receiving Medicaid apply for those at or below 150 percent FPL. In these instances, states may impose the following:

- premiums of $15-19 per family per month;
- deductibles of $2 per family per month;
- co-insurance to a maximum of 5 percent of non-institutional costs;
- co-payments may range from $0.50 to $3.00 per service; and
- institutional care cost of no more than 50 percent of the first day's costs.

States may impose nominal co-payments on some services for some groups of enrollees or to require nominal co-payments for prescription drugs and certain other non-emergency services. States may not impose any co-payments or other cost sharing requirements upon any services provided to children, pregnant women, or nursing home residents or for family planning or emergency services provided.
The Deficit Reduction Act of 1996 allowed states to set cost sharing for children whose family income is above 100%. For children whose family income is 100% -150% FPL,

cost sharing can be up to 10% of the service cost and is capped at 5 percent of quarterly or monthly (at state option) family income. For children with family incomes above 150% FPL, states can impose cost sharing can be up to 20% of the service cost and is capped at 5 percent of quarterly or monthly (at state option) family income.

The DRA also allows states to institute and charge mandatory premiums and cost-sharing in Medicaid. States are prohibited from charging premiums to Medicaid beneficiaries below 150% FPL and other specified groups (e.g. mandatory children and pregnant women, children in foster care or receiving adoption assistance, terminally ill individuals). Cost-sharing is largely prohibited for mandatory children and certain services are also exempt (e.g. preventive services for children, pregnancy-related care, emergency services, family planning, care provided to institutionalized individuals and those in hospice).]

Federal-State Cost Sharing

SCHIP is a federal block grant-like allotment provided to states based on the number of uninsured children and state revenues. The federal government matches state funds at an enhanced FMAP that is 30 percent higher than the state's FMAP creating an enhanced FMAP rate between 50 and 85 percent. A state will receive enhanced FMAP until the state's allocated SCHIP funds are exhausted.

This allotment funding mechanism sometimes acts as a disincentive to states that may be conservative when expanding Medicaid eligibility due to fear of exhausting SCHIP funds. For example, states have the flexibility to expand Medicaid beyond the 130 percent FPL minimum to the maximum 200 percent FPL, but may choose a lower rate in order to save funds.

Crowd Out

Crowd out refers to the process by which new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some privately-insured persons to drop their private coverage and take advantage of the expanded public subsidy. Crowd out also occurs when such programs act as a disincentive for employers to maintain or expand private coverage for employees. Employers may contribute fewer dollars to employees' health insurance coverage or drop coverage altogether in an effort to prompt employees to enroll their children in the new public program.

Crowd out is a concern of both state and federal programs because the creation of the public program or expansion may create shifts in coverage from private to public insurance rather than decreasing the number of uninsured children. This may result in less than anticipated improvement in access to care and health status, greater increases in public expenditures, or having the program be less cost-effective than expected.

Regulatory guidance regarding crowd-out under SCHIP is included in the Title XXI legislation indicating that SCHIP funds are explicitly designed to provide health

insurance coverage only to uninsured, not already insured, children and includes provisions to ensure that the intended target group is the primary benefactor of the new program.

Eligibility

States decide on what criteria they will use to provide health coverage to children and how narrowly they want to target coverage to groups of children. SCHIP's only eligibility requirements are to cover uninsured children who are:

- not eligible for Medicaid;
- under age 19;
- up to 200 percent FPL; and
- U.S. citizens.

Documented immigrants who entered the U.S. before August 22, 1996, may, at state option, qualify for coverage. Medicaid covers undocumented immigrants, or legal immigrants whose status makes them ineligible for coverage, only for emergency care including prenatal, delivery, and postpartum care.

Medicaid and State Children's Health Insurance Program (SCHIP) in Illinois

MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) IN ILLINOIS

Programs in Illinois

Programs for Children
All Kids
Illinois Health Connect
Your HealthCare Plus

Programs for Custodial Parents and Caregivers
Medicaid
FamilyCare
Illinois Health Connect
Your HealthCare Plus

Programs for People with Disabilities
Medicaid
Your Healthcare Plus
Illinois Cares Rx

Programs for Senior Citizens
Medicaid
Illinois Cares Rx

Programs for Veterans
Veterans Care

Programs for Women
Medicaid
Moms and Babies/Medicaid Presumptive Eligibility
FamilyCare
Illinois Health Connect
Your Healthcare Plus
Illinois Healthy Women

The Illinois Department of Healthcare and Family Services (HFS) administers Medicaid in Illinois. The federal government matches Illinois Medicaid expenditures with the minimum FMAP of 50 percent.

About 1.2 million Medicaid enrollees may choose between HMOs and Illinois Primary' Care Case Management program Illinois Health Connect. The remaining enrollees receive services through traditional fee-for-service.

In Illinois, SCHIP covers children to age 19 up to 200% Federal Poverty Level through All Kids. The Moms and Babies program for pregnant women also provides coverage up to 200% Federal Poverty Level.

MEDICAID

Eligibility and Programs

Illinois Medicaid eligibility is based on state income and asset standards. A child up to age 19 or younger, an adult with dependent children, a woman who is pregnant, persons who are blind, disabled, or age 65 or older are categorically eligible. Medicaid enrollees who have income and assets that exceed Medicaid limits, but still qualify for the program pay a portion of their medical expenses while Medicaid pays the remainder. This is called spend down and extends the program to many low-income families and individuals.

The income limits for Illinois Medicaid are 100% FPL for adults and 133%FPL for children and pregnant women. The asset limits for Illinois Medicaid are $2,000 for 1 adult, $3,000 for 2 adults, and an additional $50 for each additional person. There are no asset limits for children or pregnant women.

Categories of people that meet eligibility requirements are as follows:

- Those that qualify for **Temporary Assistance for Needy Families (TANF)**, which provides income assistance and other services, and meet the Medicaid eligibility criteria may receive Medicaid coverage. The *Personal Responsibility and Work Opportunity Reconciliation Act of 1996* de-linked Medicaid from federal welfare programs. States may, but are not required to, extend Medicaid coverage to all families receiving TANF benefits. States must, however, extend Medicaid to families with children who meet the eligibility criteria that states had in effect under their AFDC programs as of July 16, 1996.

- Those that qualify for **Aid to the Aged, Blind and Disabled (AABD)** which requires that Medicaid-eligible persons be 65 years of age or older, blind or disabled. The population largely coincides with that covered under the federal Supplemental Security Income (SSI) program. Although most persons in this group are 65 years of age or older, children are eligible if they blind or disabled. Persons eligible for

AABD cash also receive medical assistance through Medicaid. They may also be eligible for food stamp benefits.

- Children in **Foster Care/Adoption Care Assistance** programs are eligible for Medicaid. Medical assistance is also available to Title IV-E eligible foster care/adoption assistance for children from other states that are living in Illinois.

- Under the **Repatriate Program**, eligible persons are U.S. citizens with families returned to the U.S. from another country by the Department of State. Persons must be referred by the U.S. Department of State through the repatriate branch of the U.S. Department of Health and Human Services.

- **The Refugee Resettlement Program** is provided to individuals who are refugees and do not meet the requirements for TANF or AABD. Assistance under the Refugee Resettlement Program is available for:

    - persons admitted to the U.S. as refugee, asylees, or conditional entrants;
    - resident non-citizens who were formerly refugees;
    - Amerasian immigrants from Vietnam;
    - nationals of Cuba or Haiti;
    - members of the Hmong or Highland Laotian tribes when the tribe helped U.S. personnel by taking part in a military or rescue operation during the Vietnam era;
    - American Indians born in Canada;
    - persons identified as victims of trafficking by the federal Office of Refugee Resettlement; and
    - persons who are a spouse, widow, or child of a U.S. citizen or legal permanent resident who have been battered or subjected to extreme cruelty by the U.S. citizen or legal permanent resident.

- **Payment For Non-citizens Under Medicaid Emergency Medical** assists non-citizens who do not meet certain immigration requirements. These adults are only eligible for medical assistance when they have an emergency medical condition and meet the income, asset and other requirements of the Medicaid or FamilyCare. Non-citizen children will be covered for the emergency by emergency Medicaid and are eligible for All Kids.

  Pregnancy is considered an emergency medical condition, so prenatal, delivery, and postpartum services for pregnant non-citizens are covered.

  Federal law prohibits payment for care and services related to an organ transplant procedure for persons receiving emergency medical care.

Presumptive Eligibility

Children under the age of 19 are presumptively eligible (PE) for coverage when an application is received if the following conditions are met:

- declared family income is no more than 200 percent FPL;
- the child did not start receiving PE coverage within the prior 12 months; and
- the staff processing the application has no knowledge that the child does not meet federal immigration requirements.

A child with PE receives identical benefits to those enrolled in Family Assist or All Kids.

Services Covered

Illinois Medicaid covers the following mandatory services:

- inpatient and outpatient hospital care;
- home health care services for individuals aged 21 or older;
- nursing facility (NF) services for individuals aged 21 or older;
- physician services;
- laboratory and x-ray services;
- family planning services and supplies;
- federally qualified health center and federally qualified health center look-alike (FQHC and FQHCLA) and rural health clinic (RHC) services;
- nurse midwife services;
- nurse practitioner services;
- medical and surgical dental services; and
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under age 21.

Illinois covers optional services and receives federal Medicaid funds for the following:

- prescription drugs;
- intermediate care facility services for the mentally retarded (ICF/MR);
- respiratory care for home-based, ventilator-dependent individuals;
- services provided through managed care organizations (MCOs);
- hospice care services;
- podiatric, optometric, chiropractic, and dental services;
- speech, hearing, and language therapies;
- prosthetic devices;
- health insurance for children and their parents or caretakers through 1115 waivers;
- home- and community-based services through 1915(c) waivers; and
- other practitioner services that are medically necessary.

Federal Section 1915(c) waiver services in Illinois include services for the elderly, people with disabilities, those in supportive living arrangements, and people with HIV/AIDS. Waivers provide case management services, homemaker services, home health services, personal care services, adult day health services, habilitation services, respite care services, electronic home response, subsidized guardianship, and alcohol and other drug treatment.

All Kids, FamilyCare, Illinois Cares Rx, and Healthy Women are funded in Illinois through federal Section 1115 waivers. Some programs are funded through federal 1915 @ Home and Community Based Services waivers. (See www.hfs.illinois.gov/hcbs waivers/ for full explanation.)

ALL KIDS

All uninsured children age 18 or younger residing in the state of Illinois are eligible for health care coverage through All Kids.

Eligibility for All Kids is determined by age and Illinois residency not by family income or immigration status.

All Kids health care coverage offers comprehensive health care benefits for children regardless of family income or immigration status. Benefits are comparable to those in Medicaid and SCHIP and include: doctor's visits, hospital stays, prescription drugs, vision care, dental care, screenings, and medical devices like eyeglasses and asthma inhalers.

All Kids has separate coverage categories: All Kids Assist for enrollees with family income to 133 percent FPL, All Kids Share for enrollees with family income above 133 percent FPL but no more than 150 percent FPL, and All Kids Premium for enrollees with family income above 150 percent FPL. All Kids Rebate pays a rebate of $75[8] of private health insurance premiums to families who already have comprehensive pre-existing health insurance for their children. Only a few families with limited income qualify for All Kids Rebate.

Families with health insurance and monthly income that qualifies for All Kids Share, Premium Level 1 or Rebate, can choose the plan that is best for their families. All Kids Share and All Kids Premium provide a medical card to help cover services for children that the plan does not cover. All Kids Rebate reimburses the policyholder for a portion of the premium they pay for health insurance.

All Kids income limits for children who have health insurance are $26,000 per year for a two person family, $33,000 per year for a three person family, $40,000 per year for a four person family. The limit is higher for larger families.

Eligibility and Programs

All Kids is health care coverage for children age 18 or younger that reside in Illinois. Eligibility does not depend on family income or immigration status.

To qualify for All Kids a child must be uninsured for one year. Exceptions are made for children that lost coverage due to job loss by a parent or by having a TANF parent that earned their way out of previous coverage. Children who are covered by employer-sponsored coverage may qualify for All Kids Rebate or Premium Level 1 or Share.

More than 900 All Kids Application Agencies in Illinois will assist parents and caretakers in applying for All Kids. Application agents in Chicago include the seven

[8] With a rebate families receive money to help pay health insurance premiums for their children.

Chicago Department of Public Health neighborhood health centers and Office of Health Care Access, local offices of the Illinois Department of Human Services, WIC office locations, and the Chicago Public Schools. All Kids Application Agents help parents with the enrollment process and send the completed application to the state central All Kids unit in Springfield for approval.

Consumers may also contact All Kids at 800.ALL.KIDS or online at www.allkidscovered.com or www.illinois.gov/health to determine the costs for covering their children through All Kids. The All Kids website, www.allkidscovered.com, has information about All Kids in seventeen languages.

The All Kids application is available online at www.allkidscovered.com and www.illinois.gov/health and may be completed online.

Benefits

All Kids has a sliding fee scale for premiums, copays, and annual deductibles based on family size and income.

- **All Kids Assist** has no copay or premium for families with income to 133 percent FPL;

- **All Kids Share** has no premium and a maximum copay of $100 per family per year for families with income from 133% to 150% FPL;

- **All Kids Premium Level 1** has premiums of $15 for a single child, $25 for two children, and $5 for each additional child to a maximum of $40 for five or more children, and a maximum copay of $100 per family per year for families with income from 150% to 200% FPL;

- **All Kids Premium Level 2** has premiums of $40 for a single child with a maximum of $80 for two or more children, and a maximum copay of $500 per child per year;

- **All Kids Premium Level 3** has premiums of $70 for a single child with a maximum of $140 for two or more children, and a maximum copay of $750 per child per year;

- **All Kids Premium Level 4** has premiums of $100 for a single child with a maximum of $200 for two or more children, and a maximum copay of $1,000 per child per year;

- **All Kids Premium Level 5-7** has premiums of $150-250 for each child; and a maximum copay of $5,000 per child per year; and

- **All Kids Premium Level 8** has premiums of $300 for each child and no caps on premiums or copays.

- **All Kids Rebate** directly reimburses the policyholder up to $75.00 per child per month for their health insurance premium costs. If the rebate is less than the cost of the employer coverage premium, enrollees may opt for All Kids Share or Premium Level 1 for families with income from 133% to 200% FPL.

Under **All Kids Assist**:

- All Kids may pay for those that had medical bills for one of the three months before the applicant applied for All Kids or for months while their application was being processed.
- When the mother or her children are approved for coverage, the first month of coverage can be one of the following:

    - The month she applied, if she and her children were eligible for that month, or
    - Up to three months before the month she applied, if she and her children were eligible for those months.
    - Eligibility is determined by monthly income and whether the pregnancy is medically pregnancy, which is decided by health care providers who participate in All Kids.

Under **All Kids Share** and **All Kids Premium**:

- If the applicant had medical bills for one of the two weeks before she applied for All Kids Share or Premium, she may be able to get help to pay for them.
- The first time children are approved for All Kids Share or All Kids Premium, the children may be eligible for payment of medical services received from two weeks before the date of application until the date All Kids coverage begins. This is called prior coverage:
    - Prior coverage must be requested within six months from the beginning date of coverage.

Medicaid Presumptive Eligibility (PE)

Medicaid presumptive eligibility is the process of providing coverage at time of application, without final documentation and approval, so that the individual will have immediate access to services.

Children through age 18 are presumptively eligible (PE) for coverage when an application is received if the following conditions are met:

- declared family income is no more than 200 percent FPL;
- the child did not start receiving PE coverage within the prior 12 months; and

- the staff processing the application has no knowledge that the child does not meet federal immigration requirements.

A child with PE receives identical benefits to those enrolled in Family Assist or All Kids Assist.

Services Covered

All Kids offers comprehensive coverage for all uninsured children in Illinois.

All Kids covers Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, as discussed in greater detail under the Medicaid Services Covered section of this manual, and the full range of other medical services as provided under Medicaid in Illinois:

- physician services
- care at health clinics (FQHCs/RHCs/FQHCLAs)
- inpatient and outpatient hospital care
- inpatient and outpatient surgical services
- prescription drugs
- dental care
- vision care and supplies
- laboratory tests and x-rays
- transportation to medical care
- family planning and supplies
- medical equipment, prostheses, othoses, and supplies
- services of intermediate care facilities for persons with developmental disabilities (ICF)
- skilled pediatric nursing facilities
- maternity care
- long term care
- renal dialysis
- psychiatric and mental health care
- hearing services
- inpatient and outpatient substance abuse treatment services
- chiropractic care
- podiatric care
- physical therapy
- occupational therapy
- speech therapy
- home and special nursing care
- kidney dialysis
- nursing care services (NF)
- hospice care
- early intervention services, including case management
- hospital emergency room
- Healthy Kids services (checkups, screenings and shots)
- respiratory equipment and supplies.

All Kids provides the following dental services for children:

- oral exams;
- cleanings;
- topical fluoride;
- sealants;

- fillings;
- root canals;
- treatment of gum disease;
- dentures;
- extractions; and
- braces when the dentist decides they are medically necessary.

All Kids covers the following vision services:

- eye exams;
- eyeglasses;
- a second pair of eyeglasses, if glasses are lost, broken, or medically necessary; and
- a defined range of eyeglass frames.

MEDICAID PRESUMPTIVE ELIGIBILITY (MPE) AND MOMS AND BABIES

These two programs are for pregnant women:

MPE offers immediate, temporary coverage for outpatient health care for pregnant women. There are no copayments or premiums in MPE.

Pregnant women who meet the income requirements can get services once their provider certifies they are pregnant. Outpatient services are available from the day eligibility is established until the last day of the next month. Pregnant women can continue to receive services if they are enrolled in Moms and Babies. Pregnant women can apply for MPE and Moms & Babies at the same time.

There are no immigration status requirements for MPE.

Moms & Babies covers health care for women while they are pregnant and for 60 days after the baby is born. Moms & Babies covers both outpatient health care and inpatient hospital care. Moms and Babies also pays for services to babies for the first year of the baby's life, if the mother is covered by Moms & Babies when the baby is born. After the first year of life, the baby will continue to receive coverage if the baby is enrolled in All Kids. There are no co-payments or premiums in Moms & Babies.

There are no immigration status requirements for Moms and Babies.

If a woman is pregnant and 18 or younger, coverage **may** continue for 12 months from the first month of coverage provided the woman applies and meets program eligibility requirements.

Under Moms & Babies; when the mother or her children are approved for coverage, the first month of coverage can be one of the following:

- The month she applied, if she and her children were eligible for that month, or
- Up to three months before the month she applied, if she and her children were eligible for those months.

ILLINOIS FAMILYCARE

Illinois FamilyCare is a health insurance program available to a parent or relative caretakers of a child eligible for Illinois All Kids with a family income of no more than 185 percent FPL. FamilyCare eligibility is open to Illinois residents who are U.S. citizens or permanent legal immigrants who have resided in the U.S. for at least 5 years, do not live in a public institution, and have income at or below 185 percent FPL.

FamilyCare has separate coverage categories. Families with health insurance and monthly income that qualifies for FamilyCare Share, Premium Level 1 or Rebate, can choose the plan that is best for their families. FamilyCare Share and Premium provide a medical card to help cover services for children that the plan does not cover. FamilyCare Rebate reimburses the policyholder for a portion of the premium they pay for health insurance.

For additional information go to the website at www.familycareillinois.com or call the hotline at 866.468.7543. Applicants can apply online at www.allkidscovered.com or www.illinois.gov/health.

ILLINOIS HEALTH CONNECT

Illinois Health Connect is a primary care case management program for most people on Medicaid. It is mandatory for 1.8 million Medicaid enrollees in some primarily urbanized counties. Enrollees choose their own Primary Care Provider (PCP) for their medical home.

Populations covered are:

- most children in All Kids;
- FamilyCare enrollees;
- adults with disabilities not on Medicare; and
- seniors not on Medicare.

Populations exempted are:

- people in Medicare;
- children with disabilities;
- children in DCFS care;
- residents of nursing facilities or CILAs;
- American Indians/Alaska Natives;
- people on spend-down;
- people enrolled in Home and Community-Based Services (HCBS) waivers;
- people in presumptive eligibility programs;
- people in PACE; and
- people in limited benefit programs.

All services require referrals from PCPs except Direct Access Services. Direct Access Services are:

- immunizations;
- services to newborns for 91 days;
- family planning and OB/GYN services;
- EPSDT and lead screening;
- early intervention services;
- pharmaceuticals;
- mental health and substance abuse services;
- services related to the eye;
- STD and TB services;
- medically necessary transportation; and
- any services provided by local health departments.

YOUR HEALTHCARE PLUS

Your HealthCare Plus is a free, voluntary disease management program that helps Medicaid, All Kids and FamilyCare enrollees with ongoing health problems. Your HealthCare Plus targets three populations of the Medicaid and SCHIP enrollees:

- disabled adults with chronic or complex health issues;
- children and adults with asthma; and
- high frequency emergency room users (enrollees who use the emergency room more than six times a year).

Targeted chronic illnesses include: coronary artery disease, chronic obstructive pulmonary disease (COPD), diabetes and heart failure. Targeted complex illnesses include: hemophilia, HIV, End Stage Renal Disease (ESRD) and cancer. Your Healthcare Plus is designed to help enrollees manage their total healthcare. All patients and medical providers are offered written educational materials and higher risk patients may receive nurse education and counseling. Your Healthcare Plus healthcare professionals work closely with physician practices, hospitals, long-term care institutions and clinics.

ILLINOIS CARES R_X

Illinois Cares R_X is a state prescription drug program for adults 65 years or older, people with disabilities, and people diagnosed with HIV or AIDS.

Eligibility Requirements

Adults 65 years of age or older or people with disabilities aged 16 and older that have annual income of no more than $22,793 for individuals or $30,594 for couples are eligible for coverage of prescription drugs that treat 11 common diseases or conditions (see below). There are no immigration status requirements.

Adults 65 years of age or older who are U.S. citizens or immigrants that meet federal immigration status requirement that have annual income of no more than $21,936 for an individual or $29,412 for a couple are eligible for prescription drug coverage. It covers all classes of medically necessary prescription drugs.

Program Coverage

Illinois Cares R_X will cover premium and deductible costs, coinsurance charges, and coverage for some drugs during the "donut hole" coverage gap for qualifying Medicare beneficiaries enrolled in Medicare Prescription Drug Coverage (Part D).

For non-Medicare beneficiaries with income less than $22,793 for a single person or $30,594 for a couple, it covers 11 illnesses or conditions.

For non-Medicare beneficiaries, who are U.S. citizens or immigrants that meet federal immigration status requirements, with annual income of no more than $21,936 for a single person or $29,412 for a couple, it covers all classes of medically necessary prescription drugs.

Program Qualifications for Medicare Beneficiaries

Medicare beneficiaries must enroll in a coordinating Medicare Prescription Drug Plan and apply for "Extra Help" from Social Security. Medicare beneficiaries must apply for "Extra Help" even if they are not eligible. Medicare beneficiaries may be eligible for Illinois Cares Rx even when they are not eligible for "Extra Help" due to more generous income and asset eligibility standards.

Type of Prescription Drug Coverage

Illinois Cares Rx Basic

Adults 65 years of age or older or people with disabilities aged 16 and over that have a total annual income of less than $22,793 for individuals or $30,594 for couples are eligible. There are no immigration status requirements.

Illinois Cares Rx Basic covers prescription drugs that treat 11 common diseases or conditions:

- Alzheimer's disease;
- Arthritis;
- Cancer;

- Diabetes (includes insulin and the syringes and needles used to administer insulin);
- Glaucoma;
- Cardiovascular disease;
- Lung disease and smoking-related illnesses;
- Osteoporosis;
- Parkinson's Disease;
- Multiple Sclerosis; and
- HIV or AIDS (if Medicare beneficiary).

Illinois Cares Rx Plus

Adults 65 years of age or older who are US citizens or qualified immigrants that have a total income of no more than $21,936 for an individual or $29,412 for a couple are eligible.

Illinois Cares Rx Plus covers prescription drugs that are covered by Illinois Medicaid even if they are excluded from Medicare coverage by law such as narcotics and benzodiazepines.

Prescription Cost for Medicare Beneficiaries

Medicare beneficiaries will pay a copay of no more than $5.35 for most prescriptions filled. Once Illinois Cares Rx and Medicare combined have paid $2,250 in a calendar year for covered prescription drugs, most recipients will pay a coinsurance charge 20 percent of the cost of each prescription in addition to the co-payment.

There is an exception for individuals diagnosed with HIV or AIDS. They will continue to pay only the co-payment for drugs listed on the Illinois Department of Public Health AIDS Drug Assistance Program (ADAP) formulary, regardless of whether the amount paid by Illinois Cares Rx and Medicare combined reaches $2,250.

Prescription Cost for People Ineligible for Medicare

Non-Medicare beneficiaries will pay a copay of no more than $5.35 for most prescriptions filled. Once Illinois Cares Rx has paid $1,750 in benefits, non-Medicare recipients will pay 20 percent of the cost of each prescription in addition to the co-payment.

HEALTH BENEFITS FOR WORKERS WITH DISABILITIES (HBWD)

Health Benefits for Workers with Disabilities (HBWD) is the Illinois Medicaid Buy-In created under the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). HBWD eligibility is limited to people with disabilities that are at least 16 years old but no more than 64 years old.

The family income limit is 350 percent FPL with an asset disregard of $10,000 per individual at program entry. Enrollees may accumulate up to $25,000 in assets and maintain eligibility for the program.

Premiums are based on income, and Medicaid copays apply.

HBWD eligibility does not affect eligibility for personal assistants through the Illinois Department of Human services.

ILLINOIS HEALTHY WOMEN

Illinois Healthy Women is a free program to provide family planning and related reproductive healthcare to women 19-44 years of age who are citizens or meet federal immigration requirements and would have limited access when their Medicaid health care coverage ceased.

Women may be auto assigned in Illinois Healthy Women when Medicaid or SCHIP coverage ceases or they may apply on their own. Women who are autoassigned have coverage for three months and must submit an enrollment form if they want to get Illinois Healthy Women for nine more months.

Reproductive health care coverage, including annual physicals, pap smears, mammograms, contraceptives, and treatment for sexually transmitted diseases, is expected to improve the health of women and their children.

VETERANS CARE

The Veterans Care Program is designed to provide comprehensive affordable healthcare to Illinois' uninsured veterans and their families. To be eligible, veterans must meet the following requirements:

- ages 19 through 64;
- have had no health insurance for at least six months. However, you may still be eligible if your only insurance coverage in the last six months:
    - Ended due to the loss of your employment or your spouse's employment
    - Ended due to the loss of FamilyCare or other state medical assistance
    - Ended due to the life-time benefit limit in your coverage
    - Is through a spouse's plan that you are unable to access
    - Is purchased through COBRA, or
    - Is through post active-duty TriCare coverage

- Not eligible for VA healthcare:
- Not eligible for other state healthcare programs such as FamilyCare;
- Have not been dishonorably discharged;
- Have served 180 consecutive days after training; and
- Have income in the approved income range.

The monthly premium varies from $40 or $70 based on income. There are no premiums for the first two months of coverage.

For Cook County, the Veterans Care Monthly Income Threshold Amounts are: $3,901 for an individual; $4,545 for a family of two; and $5,186 for a family of three.

Covered services include:

- hospital care;
- doctor services;
- prescription drugs;
- well-child care and immunizations;
- care at clinics;
- physical, occupational, and speech therapy;
- laboratory tests and x-rays;
- alcohol and substance abuse services;
- medical equipment, supplies and appliances;
- emergency medical transportation;
- hospice care;
- home health care;
- renal dialysis;
- family planning;

- optometric care;
- podiatric care;
- limited dental care;
- chiropractic care;
- audiology services; and
- mental health services.

Co-payments are:

- $15 for doctor's visits;
- $6 for generic prescription drugs;
- $14 for name brand prescription drugs;
- $50 for hospital emergency room visits;
- $150 for hospital admissions;
- 10% of covered services for hospital or ambulatory outpatient treatment; and
- $15 for dental visits.

Glossary

GLOSSARY[9]

First enacted in 1965, Medicaid has evolved into a large health care financing program with its own terms and acronyms. Some of these derive from the federal statute, others from regulations, and still others from day-to-day operation of the program. This basic glossary explains the most common Medicaid terms and acronyms. Numbered phrases, such as "209(b) State" or "1115 Waiver" are found under "Section" below.

Assets - See **Resources.**

Beneficiary - An individual who is eligible for, and enrolled in, the Medicaid program in the state in which he or she resides. Millions of individuals are categorically and/or financially eligible for Medicaid but, for a variety of reasons, are not enrolled.

Capitation Payment - A payment made by a state Medicaid agency under a risk contract, generally to a managed care organization (MCO). The payment is usually made on a monthly basis at a fixed amount on behalf of each Medicaid beneficiary enrolled in the MCO. In exchange for the capitation payment, the MCO agrees to provide, or arrange for the provision of, services covered under the contract with the state Medicaid agency to enrolled Medicaid enrollees. See also **Fee-For-Service, MCO**.

Categorical Eligibility - A phrase describing Medicaid's policy of restricting eligibility to members of certain groups or categories, such as children, the aged, or individuals with disabilities. Individuals who fall into approved categories must also satisfy financial eligibility requirements, including income and, in most cases, resource tests imposed by the states in which they reside. Certain categories of individuals, e.g., childless adults under 65 without disabilities, are generally ineligible for Medicaid regardless of the extent of their impoverishment except as members of a group covered by a Medicaid demonstration waiver. See also **Section 1115 Waiver**.

Categorically Needy - A phrase describing certain groups of Medicaid enrollees who qualify for the basic mandatory package of Medicaid benefits. There are categorically needy groups that states participating in Medicaid are required to cover, such as pregnant women and infants with family incomes at or below 133 percent FPL. There are also categorically needy groups that states may at their option cover, such as pregnant women and infants with incomes above 133 percent and up to 200 percent FPL. See also **Medically Needy**.

Centers for Medicare and Medicaid Services (CMS) - The federal agency in the U.S. Department of Health and Human Services (HHS) responsible for the administration of Medicaid, Medicare, and CHIP/SCHIP.

[9] Kaiser Commission on Medicaid and the Uninsured. *Medicaid: A Primer. An Introduction and Overview.* Washington, DC: The Henry J. Kaiser Family Foundation. March 2001.

Children's Health Insurance Program (CHIP) - Enacted in the *1997-Balanced Budget Act* as Title XXI of the *Social Security Act*, CHIP, also known as SCHIP, is a federal/state matching program of health care coverage for uninsured low-income children. In contrast to Medicaid, CHIP/SCHIP is a block grant to the states; eligible low-income children have no individual entitlement to a minimum package of health care benefits. Children who are eligible for Medicaid are not eligible for CHIP/SCHIP. States have the option of administering CHIP/SCHIP through their Medicaid programs, through a separate program, or through a combination of both approaches. The federal matching rate for CHIP/SCHIP services, on average 70 percent, is higher than that for Medicaid, but the federal allotment to each state for CHIP/SCHIP services is capped at a specified allotment amount each year. The enhanced FMAP rate for CHIP/SCHIP in Illinois is 65 percent.

CMSO (Center for Medicaid and State Operations) - The agency within the Center of Medicare and Medicaid Services (CMS) with responsibility for administering Medicaid and the Children's Health Insurance Program (CHIP/SCHIP).

Disproportionate Share Hospital (DSH) Payments - Payments made by a state's Medicaid program to hospitals that the state designates as serving a disproportionate share of low income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid enrollees. States have some discretion in determining which hospitals qualify for DSH payments and how much they receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in statute.

Dual Eligibles - A term used to describe an individual who is eligible both for Medicare and for full Medicaid coverage, including nursing home services and prescription drugs, as well as payment of Medicare premiums, deductibles, and co-insurance. Additional Medicare enrollees are eligible for Medicaid payments for some or all of their Medicare premiums, deductibles, and co-insurance requirements, but not for Medicaid nursing home or prescription drug benefits.

Entitlement - A program that creates a legal obligation on the federal government to any person, business, or unit of government that meets the criteria set in law. Federal spending in an entitlement program is controlled through the program's eligibility criteria and benefit and payment rules, not by the appropriation of a specific level of funding in advance. Entitlement programs such as Medicare and Medicaid are also referred to, for federal budget purposes, as direct or mandatory spending. Medicaid is both an individual entitlement and an entitlement to the states that elect to participate.

EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) Services - One of the services that states are required to include in the basic benefits packages for all Medicaid-eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions as well as vision, hearing, and dental problems. EPSDT services also include follow-up diagnostic and treatment services to correct

conditions identified during a screening, without regard to whether the state Medicaid plan cover those services with respect to adult enrollees.

FFP (Federal Financial Participation) - The technical term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs. States receive FFP for expenditures for services at different rates, or FMAPs [see below], depending on their per capita incomes. FFP for administrative expenditures also varies in its rate, depending upon the type of administrative cost. See also **FMAP**.

FMAP (Federal Medicaid Assistance Percentage) - The statutory term for the federal Medicaid matching rate, i.e., the share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50 to 76.4 percent depending upon a state's per capita income. FMAPs for administrative costs vary by function and not by state. The general FMAP for administrative costs is 50 percent. Some functions, e.g. survey and certification, and fraud control units, qualify for enhanced FMAPs of 75 percent or more. The unenhanced FMAP rate in Illinois is 50 percent.

FQHC (Federally Qualified Health Center) - States are required to include services provided by FQHCs in their basic Medicaid benefits package. FQHC services are primary care and other ambulatory care services provided by community health centers and migrant health centers funded under section 330 of the *Public Health Service Act*, as well as by "look alike" clinics (FQHCLAs) that meet the requirements for federal funding but do not actually receive federal grant funds. FQHC status also applies to health programs operated by Indian tribes and tribal organizations or by urban Indian organizations.

Federal Poverty Level (FPL) - The federal government working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility for certain categories of enrollees. The FPL is adjusted annually for inflation and published by the Department of Health and Human Services in the form of Poverty Guidelines published each February in the *Federal Register*.

2007 Federal Poverty Level Guidelines (except Alaska, Hawaii and DC)					
Family Size/Percent of Poverty	100%	133%	150%	185%	200%
1	$10,210.00	$13,579.30	$15,315.00	$18,888.50	$20,420.00
2	$13,690.00	$18,207.70	$20,535.00	$25,326.50	$27,380.00
3	$17,170.00	$22,836.10	$25,755.00	$31,764.50	$34,340.00
4	$20,650.00	$27,464.50	$30,975.00	$38,202.50	$41,300.00
5	$24,130.00	$32,092.90	$36,195.00	$44,640.50	$48,260.00
6	$27,610.00	$36,721.30	$41,415.00	$51,078.50	$55,220.00

Fee-For-Service - A traditional method of paying for medical service under which providers are paid for each office visit, treatment, procedure, or other service rendered. See also **Capitation Payment**.

Financial Eligibility - In order to qualify for Medicaid, an individual must meet both categorical and financial eligibility requirements. Financial eligibility requirements vary from state to state and from category to category, but they generally include limits on the amount of income and the amount of resources or assets an individual is allowed to have in order to qualify for coverage.

Home-and Community-Based Services (HCBS) Waiver - Also known as the 1915(c) waiver after the enabling section in the Social Security Act, this waiver authorizes the Secretary of HHS to allow a state Medicaid program to offer special services to enrollees at risk of institutionalization in a nursing facility or facility for the mentally retarded. These home and community-based services, which otherwise would not be covered with federal matching funds, include case management, homemaker/home health aide services, personal care services, adult day health services, habilitation services, and respite care. They also include, in the case of individuals with chronic mental illness, day treatment and partial hospitalization, psychosocial rehabilitation services, and clinic services.

ICF/MR (Intermediate Care Facility for the Mentally Retarded) - A public or private facility, the primary purpose of which is to provide health or rehabilitative services to individuals with mental retardation or related conditions (e.g., cerebral palsy). State Medicaid programs may at their option cover services provided by ICFs/MR.

Managed Care Entity (MCE) - The federal statutory term for a managed care plan participating in Medicaid. There are two types of MCEs: Managed Care Organizations (MCOs) and Primary Care Case Management. (PCCM). MCEs may be public or private.

MCO (Managed Care Organization) - An MCO is an entity that has entered into a risk contract with a state Medicaid agency to provide a specified package of benefits to Medicaid enrollees in exchange for a monthly capitation payment on behalf of each enrollee. See also **Capitation Payment**.

Mandatory - State participation in the Medicaid program is voluntary. However, if a state elects to participate, as all have, the state must at minimum offer coverage for certain services to certain populations. These eligibility groups and services are referred to as mandatory in order to distinguish them from the eligibility groups and services that a state may, at its option, over with federal Medicaid matching funds. See also **Optional**.

Matching Rate - See **FMAP**.

Means Testing - The policy of basing eligibility for benefits upon an individual's lack of means, as measured by his or her income or resources. Means testing by definition

requires the disclosure of personal financial information by an applicant as a condition of eligibility. Medicaid and SCHIP are means-tested programs; Medicare is not.

Medically Needy - A term used to describe a Medicaid eligibility group that is optional and is composed of individuals who qualify for coverage because of high medical expenses, commonly for hospital or nursing home care. These individuals meet Medicaid's categorical requirements, i.e., they are children or parents or aged or individuals with disabilities, but their income is too high to enable them to qualify for categorically needy coverage. Instead, they qualify for coverage by spending down, i.e., reducing their income by their medical expenses. States that elect to cover the medically needy do not have to offer the same benefit package to them as they offer to the categorically needy. Illinois has historically provided the same Medicaid package to all fully eligible individuals regardless of whether they are categorically eligible or medically eligible. See also **Categorically Needy, Spend-Down**.

Medicaid Buy-In - The term describes new optional categorically needy eligibility groups to provide Medicaid coverage to working people with disabilities. These groups were created under the Balanced Budget Act of 1997 (BBA) and under the Ticket to Work and Work Incentives Improvement Act of 1999 (TTWWIIA).

Medicare Modernization Act of 2003 (MMA) – The law that created Medicare prescription drug coverage for Medicare beneficiaries, including dually eligible individuals (individuals that receive both Medicare and Medicaid.)

Medicare Buy-in The informal term referring to the payment of Medicare Part B premiums on behalf of low-income Medicare enrollees who qualify for full Medicaid coverage (dual eligibles) or just for assistance with Medicare premiums and cost sharing.

Optional - The term used to describe Medicaid eligibility groups or service categories that states may cover if they so choose and for which they may receive federal Medicaid matching payments at their regular matching rate, or FMAP. Nationally about half of all federal Medicaid funds are used to match the cost of optional services or optional populations. See also **Mandatory**.

Presumptive Eligibility - Process of providing coverage at time of application, without final documentation and approval, so that the individual will have immediate access to services.

Primary Care Case Management (PCCM)) – The Primary Care Case Management program has Primary Care Providers that are physicians, physician groups, or entities having arrangements with physicians that contract with state Medicaid agencies to coordinate and monitor the use of covered primary care services by enrolled individuals.

Resources - Sometimes referred to as assets, resources are items of economic value that are not income. Resources include financial instruments such as savings accounts and certificates of deposit, personal property such as an automobile (above a specified value),

and real estate (other than an individual's home). Some Medicaid eligibility groups must meet a resource test; others, at state option, are not subject to a resource test. In establishing a resource test, a state Medicaid program must specify both the resource standard (e.g. the amount of countable resources an individual may retain) and the resource methodology (e.g. which resources are counted and how are they valued).

SCHIP (State Children's Health Insurance Program) - Enacted in the *1997-Balanced Budget Act* as Title XXI of the *Social Security Act*, SCHIP, also known as CHIP, is a federal/state matching program of health care coverage for uninsured low-income children. In contrast to Medicaid, CHIP/SCHIP is a block grant to the states; eligible low-income children have no individual entitlement to a minimum package of health care benefits. Children who are eligible for Medicaid are not eligible for CHIP/SCHIP. States have the option of administering CHIP/SCHIP through their Medicaid programs, through a separate program, or through a combination of both approaches. The federal matching rate for CHIP/SCHIP services, on average 70 percent, is higher than that for Medicaid, but the federal allotment to each state for CHIP/SCHIP services is capped at a specified allotment amount each year. The enhanced FMAP rate for CHIP/SCHIP in Illinois is 65 percent.

Section 209(b) State - In amendments to the Social Security Act enacted in 1972, Congress created the Supplemental Security Income (SSI) program of cash assistance for low-income elderly and people with disabilities. Section 209(b) of those amendments allowed states the option of continuing to use their own eligibility criteria in determining Medicaid eligibility for the elderly and people with disabilities rather than extending Medicaid coverage to all of those individuals who qualify for SSI benefits. As of 2001, Illinois and twelve other states had elected the Section 209(b) option to apply their 1972 eligibility criteria to aged or disabled individuals receiving SSI benefits for purposes of determining Medicaid eligibility.

Section 1115 Waiver - Under Section 1115 of the Social Security Act, the Secretary of Health and Human Services is authorized to waive compliance with many of the requirements of the Medicaid statute to enable states to demonstrate different approaches to "promoting the objectives of" the Medicaid program while continuing to receive federal Medicaid matching funds. At present 19 states or counties operate Medicaid Section 1115 waivers affecting some or all of their eligible populations. In 1999 these waivered programs captured $38.3 billion in federal matching funds, over one-third of all federal Medicaid spending that year. The waivers are administered by CMS and are granted for 5-year periods, after which they may be renewed.

Section 1915(b) Waiver - Under Section 1915(b) of the Social Security Act, the Secretary of HHS is authorized to waive compliance with the "freedom of choice" and "statewideness" requirements of federal Medicaid law in order to allow states to operate the mandatory managed care programs in all or portions of the state while continuing to receive federal Medicaid matching funds. The waivers, which are granted or renewed for 2-year periods, are administered by CMS.

Section 1931 Parent Coverage - Under Section 1931 of the Social Security Act, states can de-link eligibility for Medicaid from eligibility for cash assistance in the case of parents with dependent children. Section 1931 gives a state the option of extending Medicaid coverage to parents with family incomes and resources higher than those that would allow the parents to qualify for cash assistance under the state's TANF program.

Section 1932 State Plan Option - Under Section 1932 of the Social Security Act, states may require Medicaid enrollees to enroll in Managed Care Entities (MCEs) by submitting an approvable state plan amendment (SPA) to CMS. Unlike Section 1915(b), 1115, or HIFA waivers, Section 1932 SPAs need not be periodically renewed by CMS. Illinois does not require MCE enrollment.

Spend-Down - For most Medicaid eligibility categories, having countable income above a specified amount will disqualify an individual from Medicaid. However, in some eligibility categories, most notably the medically needy, individuals may qualify for Medicaid coverage even though their countable incomes are higher than the specified income standard by spending down. Under this process, the medical expenses that an individual incurs during a specified period are deducted from the individual's income during that period. When the individual's incurred medical expenses have been subtracted from his or her income and the difference is at or below the state-specified income standard, the individual qualifies for Medicaid benefits for the remainder of the period. See **Medically Needy**.

Standard - As used in the context of Medicaid eligibility determinations, the dollar amount of income or resources that an individual is allowed to have and qualify for Medicaid. For example, states must cover all pregnant women with family incomes at or below 133 percent FPL. In determining whether a pregnant woman meets this income standard, a state must count her income; the methodology that the state applies will determine what types of income are counted and what income, if any, is disregarded.

State Medicaid Plan - Under Title XIX of the Social Security Act, no federal Medicaid funds are available to a state unless it has submitted to the Secretary of HHS, and the Secretary has approved, its state Medicaid plan and all amendments to the state plan. The state Medicaid plan must meet over 60 federal statutory requirements.

State Plan Amendment (SPA) - A state that wishes to change its Medicaid eligibility criteria, or its covered benefits, or its provider reimbursement rates must amend its state Medicaid plan to reflect the proposed change. Similarly, states must conform their state plans to changes in federal Medicaid law. In either case, the state must submit a State Plan Amendment (SPA) to CMS for approval.

Statewideness - The requirement that states electing to participate in Medicaid must operate their programs throughout the state and may not exclude individuals residing in, or providers operating in, particular counties or municipalities. This requirement may be waived with Section 1115 waivers.

Take Back Factor - A factor, set at 90 percent in FFY06 and phased forward to 75 percent in FFY15 and beyond, to be used to calculate a monthly payment by a state to the federal government to cover the Medicare costs for formerly dually eligible individuals. The payment will consider the number of dual eligibles enrolled in full Medicaid coverage in that month and a per capita amount designed to approximate the amount a state would have spend each month on Medicaid prescription drugs per full benefit dual eligible in the absence of the *Medicare Prescription Drug Improvement and Modernization Act*. The per capita amount is based on a state's per capita Medicaid spending on Medicare Part D covered prescription drugs for full dual eligibles in 2003 and trended forward through 2006 by the growth in national per capita prescription drug expenditures and in 2007 and later by per capita growth in Part D spending.

Temporary Assistance for Needy Families (TANF) - A block grant program that makes federal matching funds available to states for cash and other assistance to low-income families with children. TANF was established by the 1996 welfare law that repealed its predecessor, *Aid to Families with Dependent Children* (AFDC). Prior to this repeal, states were required to extend Medicaid coverage to all families with children receiving AFDC benefits. States may, but are not required to, extend Medicaid coverage to all families receiving TANF benefits. States must, however, extend Medicaid to families with children who meet the eligibility criteria that states had in effect under their AFDC programs as of July 16, 1996.

Title XIX - Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., is the federal statute that authorizes the Medicaid program. Related titles of the Social Security Act are Title IV-A (TANF), Title IV-E (Foster Care and Adoption Assistance), Title XVI (SSI), Title XVIII (Medicare), and Title XXI (CHIP or SCHIP).

Transfer of Assets - Refers to the practice of disposing of countable resources such as savings, stocks, bonds, and other real or personal property for less than fair market value in order to qualify for Medicaid coverage. When such transfers occur, it is usually in connection with the anticipated or actual need for long-term nursing home care. Federal law limits, but does not entirely prohibit, such transfers as a means of qualifying for Medicaid coverage.

Upper Payment Limit (UPL) Mechanism - A financing mechanism under which state Medicaid programs generate additional federal matching payments by paying certain local public hospitals or public nursing facilities at rates substantially in excess of the costs of providing care to Medicaid enrollees. Excess payments are transferred by the local public facilities back to the state Medicaid program or the state general treasury.

Waivers - Various statutory authorities under which the Secretary of HHS may, upon the request of a state, allow the estate to receive federal Medicaid matching funds for its expenditures even though it is no longer in compliance with certain requirements or limitations of the federal Medicaid statute. In the case of program waivers such as the 1915(c) waiver for home-and community-based services, states may receive federal matching funds for services for which federal matching funds are not otherwise available.

In the case of demonstration waivers such as the Section 1115 waivers, states may receive federal matching funds for covering certain categories of individuals for which federal matching funds are not otherwise available, and they may restrict the choice of providers that Medicaid enrollees would otherwise have.

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