**Section 140.2 Medical Assistance Programs**

a) Under the Medical Assistance Programs, the Department pays participating providers for necessary medical services, specified in Section 140.3 through 140.7 for:

1) persons eligible for financial assistance under the Aid to the Aged, Blind or Disabled-State Supplemental Payment (AABD-SSP) and Temporary Assistance to Needy Families (TANF) programs (Medicaid-MAG);

2) persons who would be eligible for financial assistance but who have resources in excess of the Department's eligibility standards and who have incurred medical expenses greater than the difference between their income and the Department's standards (Medicaid-MANG);

3) individuals under age 18 who do not qualify for TANF/TANF-MANG and infants under age one year (see Section 140.7);

4) pregnant women who would not be eligible for TANF/TANF-MANG if the child were born and who do not qualify as mandatory categorically needy (see Section 140.9);

5) persons who are eligible for Title IV-E adoption assistance/foster care assistance from another State and who are living in Illinois;

6) noncitizens who have an emergency medical condition (see 89 Ill. Adm. Code 120.310); however, payment is not included for care and services related to an organ transplant procedure;

7) persons eligible for medical assistance under the Aid to the Aged, Blind or Disabled (AABD) program who reside in specified Supportive Living Facilities (SLFs), as described at 89 Ill. Adm. Code 146, Subpart B;

8) persons eligible for FamilyCare as described in 89 Ill. Adm. Code 120.32;

9) beginning January 1, 2014, persons eligible as ACA Adults as described in 89 Ill. Adm. Code 120.10(h); and

10) beginning January 1, 2014, persons eligible as Former Foster Care as described in 89 Ill. Adm. Code 120.10(i).

b) "Necessary medical care" is that which is generally recognized as standard medical care required because of disease, disability, infirmity or impairment.

c) The Department may impose prior approval requirements, as specified by rule, to determine whether the medical care is necessary and eligible for payment from the Department in individual situations. Such requirements shall be based on recommendations of technical and professional staff and advisory committees.

d) When recipients are entitled to Medicare benefits, the Department shall assume responsibility for their deductible and coinsurance obligations, unless the recipients have income and/or resources available to meet these needs. The total payment to a provider from both Medicare and the Department shall not exceed either the amount that Medicare determines to be a reasonable charge or the Department standard for the services provided, whichever is applicable.

e) The Department shall pay for services and items not allowed by Medicare only if they are provided in accordance with Department policy for recipients not entitled to Medicare benefits.

f) The Department may contract with qualified practitioners, hospitals and all other dispensers of medical services for the provision and reimbursement of any and all medical care or services as specified in the contract on a prepaid capitation basis (i.e., payment of a fixed amount per enrollee made in advance of the service); volume purchase basis (i.e., purchase of a volume of goods or services for a price specified in the contract); ambulatory visit basis (i.e., one comprehensive payment for each visit regardless of the services provided during that visit) or per discharge basis (i.e., one comprehensive payment per discharge regardless of the services provided during the stay). Such contracts shall be based either on formally solicited competitive bid proposals or individually negotiated rates with providers willing to enter into special contractual arrangements with the State.

g) The Department may require that recipients of medical assistance under any of the Department's programs exercise their freedom of choice by choosing to receive medical care under the traditional fee for service system or through a prepaid capitation plan or under one of the other alternative contractual arrangements described in subsection (f) of this Section. The categories of recipients who may choose or be assigned to an alternative plan will be specified in the contract. Recipients required to make such a choice will be notified in writing by the Department. If a recipient does not choose to exercise his/her freedom of choice, the Department may assign that recipient to a prepaid plan. Under such a plan, recipients would obtain certain medical services or supplies from a single source or limited source. The Department will notify recipients in writing if they are assigned to a prepaid plan. Recipients enrolled in or assigned to a prepaid plan will receive written notification advising them of the services which they will receive from the plan. Covered services not provided by the plan will be reimbursed by the Department on a fee for service basis. Recipients will receive a medical eligibility card, which will apply to such services.

h) The Department may enter into contracts for the provision of medical care on a prepaid capitation basis from a Health Maintenance Organization (HMO) whereby the recipient who chooses to receive medical care through an HMO must stay in the HMO for a certain period of time, not to exceed six months (the enrollment period). Upon written notice, the recipient may choose to disenroll from such an HMO at any time within the first month of each enrollment period. The Department will send the recipient a notice at least 30 days prior to the end of the enrollment period, which gives the recipient a specified period of time in which to inform the Department if the recipient does not wish to re-enroll in the HMO for a new enrollment period. The recipient may then disenroll at the end of the enrollment period only if the recipient responds to the notice and indicates in writing a choice to disenroll. Failure to respond to the notice will result in automatic re-enrollment for a new enrollment period. Recipients shall also be allowed to disenroll at any time for cause.

i) The Department may enter into contracts for the provision of medical care on a prepaid capitation basis from a Health Maintenance Organization whereby the recipient who chooses to receive medical care through an HMO may choose to disenroll at any time, upon written notice.

j) The Department shall pay for services under the Maternal and Child Health Program, a primary health care program for pregnant women and children (see Subpart G).

k) Services covered for persons who are confined or detained as described in 89 Ill. Adm. Code 120.318(b) shall be limited as described in Section 140.10.

(Source: Amended at 38 Ill. Reg. 12141, effective May 30, 2014)