Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Illinois Focused Program Integrity Review

Final Report

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Objective of the Review

The Centers for Medicare and Medicaid Services (CMS) conducted a focused review to determine whether Illinois has fully implemented the requirements of federal regulations at 42 CFR 455 Subpart E that implemented the enhanced provider screening and enrollment provisions of the Affordable Care Act. The review also included a follow up on the state's progress in implementing its corrective actions related to CMS's last program integrity review in 2011, as well as a May 2014 state auditor's report that found the state made fee-for-service and managed care capitation payments on behalf of deceased Medicaid beneficiaries.

Background: State Medicaid Program Overview

The Department of Healthcare and Family Services (DHFS) Office of the Inspector General (OIG) is responsible for providing oversight to the program integrity activities in the Illinois Medicaid program. Beneficiary enrollment in 2014 exceeded three million recipients. Expenditures in fiscal year 2012 were more than $13 billion. In addition to fee-for-service (FFS) providers, managed care network providers and waiver providers are required to enroll through DHFS. Capitation payments for the state's managed care organizations (MCOs) during the most recent fiscal year (FY 2013) were $873,280,505.00. Additionally, the state has imposed on itself a mandate to enroll 50% of FFS beneficiaries into a managed care program.

Methodology of the Review

In advance of the onsite visit, CMS requested that Illinois complete a review guide that provided the review team detailed insight into the operational activities of the areas that were subject to the focused review. The team also obtained a copy of Illinois's State Plan Amendment attesting to compliance with the enhanced provider screening and enrollment requirements of 42 CFR 455 Subpart E, which became effective April 1, 2012. A four-person team reviewed the responses and materials that the state provided in advance of the onsite visit.

During the week of June 16, 2014, the CMS review team visited the Illinois DHFS. Additionally, the team also conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Illinois's enhanced provider screening and enrollment practices.

Status of Corrective Action Plan

As part of the focused review the CMS Review Team reviewed the state's corrective action plan (CAP) from the last Medicaid Comprehensive Program Integrity Review which was conducted in FY 2011. The state's original CAP response reasonably addressed the issues found in the 2012 review. However, the team examined the state's status on planned corrective actions which were not completed or fully addressed in the CAP. As listed below, the state was specifically cited in four areas.

- Failure to capture required provider ownership and control disclosures (42 CFR 455.104)
- Failure to require Home and Community Based Service waiver program providers to disclose business transaction information (42 CFR 455.105 (b))
- Failure to collect health care related criminal conviction disclosures in the Home and Community Based Service waiver programs (42 CFR 455.106)
- Failure to conduct complete searches for individuals and entities excluded from participating in Medicaid (42 CFR 455.436)

Although the state has taken some steps to correct the issues related to the first three (3) bulleted findings, they are relying on implementation of a new Medicaid Management Information System (MMIS) to fully come into compliance with the requirements of the regulations. Regardless of the fact that these three (3) regulations were not a part of the 2014 Focused Review, the state's continued progress toward correction will be monitored and encouraged.

In the case of the last finding which relates to exclusion checks, the state indicated and the 2014 Review Team verified that exclusion checks (Excluded Parties Lists System (EPLS) or state alternative mechanism (SAM)) are not being done during the monthly exclusion checks as required by 42 CFR 455.436. This issue continues to be a vulnerability to the Medicaid program. And, the state must correct this problem without relying on a new MMIS.

Results of the Review

The review team identified areas of concern and instances of regulatory non-compliance in the state's provider enrollment and program integrity activities, thereby creating risk to the Medicaid program. These issues and CMS's recommendations for improvement are described in detail in this report. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible.

As detailed throughout the report, Illinois is in the process of developing a new MMIS in conjunction with the state of Michigan, which it expects to be operational in FY15. The first phase of implementation of the new MMIS will be the provider enrollment subsystem. The state reported that for this reason, it has delayed implementation of many of the enhanced provider screening and enrollment provisions until the new system is operational. Notwithstanding a new MMIS, the state must be in compliance with all applicable federal regulations.

Section 1: Affordable Care Act Provider Screening and Enrollment

Overview of the State's Provider Enrollment Process

Illinois requires that all service providers, including managed care network providers, be enrolled as Medicaid providers. The DHFS is the primary agency responsible for provider enrollment and screening within the Medicaid program. The Department on Aging and the Department of Human Services (DHS) are responsible for collection of Medicaid provider applications for their respective waiver programs; however, DHFS is responsible for all final provider screening and

enrollment decisions. Providers enrolling in Illinois are required to complete paper based applications.

42 CFR 455.410: Enrollment and screening of providers
The regulation at 42 CFR 455.410 requires that the State Medicaid agency: (a) screen all enrolled providers; and (b) enroll all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan as participating providers; and (c) the State Medicaid agency may rely on the results of the provider screening performed by any of the following: (1) Medicare contractors. (2) Medicaid agencies or Children's Health Insurance Programs of other states.
The state is not in compliance with this regulation.
Illinois is not appropriately screening or requiring all ordering or referring physicians or other professionals providing services under the state plan, or under a waiver of the plan, to be enrolled as participating providers. The state indicated that the new MMIS's provider enrollment subsystem will require all ordering or referring physicians or other professionals to be enrolled as participating providers. However, at the time of the review, DHFS was not able to provide any policies, procedures or draft provider application documents with the information necessary to implement this requirement.
Recommendations: Develop policies and procedures to implement the requirement that all ordering and referring physicians, or other professionals providing services under the state plan or a waiver of the plan, be enrolled as participating providers.
42 CFR 455.412: Verification of provider licenses
The regulation at 42 CFR 455.412 requires that the State Medicaid agency: (a) have a method for verifying that any provider purporting to be licensed in accordance with the laws of any state is licensed by such state; and (b) confirm that the provider's license has not expired and that there are no current limitations on the provider's license.
The state is in compliance with this regulation.
The DHFS demonstrated that it has a procedure in place to validate professional licensure during the enrollment, re-enrollment, and reinstatement processes for both in and out of state providers. DHFS notes any limitations on a provider's license and forwards the application to the DHFS-OIG for further review and approval or denial of enrollment. The state also has procedures for monitoring the expiration dates of Medicaid providers' licenses. DHFS receives a monthly report listing all active and nonparticipating Medicaid providers having expired licenses and conducts follow up as appropriate. If a license listed on the report cannot be validated as having been renewed or updated, then the provider's file shall be made inactive.
Recommendations: None
42 CFR 455.414: Revalidation of enrollment
The regulation at 42 CFR 455.414 requires that the State Medicaid Agency revalidate the enrollment of all providers regardless of provider type at least every 5 years.
The state is at risk of not complying with this regulation by March 24, 2016.

The state has not started revalidating the enrollment of providers. DHFS representatives informed the review team that the revalidation of all providers will be accomplished with the transition to the new MMIS system, which is scheduled to occur in 2015. The state was not able to provide a formal plan, policies, or procedures documenting how it intends to accomplish the revalidation once the new MMIS is operational. Because of the size of Illinois's Medicaid program, a large volume of revalidation work will need to be completed in order to meet the federal deadline established by CMS of March 24, 2016 to complete a revalidation of all current providers.
Recommendations: Develop a formal plan, policies, and procedures to ensure that all Illinois Medicaid providers enrolled on or before March 25, 2011 will be revalidated by the required completion date of March 24, 2016. The plan should include a contingency if the transition to the new MMIS is not completed as expected in 2015.
42 CFR 455.416: Termination or denial of enrollment
The regulation at 42 CFR 455.416 describes several conditions under which a State Medicaid agency must terminate or deny enrollment to any provider. These include situations in which the Medicare program or another state Medicaid or Children's Health Insurance Program has terminated a provider for cause on or after January 1, 2011 unless the State Medicaid Agency determines that denial or termination of enrollment is not in the best interests of the Medicaid program and documents that determination in writing.
The state is in compliance with this regulation.
DHFS provided the review team with its policies and procedures to deny or terminate providers who have been denied or terminated for cause by Medicare or another state's Medicaid or CHIP program as required by the regulation. Further, the state has access to the CMS server which lists for-cause terminations by Medicare and other states, and reports their state-initiated actions to CMS for inclusion on this list.
Recommendations: None
42 CFR 455.420: Reactivation of provider enrollment
The regulation at 42 CFR 455.420 requires that the State Medicaid Agency, after denial or termination of a provider for any reason, require the provider to undergo rescreening and pay the associated application fees pursuant to 42 CFR 455.460.
The state is in partial compliance with this regulation.
The state requires providers who have been deactivated or terminated to resubmit the enrollment documents required for an initial enrollment and undergo rescreening. However, the state does not have a process to collect the associated application fees. The state indicated that a process to collect application fees for reactivated Medicaid-only institutional providers will be implemented with the new MMIS.
Recommendations: Ensure that the state collects the appropriate application fees from any applicable providers during the reactivation process.
42 CFR 455.422: Appeal rights
The regulation at 42 CFR 455.422 requires that the State Medicaid agency give providers terminated or denied pursuant to 42 CFR 455.416 any appeal rights available under state law or regulations.
The state is in compliance with this regulation.

Illinois provides appeal rights to providers denied enrollment pursuant to 42 CFR 455.416 as evidenced by state statute and regulatory citations as well as policies and procedures for provider appeal rights.
Recommendations: None
42 CFR 455.432: Site visits
The regulation at 42 CFR 455.432 requires that the State Medicaid agency conduct pre-enrollment and post-enrollment site visits of providers who are designated as ‘‘moderate’’ or ‘‘high’’ categorical risks to the Medicaid program.
The state is not in compliance with this regulation.
The state is not currently conducting site visits due to staffing limitations. However, the state does have access to the Provider Enrollment, Chain, and Ownership System to determine if the provider was screened by Medicare and had a site visit performed within the last 12 months**.**
Recommendations: Develop and implement a process to conduct pre and post-enrollment site visits of all providers categorized as moderate and high risk. Or, where appropriate, the state can verify that a site visit was performed within the prior 12 months by Medicare using the Provider Enrollment, Chain, and Ownership System.
42 CFR 455.436: Federal database checks
The regulation at 42 CFR 455.436 requires that the State Medicaid Agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General’s List of Excluded Individuals and Entities (LEIE), the EPLS, the SAM, the Social Security Administration’s Death Master File, the National Plan and the Provider Enumeration System upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.
The state is not in compliance with this regulation. As noted above, this is a repeat finding.
The state does not have access to the Social Security Death Master File so it is not possible for the state to check this database at the time of provider enrollment. Additionally, the state does not check the EPLS on a monthly basis as required by the regulation. Also, the state’s current MMIS does not capture persons with ownership or controlling interest in the provider, agents, and managing employees of the provider so complete database checks cannot be performed.
Recommendations: • The state must obtain access to the Social Security Death Master File and develop a process to check the names providers, persons with an ownership or control interest in the provider, agents, and managing employees of the provider against all required federal databases at the time of enrollment and reenrollment. • All disclosed parties must be checked against the EPLS and the LEIE or Medicare Exclusion Database on a monthly basis to ensure that federal funds are not paid to excluded persons or entities.
42 CFR 455.440: National Provider Identifier
The regulation at 42 CFR 455.440 requires that the State Medicaid Agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.
The state is not in compliance with this regulation.

The state does not require the ordering and referring provider name and NPI number on claims for some provider types such as optometrists, podiatrists, and physicians when providing non-consultative services. Edits exist to reject claims for those provider types listed as requiring ordering/referring provider name and NPI. One such edit is #016 which generates the E85 Missing/Invalid ordering/referring practitioner number, DHS validates the NPI that is listed as ordering/referring by utilizing a check-digit operation on the NPI listed on the claim. All other provider types are captured in the MMIS. The state provided sample claims for high and moderate risk providers that are captured. The state said it plans to address this area of non-compliance by implementing a new MMIS system in August 2015. The new system will require all ordering or referring physicians or other professionals to be enrolled as participating providers, thereby satisfying the regulation.
Recommendations: Develop procedures to capture the NPI during the enrollment process for all ordering and referring providers. Develop and implement edits to reject claims lacking an NPI number or containing an incorrect NPI number.
42 CFR 455.450: Screening levels for Medicaid providers
The regulation at 42 CFR 455.450 requires that the State Medicaid Agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of ‘‘limited,’’ ‘‘moderate,’’ or ‘‘high.’’
The state is not in compliance with this regulation.
The state has established screening levels for limited, moderate, and high risk providers, but is not performing site visits or screenings for moderate and high risk providers as required by the regulation. Further, the state does not have a process to adjust a provider’s risk level in instances where the provider has an existing overpayment; when the state imposes a payment suspension based on a credible allegation of fraud; or when the provider has been excluded by Human Services-Office of the Inspector General or by another State Medicaid agency within the previous 10 years, in accordance with the requirements of the regulation.
Recommendations: The state must inventory their policies and procedures to verify that all required screenings of Medicaid providers are part of the enrollment and re-enrollment process and ensure that the all screening activities are performed based on the provider’s categorical risk level. These screening activities must also be performed for new practice locations and revalidations of enrollment.
42 CFR 455.460: Application fee
The regulation at 42 CFR 455.460 requires the States Medicaid Agency to collect the applicable application fee prior to executing a provider agreement from certain prospective or re-enrolling Medicaid-only providers as stipulated in the regulation.
The state is not compliance with this regulation.
As noted previously, the state does not have a process to collect the applicable application fees from enrolling or re-enrolling Medicaid-only providers. The state indicated that this process will be implemented with the new MMIS. In cases where providers are enrolled in Medicare, processes do exist to collect application fees. Regardless, no fees are being collected for Medicaid institutional providers.

Recommendations: Develop and implement a process in compliance with all the requirements at 42 CFR 455.460 related to collecting applicable application fees for enrolling or re-enrolling Medicaid-only providers.
42 CFR 455.470. Temporary moratoria
The regulation at 42 CFR 455.470 requires the State Medicaid Agency to impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid program unless the SMA determines that imposition of a temporary moratorium would adversely affect beneficiaries' access to medical assistance.
The state is in compliance with this regulation.
The state demonstrated compliance with the regulation. The state currently has a Home Health Agency federally mandated moratorium that was initiated on July 2013 for Cook County and its surrounding counties.
Recommendations: None

Section 2: State Activities in Response to State Compliance Examination

During the focused review, the CMS review team met with staff from DHFS-OIG to discuss the actions taken by the state to address program integrity-related concerns contained in a recent state compliance examination which found that eligibility records were not updated timely for deceased Medicaid beneficiaries thereby causing overpayments.

The Illinois Office of the Auditor General conducted a compliance examination[1] of the DHFS program to determine whether Medicaid payments were made for deceased beneficiaries and to deceased providers. No deceased providers were found. The auditors compared DHFS records of eligible beneficiaries to the Department of Public Health death records dating back to 1970. The audit revealed that approximately $12.3 million was paid for 2850 deceased beneficiaries. The majority of these funds (93%) were paid under capitation arrangements for beneficiaries who were enrolled in a managed care program.

The state indicated in their response to the audit that procedures are in place to update beneficiary eligibility records and they have begun recouping overpayments. The state has also implemented several initiatives to help eliminate payments for beneficiaries who are deceased. These initiatives include utilizing authorities permitted under the Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART Act) controls to isolate identity theft, and a variety of other methods as explained below.

Recently, the state has implemented a process to identify payments made for deceased beneficiaries. The DHFS-OIG now routinely conducts an analysis to stop erroneous capitation payments. Once a DHS case worker enters the date of death all claims for the deceased should be rejected. In order to further identify services after death the DHFS-OIG has begun to: conduct a spike analysis utilizing a Program Initiation Request, develop a monthly system for members and providers to stop capitation payments, and seek recovery for all monies not related to fraud.

[1] http://www.auditor.illinois.gov/Audit-Reports/Compliance-Agency-List/DHFS/FY13-DHFS-Fin-Comp-Full.pdf

The SMART Act allows the DHFS-OIG to use civil and administrative recovery for treble damage. Claims are currently not being paid as soon as death is recorded. Encounter data is being captured from the MCOs.

The state is expecting that this effort will assist in the identification and recovery of all non-fraud related monies that were paid in error. In addition, the SMART Act authorizes the DHFS -OIG to conduct pre and post-payment claim audits. Providers selected for pre-payment claim review can have the payment denied under the Act rather than the state attempting to recoup the payment after an incorrect payment is made. The Act also facilitates claim reviews to identify improper billing practices.

Additional controls have been implemented to identify the clients who are deceased to help avoid making improper payments, such as:

- The state's contracted MCOs are required to offset overpayments from future capitation payments. Otherwise, DHFS-OIG will recoup overpayments from capitation payments.
- FFS providers are required to self-disclose overpayments received for deceased beneficiaries.
- DHFS-OIG requires the MCO to maintain contact with the beneficiaries enrolled in the plan. If there is no contact after 90 days, the MCO is required to notify DHFS-OIG.

Although the state indicated that progress is being made toward updating old eligibility records of deceased Medicaid beneficiaries and have taken action to recoup the associated overpayments, it does not appear that adequate safeguards have been implemented to prevent a recurrence of this issue. As noted previously in this report, the DHFS-OIG confirmed that it does not have access to the Social Security Administration Death Master File for use in identifying deceased beneficiaries and or providers. The DHFS-OIG indicated that the state has access to Illinois' vital statistics information, but the data is not current. The state must take action to timely match Medicaid beneficiary eligibility and provider enrollment records to the Illinois Department of Public Health death records as indicated in the state's response to the audit. Additionally, the DHFS-OIG must develop procedures to ensure that contracted MCO's are verifying that beneficiary eligibility records are matched against state death records to ensure that Medicaid funds are safeguarded against erroneous payments and potential fraud and abuse.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Illinois to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be

helpful to Illinois based on its identified risks include those related to provider enrollment. More information can be found at http://www.justice.gov/usao/training/mii/.

- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Illinois review the noteworthy practices on provider enrollment and disclosures and the effective practices in program integrity and consider emulating these practices as appropriate.
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.104 Disclosures of Ownership and Control website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf

Conclusion

This focused review also identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately. We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place and identify which area of the State Medicaid Agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

CMS looks forward to working with Illinois to build an effective and strengthened program integrity function.

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Bruce Rauner, Governor
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October 28, 2015

Mark Majestic
Director
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Dear Mr. Majestic:

Thank you for the opportunity to respond to your letter and related report dated September 2015. Illinois recognized when the Affordable Care Act legislation and regulations were passed that our antiquated provider enrolment system would not allow for compliance with the new regulations and submitted the appropriate APDs and contracted for the development and implementation of a new provider enrollment system (IMPACT) to enable Illinois to become compliant. Since your review, Illinois has implemented a new provider enrollment system that went live in July 2015. Below you will find our response along with a corrective action plan for each concern listed in the report:

42 CFR 455.410: Enrollment and screening of providers

CMS Recommendation: Develop policies and procedures to implement the requirement that all ordering and referring physicians, or other professionals providing services under the state plan or a waiver of the plan, be enrolled as participating providers.

Response: Illinois is currently enrolling ordering and referring physicians and other professionals. Illinois is also in the process of revalidating these providers through the new State enrollment system, IMPACT. Provider handbooks and policies are being appropriately undated.

42 CFR 455.414: Revalidation of enrollment

Recommendation: Develop a formal plan, policies and procedures to ensure that all Illinois Medicaid providers enrolled on or before March 25, 2011 will be revalidated by the required completion date of March 24, 2016. The plan should include a contingency if the transition to the new MMIS is not completed as expected in 2015.

Response: IMPACT, the new provider enrollment system, went live on July 20, 2015. Illinois' goal is to have all institutional providers revalidated by December 31, 2016, we may not meet this requirement. However, Illinois will continue diligently revalidating all providers as quickly as possible with the resources that we have.

42 CFR 455.420: Reactivation of provider enrollment

Recommendation: Ensure that the state collects the appropriate application fees from any applicable providers during the reactivation process.

Response: At this time there is not an application fee. Illinois will seek to implement a fee in the next 12 months.

E-mail: hfs.webmaster@illinois.gov **Internet:** http://www.hfs.illinois.gov/

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Bruce Rauner, Governor
Felicia F. Norwood, Director

42 CFR 455.432: Site visits

Recommendation: Develop and implement a process to conduct pre and post-enrollment site visits of all providers categorized as moderate and high risk. Or, where appropriate, the state can verify that a site visit was performed within the prior 12 months by Medicare using the Provider Enrollment, Chain and Ownership System.

Response: Illinois Department of Healthcare and Family Services, Office of Inspector General has developed processes to perform site visits for moderate and high risk providers and has been performing site visits on high risk Non-Emergency Transportation providers since the early 2000's. Furthermore, the implementation of these processes through the new IMPACT Provider Enrollment system is under development. IMPACT will allow the site visit processes to be more efficient.

42 CFR 455.436: Federal database checks

Recommendations:

- The state must obtain access to the Social Security Death Master File and develop a process to check the names, providers, persons with an ownership or control interest in the provider, agents and managing employees of the provider against all required federal database at the time of enrollment and reenrollment.
- All disclosed parties must be checked against the EPLS and LEIE or Medicare Exclusion Database on a monthly basis to ensure that federal funds are not paid to excluded persons or entities.

Response: Each time a provider enters into IMPACT to do an initial enrollment, revalidation or any modification to their account, a full check is done on licensing, sanctions and criminal history on every owner with greater than 5 percent ownership, agent or managing employee.

42 CFR 455.440: National Provider Identifier

Recommendation: Develop procedures to capture the NPI during the enrollment process for all ordering and referring providers. Develop and implement edits to reject claims lacking an NPI number or containing an incorrect NPI number.

Response: Illinois has developed an edit in which an NPI must be present on the claim to ensure payment or the claim will be rejected.

42 CFR 455.460: Application Fee

Recommendation: Develop and implement a process in compliance with all the requirements at 42 CFR 455.460 related to collecting applicable application fees for enrolling or re-enrolling Medicaid-only providers.

Response: At this time there is not an application fee. Illinois will seek to implement a fee in the next 12 months.

Sincerely,

Teresa Hursey
Acting Medicaid Director
Illinois Department of Healthcare and Family Services

Cc: Brian Ley, Director, MFCU
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