Questions from 9/20/16 F2F Conference Participants

1. Can children get SSDI on parent's employment?

Some Disabled Adult Children (DACs) who are over age 18,

- have a disability that started prior to age 22,
- and have parent(s) who are retired,disabled or deceased
- and who previously worked at jobs for a sufficient period of time and paid into Social Security while working

may be eligible for SSDI benefits.
For more information, please check with the Social Security Administration:
https://www.ssa.gov/planners/disability/dfamily.html

2. Do HFS Family Community Resource Centers have Representative Forms?

Approved Representative Forms are available for download on the HFS website:
https://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Pages/medicalforms.aspx

- Approved Representative Consent Form IL 444-2998 (pdf)
- Approved Representative Consent Form IL 444-2998S (Spanish) (pdf)
- Power of Attorney HFS 2306 (pdf)
- Limited Power of Attorney HFS 2316 (pdf)

If you are your child's guardian you do not have to complete the approved representative form, but you will need to provide the guardianship papers to the state.

3. Does Medicaid cover behavioral health for children under 19?

Children under age 21 who are insured by Medicaid are protected by a Federal regulation called EPSDT: Early Periodic Screening Diagnosis and Treatment. This regulation states that all children insured by Medicaid are required to receive treatment services prescribed by their physician(s) to treat diagnosed physical and mental conditions.

- https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html
- http://www.healthlaw.org/issues/child-and-adolescent-health/epsdt/health-advocate-epsdt#.V-qf7lTx61s

The place to start is with the care coordinator from your MCO, or with Illinois Health Connect if not in managed care. You need to obtain a prescription from a physician, and then request a referral. IF care coordinator/IHC unable to secure a provider per the referral, then you can file a grievance, then an appeal with the MCO. IF this does not work, then file appeal with HFS.

Also, consider contacting Robert Farley, the attorney who recently won the class action lawsuit for behavioral health services for children insured by Medicaid. He is still working out the

details of the settlement and is collecting information from impacting children and families. He can be reached at 630-369-0103 http://www.farley1.com/

Here is more information about that legal action:

Preliminary Approval Given for Class Action Settlement Involving Medicaid Eligible Children in Illinois Diagnosed with Mental Health/Behavioral Disorders and Needs
Settlement resolves a lawsuit filed by Robert H. Farley, Jr. in Federal Court in 2011, impacting 20,000 to 40,000 children.
On September 6, 2016, Federal Judge Jorge L. Alonso gave preliminary approval of a Class Action Settlement concerning all Medicaid eligible children under the age of 21 in the State of Illinois who have been diagnosed with a mental health or behavioral disorder and who need intensive Home and Community Based Services to treat their disorders. The Settlement Agreement requires the State of Illinois to insure the availability of services, supports and other resources so that the children can receive appropriate treatment. Learn More...
Read the Settlement Agreement • Read the Notice of Proposed Class Action Settlement and Hearing

4. How can you appeal a denial of benefits if denied?

If appealing a denial of medical services by a Medicaid Managed Care plan the appeal needs to be filed with the plan before appealing with the state. If you disagree with the plans decision then you use the appeal process cited below.

https://www.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/appeals.aspx
All Kids Member Handbook: About Appeals & Fair Hearings
What are appeals and fair hearings?
An appeal is a complaint you make when you feel an action was wrong. When you appeal an action, you are asking for a fair hearing about it.
A fair hearing is a meeting with a fair hearing officer and someone from the Department and you. You can talk about your complaint during the fair hearing, and the fair hearing officer will decide what to do.
You can appeal if the Department:

1. *Denies your application*
2. *Stops your benefits (coverage)*
3. *Says that you will start to get fewer benefits*
4. *Changes your premiums or co-payments*

You can also appeal if you think we made a mistake about any decision. You must make your appeal within 60 days of when the action happened.
You may not get a fair hearing if the action happened because of a change in the law.
If you are in a managed care health plan, you can appeal any decision that the plan makes if you think it is wrong. Check your plans member handbook to find out how to make an appeal or call your plan for more information. The number is on your managed care health plan card.

How to make an appeal

You can write a letter asking for a fair hearing or fill out a Notice of Appeal form. (You can get one from the All Kids office.) You can also call to make an appeal.

If you write a letter or fill out the form, you should do one of the following:

- *Mail your letter or form to:*

Bureau of Administrative Hearings
401 South Clinton, 6th Floor
Chicago, IL 60607
or fax it to: 1-312-793-0095

- *Mail your letter or form to:*

All Kids Unit
P.O. Box 19122
Springfield, IL 62794

- *Take the letter or form to your local Department of Human Services.*

If you want to make an appeal over the telephone, call 1-800-435-0774 (TTY: 1-877-734-7429). The call is toll-free.

- Child Care Assistance - Appealing a Decision
  http://www.dhs.state.il.us/page.aspx?item=31172
- Appeals and Fair Hearings For Those Receiving Cash, SNAP, or Medical Assistance - DHS 377
  http://www.dhs.state.il.us/page.aspx?item=32119
- DOI Insurance Complaints and Issues:
  https://mc.insurance.illinois.gov/messagecenter.nsf
- AG's Health Care Bureau:
  http://www.illinoisattorneygeneral.gov/consumers/healthcare.html

5. My 26-year-old daughter has Down syndrome. What is a caseworker? Who gets one? Where does one get a caseworker?

See our document "Who's Who in Adult Services" for this information:
http://www.familyvoicesillinois.org/family-manual-fact-sheet-whos-who-in-adult-services-and-supports/

Individuals may have "caseworkers" (also referred to as care coordinators, social workers, case managers) connected to an agency or program they are involved with. Some individuals can have more than one caseworker. Some programs, for example, Medicaid Managed Care insurance companies, often require enrollees to specifically request a care coordinator.

6. Can Medicaid order a spenddown when Social Security classifies you as a 1619b (working while receiving disability so the workshop earnings don't count- up to 27 K in Illinois) receiving only the 700/month disability pay?

If Social Security has correctly classified the case as 1619 b in their system then when the state sets up their Medicaid case it should as this in their system. This means the person with 1619b classification is not to be put into a spenddown. State policy says "All income and assets of a person who qualifies under Section 1619 are exempt. You do not have to verify income or assets for a Section 1619 case, even if new income or increased earnings are reported or discovered. The person is eligible for Medicaid coverage without a spenddown amount." PM 06-06-02 http://www.dhs.state.il.us/page.aspx?item=13836

Sometimes this coding is not in place or does not show in the state system. You should receive a letter from Social Security verifying this status so it would be best to always provide the state a copy. You may also want to check with Social Security to ensure this coding is in place. It is also important to remember that this designation needs to be renewed yearly with Social Security.

7. My son was put on Medicare shortly after receiving SS Disability and initially was labeled QMB but lost QMB status in a letter supposedly due to too much income although his disability pay is 700/month. My son with Asperger's may need CILA housing in the future and needs to have Medicaid, correct?

QMB allows a person to have up to $1015 a month in income. If the income is below this amount then your son should automatically be enrolled in both QMB and Medicaid. This results in the Medicare premiums being paid by the state. The state issues QMB ONLY Medicaid cards if a person is not enrolled in Medicaid. If not enrolled you may need to contact the state caseworker to make sure the income being used is correct and that they have his Medicare number correctly entered in the computer system.

Yes, if he is in a CILA he needs Medicaid.

8. Medicare booklet stated you lose Marketplace insurance (Medicaid version) once Medicare starts?

Uncertain that we are capturing your question but if the person is getting $700/month from SSDI, then they would get $33.00 month from SSI, to make up the $733/month total.

Medicare starts after 24 months of receiving SSI.

If this person is in DT program, the guardian needs to make sure that the provider agency has filed the 2653 form (Notice of Community-Based Services).

Once enrolled in Medicare the Marketplace coverage should be stopped. This requires taking the action to report to the Marketplace that coverage is no longer needed. There is NO communication between the two systems.

9. How do we get OTC med covered for people with CILA Services? Consumers are

responsible for paying for these, so when they cannot, the agency pays. Is there any other resource to pay for these?

The first step is to determine the insurance status of each individual who is in need of OTC medication. Examples of common insurance coverage scenarios for adults living in CILAs may include:

1. People who get SSI, have Medicaid only, and participate in the Integrated Care Program (ICP).
2. People who get SSI, have Medicaid only, and live in a part of the state that is not included in the ICP.
3. People who get SSI, have Medicaid insurance and also private insurance coverage from a parent.
4. People who get SSDI, have both Medicare (based on a parent's work record and Medicaid insurance.
5. People who get SSDI, have Medicaid insurance, Medicare based on their own work record.
6. People who get SSDI, have both Medicare and Medicaid, and also private insurance (either from a parent or from their own work).

The second step is to check on the OTC coverage, if any, from the individual's insurance.

Please note that Medicare Part D generally does NOT cover any OTC medications: https://www.cms.gov/medicare/prescription-drug coverage/prescriptiondrugcovcontra/partdmanuals.html

People who have Medicaid insurance and are enrolled in the ICP need to check with their care coordinator and also review their member handbook to ascertain if any OTC medications may be covered: https://www.illinois.gov/hfs/MedicalProviders/cc/icp/Pages/default.aspx

Here is a listing of all of the current ICP Managed Care Organizations (MCOs) in Illinois: https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/default.aspx
Care Coordination Expansion Map: Expansion Map (pdf) (html)

Member handbooks can be obtained on the website of your ICP MCO, or by calling the toll-free customer service number on your health plan card.

For people insured by "regular" (Fee-for-Service) Medicaid, you can obtain information about Illinois Medicaid coverage of certain OTC drugs on the HFS Pharmacy page: https://www.illinois.gov/hfs/medicalproviders/pharmacy/Pages/default.aspx

Medicaid patients can and should have access to medications that are medically necessary. The Illinois Medicaid program covers prescription drugs, as well as some over-the-counter (OTC) products, made by manufacturers that have a signed rebate agreement with the federal Centers for Medicare and Medicaid Services (CMS). Some prescription drugs and OTC products

require prior approval from HFS before reimbursement.
https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/illinoisrx/Pages/default.aspx

Persons with private insurance (which is the first payor), will need to check with their own insurance company via the customer service number on their insurance card or by contacting their private insurance care coordinator. Individuals should also discuss this with their own physicians to see if an OTC can be replaced with a prescription drug that is in the MCO and/or Medicaid formulary.

It is important to note that EPSDT coverage goes up to the person's 21st birthday, so this can assist with OTC medications for persons who are age 18-21.

If OTCs are not covered for an individual, then we suggested checking with the pharmacy used by the provider agency (the provider that puts the meds in the "bubble packs") for their price on the OTCs and ask if they offer a volume discount. Their prices may be much lower than retail prices.

Nutritional supplements (for oral feeding) are sometimes covered by Medicaid, dependent on the person's BMI (Body Mass Index) and physician documentation. Here are links for HFS forms related to nutritional products:
https://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Pages/medicalforms.aspx

- Questionnaire for Enteral Nutrition HFS 3701N (pdf)
- Questionnaire for Food Thickeners HFS 3701M (pdf)

10. With the online application system for Medicaid, is the state looking to have information disseminated online rather than sending letters in the mail? A180, what about online rede's?

When is the IES going live? KN- IES Phase 2 has been delayed. No date has been given as to when it will go live.

Are we correct to assume that hard copy option will still be around for a while? The state will still send hard copy letters even after IES Phase 2 begins. If a letter is lost or you think you should have been contacted once IES Phase 2 is live you will be able to go to the website and use the Manage My Case function to locate any letters sent through the mail.