An Analysis of the Successes, Challenges, and Opportunities for Improving Healthcare Access

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It goes without saying that access to good quality, comprehensive healthcare is critical for people living with HIV/AIDS. Advocating effectively for improved healthcare access requires understanding the underlying legal and policy landscape of a state, the state’s fiscal and cultural environment, and existing barriers to healthcare access.

The State Healthcare Access Research Project (SHARP) is researching and analyzing this information, and examining states’ capacities to meet the care and treatment needs of people living with HIV/AIDS. Working together with community partners in SHARP states, the project is identifying past successes, current challenges, and future opportunities to improve access to care and services for people living with HIV/AIDS.

Collaboration with community partners is integral to the SHARP process. We have met in-state with people living with HIV/AIDS, community-based AIDS services providers, healthcare providers, state and federal government officials, and other researchers and advocates. These community partners have shared their opinions and insights about the successes and challenges faced by people living with HIV/AIDS as they seek care. They have also shared their perspectives on the political, cultural, and fiscal factors unique to their state.

Our goal is for the SHARP reports to be informative and useful. It is our hope and intention that they will become a framework for future efforts to expand healthcare access tools that can be used as part of a broader strategy to bring healthcare to more people living with HIV/AIDS.

SHARP is being conducted by the Health Law Clinic of Harvard Law School and the Treatment Access Expansion Project (TAEP), with support from Bristol-Myers Squibb. The Health Law Clinic has provided legal services to low- and moderate-income people living with HIV/AIDS for 20 years, and actively participates in HIV healthcare access advocacy efforts. TAEP is a national organization focused exclusively on HIV healthcare access advocacy. The mission of both organizations is to help bring good quality, comprehensive healthcare to more people living with HIV/AIDS.
We gratefully acknowledge the contributions of the following individuals, who shared their knowledge, experience, perspectives, and opinions with us in the development of this report.

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The following acronyms are used frequently throughout this report:

- ADAP . . . . . AIDS Drug Assistance Program
- FPL . . . . . . Federal Poverty Level
- IDHFS/DHFS . . Illinois Department of Healthcare and Family Services
- IDHS/DHS . . . . Illinois Department of Human Services
- IDPH . . . . . . Illinois Department of Public Health
- SSDI . . . . . . Social Security Disability Insurance
- SSI . . . . . . Supplemental Security Income
part I: introduction

While Illinois may have received more attention recently for its colorful politics, it is a state that has made some significant accomplishments in ensuring access to healthcare for people living with HIV/AIDS. Illinois is home to an engaged and empowered community of people living with HIV/AIDS, along with many dedicated and knowledgeable advocates who work together to expand access to care and services. This report will highlight some of their successes, along with some remaining challenges and potential opportunities to further improve healthcare access.

Illinois is a diverse state geographically, encompassing both heavily urban areas and rural ones. Many healthcare access issues are similar for urban and rural environments, but may manifest differently in rural settings. Some unmet needs, such as transportation, are more acute in rural areas. While the majority of Illinoisans, including the majority of those who are HIV-positive, live in urban areas, it is important not to overlook the distinct needs of rural residents living with HIV, and to bear in mind that a one-size-fits-all approach may not be the most effective.

Illinois is also diverse in terms of race and ethnicity, and as in the rest of the country, HIV/AIDS in Illinois disproportionately affects communities of color. HIV/AIDS is not just a matter of individual and public health, but also one of social justice, as it is interwoven with, among others, the issues of poverty, stigma, discrimination, educational and employment opportunities, and the criminal justice system. One stark illustration of this is that while Black and Hispanic residents make up 30% of Illinois’s population, they account for half of the people living without health insurance and 63% of cumulative HIV and AIDS cases in the state. Efforts to improve access must focus particularly on helping to remedy these disparities.

Past healthcare access successes in Illinois include raising the Medicaid income eligibility from 42% to 100% of the FPL, establishing a centrally coordinated case management model, creating a state pharmaceutical assistance program (SPAP) for people with HIV/AIDS, and developing effective rapid and perinatal testing programs. Each of these has brought care and services to more people living with HIV/AIDS.
But despite these achievements, challenges remain. Illinois Medicaid has been chronically underfunded, resulting in significant delays in payments to providers and inadequate reimbursement rates when providers do get paid. The unique case management consortium is dependent on discretionary Ryan White funding—an uncertain source in perilous economic times. A new HIV testing law has not been widely implemented due to lack of adequate funding.

Some of the challenges are related to the aforementioned colorful politics—past conflicts between the former governor and the legislature. With the advent of a new administration in Illinois come new opportunities for change and progress in bringing access to care to more people living with HIV/AIDS in the state.
OVERVIEW OF THE HIV/AIDS EPIDEMIC IN ILLINOIS

Illinois has a total population of 12,852,548. In April 2009, IDPH stated that there were 34,934 people reported as living with HIV or AIDS in Illinois (17,277 HIV; 17,657 AIDS). The AIDS Foundation of Chicago further estimates that there are approximately 10,000 Illinoisans that do not currently know they are HIV-positive, bringing the likely total number of infected people to nearly 45,000. This number is consistent with the Centers for Disease Control and Prevention (CDC) estimate that 1 in 5 people with HIV or AIDS have never been tested. It is estimated that there are approximately 3,000 new infections in Illinois each year. Forty-one percent of the Illinois population lives in Cook County, which includes Chicago and suburbs. More than 78% of Illinoisans living with HIV/AIDS live in Cook County, and this area also has the largest number of healthcare providers.

Demographics

The prevalence of HIV/AIDS is not evenly distributed among different racial, ethnic, or gender groups. Of the cumulative reported HIV cases in Illinois, 50% (9,090) have occurred in non-Hispanic Blacks, despite Blacks making up only 15% of Illinois’s population. Non-Hispanic Whites comprise 65% of the state’s population and constitute 32% (5,751) of HIV cases, and Hispanics make up 13% (2,356) of reported cases and 15% of the overall population. These rates are similar for cumulative reported AIDS cases: non-Hispanic Blacks (50% or 18,187 cases), non-Hispanic Whites (35% or 12,794), and Hispanics (13% or 4,810). Males constitute a larger portion of the adult reported HIV/AIDS cases by a ratio of over 4:1 (43,263 cumulative male HIV/AIDS reported cases vs 10,455 female reported cases), even though females make up 51% of the state’s population.

Modes of transmission

Modes of transmission differ significantly not only between genders, but also across the different racial/ethnic groups. For males with HIV or AIDS, men having sex with men (MSM) was the mode of transmission reported most often among White males, constituting approximately 78% of HIV cases. Injection drug use (IDU) accounted for 4% of HIV cases and 8% of AIDS cases among White males. The reported transmission modes for Black males were more varied, with about 45% of HIV/AIDS cases among Black males attributed to MSM, and 19% of HIV cases and 29% of AIDS cases
attributed to IDU. Among Hispanic males, 61% of cumulative HIV infections and 53% of AIDS cases have been attributed to MSM; 10% of HIV and 22% of AIDS cases have been reported as IDU.

The modes of transmission for White and Black non-Hispanic women are fairly similar, with heterosexual transmission accounting for 44% of HIV cases and 39% of AIDS cases among White women, and 40% of HIV/AIDS cases among Black women. For Hispanic women, 54% of HIV cases and 59% of AIDS cases were reported as heterosexual transmission, while 14% of HIV cases and 27% of AIDS cases were attributed to IDU.

**STATE ECONOMIC PROFILE**

Illinois has a continually growing gross domestic product (GDP), which rose to $633,697,000,000 in 2008, a $16B increase (approximately 2.5%) from 2007. This growth was down slightly from the approximately 4% growth ($28B increase in GDP) that Illinois experienced between 2006-2007. This slow-down in growth was accompanied by a subsequent increase in the unemployment rate from 4.9% in 2007 to 6.9% in 2008.

The slower growth of Illinois’s GDP was also reflected by the fact that 33% of Illinoisans had income below 200% of FPL in 2006-2007 (with 15% of Illinois’s population having income below 100% of FPL). This is slightly lower than the national average of 36% of the population having income below 200% of FPL. The median annual income for the state was $51,320 between 2005 and 2007, ranking Illinois 18th in the nation. Per capita personal income in 2007 was $40,919, which ranked 13th in the nation, and was above the national average of $38,564.

In 2003, then-governor Rod Blagojevich released a new program entitled *Opportunity Returns*, which divided the state into 10 regions and then focused resources in those regions to emphasize industries that would best boost the overall economy.

**Industries and employers in Illinois**

Illinois calls itself home to 33 of the Fortune 500 companies. The top 10 Illinois Fortune 500 companies are located in Chicago (Boeing), Bloomington (State Farm Insurance Co.), Deerfield (Walgreens), Hoffman Estates (Sears Holdings), Peoria (Caterpillar), Decatur (Archer Daniels Midland), Northfield (Kraft Foods), Northbrook (Allstate), Schaumburg (Motorola), and Abbott Park (Abbott Laboratories).
The Illinois economy is composed of a wide variety of industries. For example, Illinois is the fifth largest industrial state in the nation. A total of 11,800 manufacturers operate approximately 19,000 plants around the state. This also allows Illinois to serve as a headquarters for transportation and shipping, especially because of its key location for air (O’Hare International Airport), rail, port (Lake Michigan), and highway (centrally located in the Midwest). The major manufacturing industries of Illinois—food, chemicals, machinery, fabricated metals, computer/electronics, plastics and rubber, and transportation equipment—provide the state with a value added of almost $94.1B each year. Manufacturing and trade combined constitute over 30% of all nonagriculture payroll jobs in Illinois.

Food production is Illinois’s number one manufacturing industry, with more than 1,300 food manufacturing companies operating within its borders. Illinois’s extensive agricultural industry provides the raw materials necessary for this production. Illinois ranks seventh nationally in cash receipts from crops and livestock. The state ranks first in the nation for soybean production, second for corn production, and fourth for swine. Illinois also has the fourth largest amount of exported agricultural commodities, accounting for nearly 7% of all US agricultural exports. Annually, Illinois generates $8.3B from its agricultural products, with corn comprising 40% of that amount, soybeans making up a third, and livestock, dairy, and poultry comprising an additional 22%.

In the services sector, the financial market and technological innovation lead the state. Illinois is home to 2,300 commercial banks, 1,000 savings institutes, 500 credit unions, and more than 2,000 insurance carriers. In terms of technology, there are 144 university-based research centers and 71 federal research centers in Illinois. More than 440 companies have research and development departments located within the state.

Tourism is also an important economic growth area in Illinois, jumping from $26.2B in 2006 to $28.3B in 2007. The breakdown for the largest percentage of employment by sector is as follows: trade, transportation, and utilities (20.2%); government (14.4%); professional business and services (14.1%); education and health services (12.7%); and manufacturing (11.7%).
Revenues (taxation) and expenditures

In fiscal year (FY) 2007, state revenues totaled $48.5B, with federal revenue accounting for the largest portion ($14.5B or 30% of revenue), followed by income tax ($12.5B, or 25% of income) and sales tax ($9.8B or 20% of revenue.)

Total state spending in 2007 was $51B, or $2.5B greater than revenue. Health and Social Services expenditures accounted for 42% of total expenditures ($21.2B), followed by education ($12.5B or 25% of spending).

Sales tax rates across the state differ based on locality. The general sales tax rate is 6.25%, but for qualifying food (grocery store, not restaurant), drugs, and medical appliances, it is only 1%.

The gas tax rate is 50.8 cents per gallon (cpg), including the federal tax of 18.4 cpg. The Illinois gas tax ranks ninth highest in the nation, with a national average at 45 cpg. Illinois ranks seventh in the nation for diesel fuel tax, with a rate of 63.3 cpg, including a federal tax of 24.4 cpg. The national average for diesel fuel tax is 50 cpg.

Twenty percent of adults in Illinois are smokers, compared with 19% nationally. The Illinois cigarette tax is currently $0.98/pack, which is the 21st highest rate in the nation. The Chicago combined tax is $4.05/pack, which is the highest in the nation. In 2006, Illinois collected $621M from its cigarette tax, and $19M from its tobacco products tax. Furthermore, the tobacco settlement has provided the state with $2.065B so far, which has gone to programs for the elderly, tobacco-use prevention, medical research, venture-tech, and Medicaid.

The income tax rate in Illinois is a 3% flat rate. Among the 6 states that impose a flat income tax rate, Illinois is the lowest at 3%, while Massachusetts is the highest at 5.3%. In FY06, Illinois ranked 33rd for income tax collections per capita. Property taxes are based on locality and are not controlled by the state. However, this tax tends to be assessed at 33.33% of the fair market value of the property.

Corporations in Illinois pay 4.8% income tax and 2.5% replacement tax. Partnerships pay 1.5% personal property tax replacement income tax (replacement tax). Partnerships are subject to the replacement tax, but do not pay the regular Illinois income tax.

In February 2008, then-governor Blagojevich announced a lottery in which 100% of the net proceeds were to be used to support HIV/AIDS education, prevention, care, and treatment programs. This lottery, a “Quality of Life” game called “Red Ribbon Cash,”
has thus far resulted in an additional $1.4M budgeted for public and private entities in Illinois. Funds will be distributed on a competitive basis, with grants based on an organization’s budget size and targeted to organizations that serve high-risk populations.\textsuperscript{53}

However, as a result of the downturn in the economy, as well as tension between the general assembly and the governor, about $1.2M in HIV funding was vetoed in FY08 (in addition to significant other funding).\textsuperscript{54} Some advocates believe that this cut in funding was largely fueled by the governor’s frustration with the General Assembly for not passing his health reform in 2007 (see \textit{Overview of State Political Environment} section for more information).

\textbf{STATE DEMOGRAPHIC PROFILE}

With a population of 12,852,548, Illinois is the fifth most populous state in the nation.\textsuperscript{55} As is the case in most of the nation, the population is split almost equally by gender, with females making up 51\% of the population (6,519,146) and males constituting the other 49\% (6,333,402).\textsuperscript{56} The majority of the population is non-Hispanic White (65\% or 8,352,822) with an almost equal distribution of non-Hispanic Blacks and Hispanics (15\% each, or 1,882,375 and 1,919,690, respectively).\textsuperscript{57} Thus, compared to the national average of 66\% White, 15\% Hispanic, and 12\% Black, the state tends to be composed of a higher percentage of minorities.\textsuperscript{58} Illinois also has an 8\% rate of noncitizens living in the state.\textsuperscript{59}

Approximately 89\% of the Illinois population lives in a metropolitan area, with only 11\% living in rural Illinois.\textsuperscript{60} The most populous counties are Cook (5,376,741), DuPage (904,161), Lake (644,356), Will (502,266), and Kane (404,119).\textsuperscript{61} These are also the counties with the highest number of reported HIV/AIDS cases.\textsuperscript{62}

Illinois has a number of prisons and jails across the state, with the largest correctional facilities located in Cook, Winnebago, DuPage, Will, and Kane counties.\textsuperscript{63} As of June 30, 2007, there were 45,565 prisoners within the corrections system, 94\% of whom were males.\textsuperscript{64} In June 2007, more than half of the corrections population was composed of non-Hispanic Blacks (59\%), with the remainder being non-Hispanic White (29\%), Hispanic (12\%), and Asian (0.3\%).\textsuperscript{65} As of November 2006, there were 524 adults with HIV/AIDS in Illinois corrections facilities, 88\% of whom were male, 78\% of whom were Black, 15\% of whom were White, and 7\% of whom were Hispanic.\textsuperscript{66}

The Illinois corrections system has increased its testing within the correctional facilities, administering 34,915 HIV tests in 2006, with 182 of the tests coming back positive.\textsuperscript{67}
Since January 2006, 36 Illinois prisons are providing prisoners with voluntary HIV counseling and testing with no copayment. Prisoners are offered HIV testing during orientation, and then again upon their release.

Health issues

Illinois is very well set to deal with many of the health issues it faces. There are currently 190 hospitals in Illinois, which constitutes 3.9% of all of the hospitals in the US. Ten of these hospitals, including the University of Chicago’s and Northwestern’s, have been listed in US News and World Reports “America’s Best Hospitals.” In addition, Illinois ranks fourth in the nation for number of rural health clinics, with 197. However, almost a quarter of the counties in Illinois have no hospital provider (e.g., Johnson, Brown, Alexander, Monroe, Kendall, Clark, Pulaski, Menard, Cass, Carroll, Gallatin, Jasper, Marshall, White, Douglas, Moultrie, Pope, Edwards, Henderson, Cumberland, Scott, Calhoun, Putnam, and Stark). These counties are located primarily on the outskirts of the state, where access to hospitals can be found in nearby cities such as St Louis, Missouri.

The Illinois healthcare industry provides 7.1% of Illinois’s total employment, and is estimated to grow at a rate of 1.3% annually through 2014. According to the Bureau of Labor Statistics Occupational Employment Statistics for May 2008, healthcare-related employment ranked sixth of 22 occupational areas in terms of number of persons employed (453,980 total). This includes both healthcare practitioner and technical occupations (doctors, nurses, dentists, medical technicians), as well as healthcare support (assistants, aides, orderlies). In 2007, there were 41,826 registered nonfederal physicians in the state, as well as 104,130 nurses and 8,705 dentists.

In 2006-2007, the breakdown for insurance coverage was as follows: employer-based (58%); individual insurance (4%); Medicaid (11%); Medicare (11%); other public (1%). However, there were still more than 1.7 million Illinois residents without any form of insurance in 2006-2007, ranking the state 25th nationally in percent of uninsured residents. The percent of the uninsured population can vary widely across the state. According to the Census Bureau, in 2005, 8.2% of the population in Alexander County were uninsured, while 21.8% of Cass County residents had no health coverage. Cook County was also in the “very high uninsured” category, with almost 16.9% of the population living without health insurance. In 2006-2007, 37% of the uninsured
population under age 65 in Illinois had income below 100% of the FPL (636,886), with another 29% falling between 100-200% FPL.\(^8\) Despite making up only 15% of the total population each, non-Hispanic Blacks and Hispanics comprised 22% and 28%, respectively, of the uninsured population.\(^8\) This means that though these minority groups made up only 30% of the total population, they made up 50% of those uninsured in 2006-2007.

The Illinois government had been working to try to provide healthcare access to underserved populations, but strife between the legislature and former governor Blagojevich created significant obstacles to passing legislation. For example, in September 2008, the legislature passed a bill that offered significant discounts for hospital care to uninsured Illinoisans. Under the bill, consumers would pay charges based on the actual cost plus a 35% markup, rather than the prevailing 200-300% markup.\(^8\) This would have resulted in a 55-65% savings in healthcare costs for the uninsured. Furthermore, the bill set a maximum cap of 25% of the household’s gross income for medical costs in any 12-month period. In urban areas, families who earn up to 600% of the FPL for a family of 4 would qualify, while in rural areas the eligibility limit was set to 300% of the FPL for a family of 4.\(^8\)

The bill initially passed both the Illinois House and Senate unanimously.\(^8\) However, the legislature was required to revote on it because Blagojevich vetoed the bill when it came to him. Former governor Blagojevich had initially supported the proposal at 800% and 600% of the FPL for urban and rural areas respectively, and was disappointed by the reduction in percentage that the legislature passed in its version of the bill.\(^8\) He was also upset that the attorney general was appointed to oversee the implementation and administration of the bill, instead of the IDPH (an agency of the executive branch).\(^8\) Therefore, because of the strife between these 2 governmental branches, it took longer for the bill to pass\(^8\) (because the legislature was required to vote on it twice), and put the bill at risk of failing in a second legislative vote.

The leading causes of death in Illinois include disease of the heart (27.2%), malignant neoplasms (23.3%), cerebrovascular disease (6%), chronic lower respiratory disease (4.9%), accidents (4%), diabetes (2.9%), influenza and pneumonia (2.8%), and Alzheimer’s disease (2.7%).\(^8\) Through 2007, there had been 18,799 reported deaths among Illinoisans due to AIDS (3.3% of the total AIDS deaths in the US).\(^8\)
SURVEY OF HEALTH PROGRAMS SERVING HIV-POSITIVE INDIVIDUALS

Federal funding for HIV/AIDS to Illinois totaled $107,738,768 in FY07. Of the federal funding, the US CDC contributed $18,840,058, with the majority of that funding going to prevention ($9,512,767) and HIV/AIDS surveillance ($2,863,998). Ryan White funding totaled $75,741,586, 33% of which was for Part A ($25,153,442) and 48% of which was for Part B ($36,392,873). ADAP funding, under Part B, was $27,628,149.

The state contributed $26,083,100 to the IDPH in FY09. Of this amount, $19,001,200 was allocated to AIDS/HIV education; drugs; services; counseling, testing referral, and partner notification; and patient and worker notification. A total of $3,150,000 was allocated to minority HIV/AIDS prevention and outreach. Certain areas that were funded in previous years were not allocated line-item funding from the state in FY09, including General Revenue Fund Grant to Chicago State University for HIV/AIDS Policy and Research Institute in the College of Health Sciences and funding for the African American HIV/AIDS Response Fund. However, these areas may be funded via other non-line-item-specific funds. This budgetary information does not include federal funding, or other state sources for HIV/AIDS funding that are not specifically budgeted for HIV/AIDS (eg, does not include IDPH or Department of Corrections funding, both of which provide some HIV/AIDS prevention and care services).

In mid-July 2009, the Illinois legislature passed a FY10 budget (FY10 began July 1, 2009) that funded IDPH at 50% of the previous year’s funding level. The legislature granted the governor discretion to allocate $3.4B to restore a portion of the cuts. Governor Quinn directed $40M to IDPH, approximately $6M short of full funding. Governor Quinn’s decision means that for FY10, Illinois HIV programs will have close to full funding, as the governor restored 97.4% of the state’s HIV budget. However, concerns remain about FY11 and beyond, as a $10B budget deficit is expected, and Illinois still needs to find long-term, sustainable solutions to its budget problems.

There are a variety of ways in Illinois that people with HIV/AIDS can receive care, including Medicaid, Medicare, Illinois Cares Rx, and ADAP, and providers funded by Ryan White. Children (age 18 and under) with HIV/AIDS may receive care through All Kids.
Medicaid

People with HIV/AIDS may receive care through Medicaid. Illinois Medicaid is administered through DHFS, although people may apply at local DHS offices. Generally, to get Medicaid, adults under 65 in Illinois must either meet the low-income requirements and the Social Security definition of disability or blindness, or be in a low-income family with dependent children. In terms of the disability requirements, unlike in most states, people who get SSI disability benefits must apply separately for Medicaid, and getting SSI does not mean you will be eligible for Medicaid in Illinois. This is because of Illinois’s 209(b) status. Generally, however, people disabled by HIV/AIDS and eligible for SSI or SSDI will meet disability requirements and qualify for Medicaid. Medicaid also covers pregnant women during the pregnancy and for 60 days after the birth. Parents who have income up to 185% of FPL can be covered under Medicaid.

Children, parents, and low-income pregnant women make up 72% of those receiving Medicaid services. Fourteen percent of recipients are disabled adults, 8% are senior care participants (prescription drug assistance), and 7% are low-income elderly. However, despite making up only 29% of the beneficiaries, the elderly, blind, and disabled make up 65% of Medicaid spending.

The Medicaid “income standard”—or income limit for the blind, disabled, and age 65 and over—is 100% of FPL, meaning that beneficiaries must have countable income below this amount to be eligible. For 2009, the FPL is $902.50 monthly ($10,830 annually) for individuals, $1,214.16 monthly ($14,570 annually) for couples. These requirements are met by people disabled by HIV/AIDS or for another reason who only get SSI. Adults under 65 must also meet an asset test with countable assets not exceeding $4,000 for one person, or $6,000 for a family of 2 or more. People with incomes higher than the Medicaid income limit may be able to get Medicaid with a “spend-down” (an amount of medical bills the person has to incur before they are eligible for a Medicaid card). Generally the spend-down amount is calculated using a formula that subtracts $902.50 (or whatever the current FPL is) from a person’s monthly income.

As federal law requires, Illinois provided the mandatory services covered by Medicaid in 2006, including inpatient hospital care (except for psychiatric), outpatient hospital care, and laboratory and x-ray services. A list of other mandatory services covered by Illinois Medicaid is located in Appendix A.
In addition, Illinois Medicaid covers a large number of optional services frequently used by people with HIV/AIDS, such as prescribed medications and dental services for dentures and emergencies. A list of other optional services covered by Illinois Medicaid is located in Appendix A.

The federal Medical Assistance Percentage (FMAP, the federal Medicaid matching rate) for Illinois’s Medicaid is 50%. This means, in effect, that for every state dollar spent on Medicaid, Illinois receives $1 in federal funds. In FY07, total appropriated Medicaid expenditures reached $11.6B (21% of total state appropriations). The majority of that funding came from the General Revenue Fund (59.7%), with the rest coming from the Cook County Provider Trust Fund (12.6%), the Hospital Provider Fund (10.4%), the Long Term Care Provider Fund (5.7%), the Drug Rebate Fund (4.6%), and the Tobacco Settlement Recovery Fund (3.2%).

Approximately 2.1 million people in Illinois on average per month were covered by Medicaid in FY07, or about 17% of the state’s population. In FY08, DHFS reported 10,793 HIV-positive clients.

Medicare

Medicare is a federally-funded program that provides health insurance to people over age 65 who are eligible for Social Security. Adults who are under 65, who are disabled either by HIV/AIDS or for another reason and who have worked enough years to be eligible for SSDI will also automatically qualify for Medicare after receiving their SSDI benefit for 2 years. (Note those individuals on SSI and not SSDI will not qualify for Medicare). It is possible for a person to qualify for both Medicaid and Medicare (this is often referred to as “dual eligibility”). In the US, Medicare covers an estimated 100,000 people with HIV/AIDS, approximately one-fifth of people with HIV/AIDS estimated to be receiving care.

Medicare coverage is broken up into areas known as Part A, Part B, and Part D. There is generally no cost for Medicare Part A, which covers hospital bills. Medicare Part B covers doctor visits and laboratory tests and requires a premium, which for 2009 is $96.40 per month (or more for higher-income individuals).

**Medicare Part D**

Medicare Part D helps beneficiaries pay for prescription drugs and requires an additional premium that varies depending on which prescription drug plan is chosen. Part D plans are required to offer a statutorily defined standard benefit. The standard benefit
for 2009 has a $295 deductible, then coinsurance of 25% up to $2,700 in total drug costs, followed by a gap in coverage between $2,700 and $6,153.75 (known as the “donut hole”) where enrollees must pay 100% of the costs of their drugs. After enrollees have incurred $4,350 in out-of-pocket expenses, they qualify for “catastrophic coverage,” and pay 5% of drug costs for the rest of the year, with the federal government paying the other 95%.

Prescription drugs are a major cost of care for people with HIV/AIDS. It is therefore important to consider what programs are available to assist individuals with Medicare Part D premiums and additional costs such as copayments. In Illinois, these programs include Extra Help and Illinois Cares Rx.

**Extra Help**
Extra Help is a federal subsidy program that helps pay for some or most of the costs of Medicare prescription drug coverage for low-income beneficiaries. For qualifying individuals, Extra Help will pay for the entire Medicare drug coverage premium if the drug plan selected has a premium at or below the Extra Help premium amount for the state (a figure set by the federal government) and only offers basic coverage. In Illinois, the 2009 Extra Help premium amount is $30.18. Those qualifying for full Extra Help benefits pay no monthly premium or deductible and a copayment of $2.40/generic and $6.00/brand-name, with no copayment after reaching the catastrophic coverage level of $6,153.75 in total annual drug costs. Individuals who qualify for partial Extra Help pay a sliding scale monthly premium, a $60 annual deductible, 15% coinsurance, and $2.40/generic and $6.00/brand-name copay after $6,153.75 in total annual drug costs. To qualify for full Extra Help, an individual must have income below 135% of FPL ($1,218 monthly) and resources less than $8,100; for partial Extra Help, the income limit is 135-150% of FPL ($1,219-$1,354 monthly) and resources less than $12,510.

**Illinois Cares Rx**
Individuals enrolled in Medicare Part D who do not qualify for full Extra Help, or who do qualify for partial Extra Help may be able to receive assistance through Illinois Cares Rx, the SPAP. Illinois is one of a few states that modified its SPAP to help low-income people living with HIV pay for their HIV-related medications.

The Medicare Part D/AIDS Drug Assistance Program Coordination Act of 2006 (Public Act 94-0909) expanded Illinois Cares Rx to cover HIV/AIDS as one of the program’s 10 covered diseases. Before the 2006 coverage expansion, there were approximately 195 ADAP clients with annual incomes between 135% and 200% of the FPL who were...
eligible for both ADAP and Medicare Part D, but who were unable to afford steep out-of-pocket costs during Part D’s coverage gap (the “donut hole”). These clients continued to obtain their prescription medications through ADAP, increasing costs to the state. Federal rules do not allow ADAP spending on medications to count towards out-of-pocket costs that would get a consumer out of the donut hole.

As a result, the state had to use its scarce ADAP funding to pay for clients’ prescription medications, resulting in approximately $15,000 spent per year per client, on average. In addition, individuals were solely responsible for paying for medications that were not covered by the ADAP program, even if those medications were part of their Medicare Part D drug formulary.

Illinois Cares Rx now covers the Medicare Part D out-of-pocket costs for medications on the ADAP formulary. This allows people with HIV to obtain all HIV-related prescriptions through the Medicare Part D program, instead of ADAP. As a result of shifting the costs of medications for these consumers from ADAP to Medicare Part D, the state spends approximately $10,500 (or 70%) less on each HIV-positive beneficiary. This cost-shifting leaves the state with additional ADAP dollars to cover more people in need. Shifting people living with HIV/AIDS to Illinois Cares Rx also has the advantage of moving people from a program dependent on limited, discretionary funding (Ryan White/ADAP) to a potentially more stable entitlement program (Medicare).

As of June 2009, eligibility for the Rx Basic HIV benefit is determined by asking: (a) Is the applicant on Medicare, (b) Is the applicant’s income less than $25,532, and (c) Does the applicant have HIV? If the answer is yes to all 3 questions, the applicant is likely eligible for Illinois Cares Rx.

In May 2009, both houses of the Illinois General Assembly passed House Bill 366, House Floor Amendment 3. The bill eliminates Rx Basic, instead creating one program that brings all beneficiaries up to the Rx Plus coverage level (meaning that any medication on the Part D formulary is covered). Income eligibility remains tied to a particular dollar amount (rather than a percentage of FPL), but may be adjusted annually through the administrative rulemaking process to reflect the Social Security cost of living adjustment. On August 14, 2009, there was a governor’s amendatory veto of HB366, recommending several changes to the bill, mostly concerning financial eligibility and the effective date of the legislation.
Ultimately, Illinois Cares Rx saves the state money in ADAP dollars by shifting some beneficiaries who previously would have been entirely on ADAP to Medicare Part D. It also ensures that beneficiaries are able to use the more comprehensive prescription drug formularies available through Medicare Part D.

**AIDS Drug Assistance Program**

IDPH administers ADAP. Currently, nearly 3,000 clients use ADAP services per month, accessing 8,500 prescriptions per month. Clients approved for ADAP must reapply on an annual basis in order to continue to receive services.

ADAP provides 94 different drugs, up from the 90 provided in 2007, including all antiretroviral therapies approved by the US Food and Drug Administration. Clients have a benefit cap of $2,000 a month, except for 3 very high-cost drugs. This cap is sufficient to support triple and quadruple combination therapies.

ADAP is available to individuals whose gross income is under 500% of the FPL (for 2009, this is an annual income of $54,150). Individuals receiving Medicare whose income is above the Illinois Cares Rx HIV Benefit eligibility level of approximately 240% of FPL may therefore seek assistance from ADAP. Individuals who are dually eligible for Medicaid and Medicare or are receiving coverage under Extra Help are not eligible for ADAP.

The state covers 25% of ADAP, and the federal government contributes 75% through a Part B ADAP earmark. The total amount spent on ADAP in 2007 was $36,878,149 (combined state and federal funds), a decrease of 7% as a result of the transition from ADAP to Illinois Cares Rx to cover Medicare Part D participants (equaling at least 900 consumers). In Illinois, the cost for a person to be covered by ADAP for a year was $12,193 in 2005, compared with a cost of $4,527 under the Illinois Cares Rx program. This is a 63% reduction in cost as a result of Illinois’s SPAP.

Illinois ADAP clients tend to have the following characteristics: 94% are uninsured, 82% are male, 17% are female, 38% are Black, 31% are White, and 27% are Hispanic. Forty-six percent of ADAP participants have an income level below 100% FPL, and another 27% fall between 100-200% FPL.

There is currently no waitlist for ADAP in Illinois.
Programs helping children

Children with HIV/AIDS may be covered by All Kids, the state’s Medicaid program for children, which covers more than 1.5 million Illinois children. Children are eligible if they are Illinois residents, aged 18 years or younger, and meet the insurance requirements. Uninsured children can qualify for All Kids no matter how much money their parents earn, and even when children are covered by insurance, they may also qualify for some All Kids coverage under certain circumstances. Children in families with income below 133% of FPL are covered for free in a single-person household. Children in families with income between 133% and 150% of FPL pay a $2 copayment for each medical service and prescription received, up to a maximum of $100 per family per year. Children in families with higher income levels can be covered on a sliding scale of premiums. All Kids covers doctor visits, hospital stays, prescription drugs, dental care, vision care and eyeglasses, regular check-ups and immunizations, as well as special services such as medical equipment, speech therapy, and physical therapy.

DESCRIPTION OF RELEVANT STATE LAWS, REGULATIONS, AND POLICIES

Transmission

Illinois is one of 32 states with a criminal statute related to HIV transmission. Under this law, any person knowing that he/she is HIV-positive who engages in intimate contact with another; transfers, donates, or provides his or her blood, tissue, semen, organs, or other potentially infectious body fluids for transfusion, transplantation, insemination, or other administration to another; or dispenses, delivers, exchanges, sells, or in any other way transfers to another any nonsterile intravenous or intramuscular drug paraphernalia is guilty of a class 2 felony. Informed consent is an affirmative defense and the statute does not require that the other party must contract HIV.

Testing

Any testing or test results shall be conducted in accordance with the AIDS Confidentiality Act and the HIV/AIDS Confidentiality and Testing Code.

In general, a patient must give written or verbal informed consent prior to an HIV test. A healthcare facility or provider may offer opt-out HIV testing where the patient is informed that the subject will be tested for HIV unless he or she declines. Illinois law specifies that pre-test information must be provided to the patient before testing in
all situations. Pre-test information may be provided verbally, in writing, or by video. Consent before testing is not required in certain situations because a patient is specifically required by state or federal law to be tested.

Illinois has special requirements with regard to testing pregnant women and newborns. Every healthcare professional or facility that cares for a pregnant woman during labor or delivery must provide the woman with HIV counseling and opt-out rapid HIV testing if the mother’s HIV status is unknown. If the mother’s HIV status is still unknown, the newborn must be tested for HIV as soon as medically possible, and the parent cannot refuse.

Confidentiality and notification

Most confidentiality issues are handled by provisions of the comprehensive AIDS Confidentiality Act (410 ILCS 305) and the accompanying HIV/AIDS Confidentiality and Testing Code.

Any person upon whom an HIV test is performed shall have the right to request anonymity. Under anonymous testing, an individual must provide written informed consent by using a coded system that does not link individual identity with the request or the result except when written informed consent is not required by law.

A doctor is allowed to notify the spouse of a patient who tests positive if, after trying to persuade the patient to notify their spouse and allowing reasonable time for the patient to do their own notification, the patient chooses not to. A doctor should make a reasonable effort to notify the parents of a minor (18 years or younger) who tests positive if notification would be in the best interest of the child and the doctor has allowed a reasonable time for the minor to do that on his or her own. However, the doctor is not legally required to notify the parents.

Illinois is one of just 5 states that require any school notification of HIV/AIDS cases in children of school age. Recent attempts to alter this requirement have failed and the law still remains in force.

Harm reduction

In terms of laws affecting harm reduction programs, Illinois allows adults 18 years of age and older to purchase up to 20 syringes at their local pharmacy without a prescription. Local governments have interpreted state law to allow the operation of syringe exchange programs. The Web site of the AIDS Foundation of Chicago lists 7 syringe exchange programs available in Illinois as of April 2008.
OVERVIEW OF STATE POLITICAL ENVIRONMENT

One of the biggest challenges that faced Illinois in recent years was the tension between the General Assembly—controlled by Democrats—and former governor Blagojevich, also a Democrat. Both had a habit of strong-arming each other by attempting to block or veto the other’s actions. The tension between the executive and legislative branches has a complex history, and is related both to the system of checks and balances in Illinois government, and to interpersonal relationships among key political players. Standoffs between the governor and General Assembly and between the Illinois House and Senate stymied efforts to pass legislation.

On December 9, 2008, Blagojevich was arrested on federal corruption charges. He was then removed from office on January 29, 2009, after being found guilty in a weeklong impeachment trial. Governor Pat Quinn, the former lieutenant governor, is currently in office. Governor Quinn is viewed as an advocate for increasing access to healthcare.

Many state government agencies also provide a source of frustration for community-based organizations. Some leaders feel that for every 3 employees slated to do a certain task, only one is actually interested and the other 2 are there “just to collect a paycheck.” Particularly in Chicago, there is a feeling that many government positions are filled through “cronyism,” and not any sense of expertise or ability.

STATE LEGAL SERVICES AND ADVOCACY CAPACITY

There are many advocacy and support organizations serving people living with HIV/AIDS around Illinois, primarily in the Chicago area. There are also a number of organizations providing legal resources, representation, and advocacy. Illinois is fortunate to have a strong community of knowledgeable, dedicated, and capable advocates, and is well-positioned to use this depth of talent to help expand access to care and services for HIV-positive Illinoisans.
By conducting focus groups and one-on-one interviews with key stakeholders, including community-based advocates, healthcare providers, people living with HIV/AIDS, and government officials, we have identified a number of successes, challenges, and opportunities for the future. These successes, challenges, and opportunities are discussed below.

**MEDICAID EXPANSION**

**Past success**

The Illinois Medicaid program is administered by DHFS. Through an interagency agreement with DHFS, DHS determines eligibility for medical assistance. DHS’ local offices are organized and supervised by regions.

Illinois operates its Medicaid program under a 209(b) waiver. As a 209(b) waiver state, Illinois opted to continue to use the Medicaid eligibility standards it had in place when the SSI program was enacted in 1972. Unlike most other states, as a 209(b) state, Illinois is not required to automatically grant Medicaid eligibility to all individuals receiving SSI benefits. Instead, until relatively recently, Illinois conditioned Medicaid eligibility to income at or below 42% of FPL. In 2000, community advocates working with legislators successfully raised income eligibility for all aged, blind, and disabled individuals from 42% of the FPL to 100% of the FPL, granting Medicaid access to an additional 100,000 Illinois residents who live at or below the poverty level, including more than 1,500 individuals living with HIV.

The Illinois Medicaid program offers a robust range of services under the “optional” federal Medicaid provisions. See Appendix A for a list of such services.

**Challenges**

Many of the challenges discussed in this section stem from the overriding issue of lack of sufficient revenue for Illinois’s Medicaid program. None of the opportunities identified in the following section can address the historic underfunding of health and human services in Illinois or close the structural deficit. Without budgetary reform and the identification of new revenue, Illinois Medicaid problems will persist.

One of the challenges faced by Illinois Medicaid is the payment delays allowed by the current system. Under Section 25 of the Illinois State Finance Act, the state can pay Medicaid providers the following year to help “balance” the state budget. According
to the Illinois auditor general’s May 2008 report on the audit of the Medicaid payment process, an average of $1.5B in unpaid medical claims have been carried over into the next fiscal year between FY05 and FY07. In the report, DHFS officials said they must delay payments to ensure that they do not run out of funds to meet critical payments. While claims are processed relatively quickly (an average of 6 days according to the auditor general’s report), inadequate funding forces DHFS to delay submitting claims to the comptroller for payment (an average of 57 days). Essentially, DHFS needs to monitor cash flow to maximize the medical services that can be paid for from a too-small pool of funds. Because of payment delays and bills carried over into the next fiscal year, 3.3 million claims submitted to DHFS accrued a potential liability of almost $81M in Prompt Payment Act interest since FY00, according to the auditor general’s report.

In addition to these payment delays, DHFS takes an average of 87 days to notify nonexpedited providers of a rejected service when the rejected service was submitted on a reimbursement claim along with a service that was approved for payment. According to the auditor general’s 2008 report of the Medicaid payment process, 67% of surveyed healthcare providers responded that they had experienced a problem with the claims rejection process. The DHFS policy handbook instructs providers to resubmit a claim if the claim has not been addressed after 60 days from the date the provider submitted the claim. In 2006, 46.1 million of the 94.8 million paid claims were not paid by DHFS within 60 days. Thus, providers were required to submit a second billing invoice to DHFS 49% of the time.

Under the 1999 Prompt Payment Act, DHFS is supposed to pay automatic interest to providers who have accrued more than $50 in interest as the result of payment delays. In cases where interest is below $50, Illinois administrative rules allow for providers to request interest on a bill owed to them. DHFS has set up a process for providers to request this interest, although a survey by the auditor general of Medicaid providers found that 66% said they did not know they were entitled to request interest payments. There are approximately 273,000 claims that have accrued a potential liability of $36.1M in automatic interest. Unfortunately, the lack of adequate funding for Medicaid means that payment of interest due to providers would likely require cutting payments for core services.

In addition to payment delays and loss of interest payments, providers receive very low reimbursement rates for Medicaid services. On average, Illinois Medicaid pays approximately 56% of what Medicare pays for the same service, and often reimburses
only about one-third of the actual cost of providing care. In combination, these factors have a serious negative effect on Medicaid patients. Together they create an environment that discourages providers from accepting Medicaid clients. Hospitals across Illinois, particularly those with large numbers of Medicaid patients, are closing their doors as a result of financial struggles—including Advocate Bethany, Fairfield Memorial, Lincoln Park Hospital, and Washington County. Further, Holy Cross, Rush North Shore, St. James Olympia Fields, Taylorville Memorial, and Weiss Memorial have closed their maternity units. Many additional institutions and providers are concerned about being able to survive.

There is evidence that providers are increasingly hesitant to accept Medicaid patients in their inpatient care practices. Throughout the state, there are anecdotal stories of providers informing patients that they do not have room for new Medicaid patients in their practices. Some providers have elected not to accept Medicaid at all.

Ultimately, Medicaid clients are finding it increasingly difficult to obtain the healthcare services they need and deserve. Low reimbursement rates, payment delays, and loss of interest payment further exacerbate declining access to early intervention healthcare services. Some providers are setting Medicaid caps (the number of Medicaid patients that they can afford to serve), making it more difficult for people living with HIV/AIDS to find a provider who will accept new patients. As a result, many Medicaid patients will become sicker and end up in hospital emergency rooms, resulting in an even greater cost to the state, healthcare systems, and people living with HIV/AIDS.

Opportunities

While there are numerous opportunities to help expand Medicaid coverage in Illinois, all of them are unlikely to be effective without increasing the funding available for Medicaid programs. Chronic underfunding of the program has resulted in the problems identified above, and continued underfunding will hinder efforts to improve access to medical services for some of Illinois’s most vulnerable residents.

Reform Section 25

Either legislative action by the General Assembly or administrative action by state agencies is necessary to reduce delays in the Medicaid payment process. Section 25, for example, could be amended to prohibit rollover budgeting, greatly reducing providers’ wait times for Medicaid reimbursement of claims. While reducing late reimbursement, Illinois should also implement procedures that guarantee prompt payment of interest to providers as required under the 1999 Prompt Payment Act and streamline DHFS claims.
resubmission processes. In order to do this without cutting other state government programs and services, Illinois will likely need to identify a new revenue source dedicated to reducing the backlog.

**Outsource Medicaid reimbursement system**

Currently, claims for Medicaid submitted by medical providers are processed by the Medicaid Management Information System, which is run by the state. Many other states contract with outside fiscal providers to process claims. It is uncertain whether outsourcing claims would save money or reduce payment delays, but Illinois could investigate this option to determine whether it is appropriate for the state.

**Increase Medicaid reimbursement rates**

Illinois should also consider increasing Medicaid reimbursement rates. There is evidence that low Medicaid reimbursement rates have greatly reduced Medicaid patients’ access to qualified healthcare providers and specialists. To address this concern, rate increases should focus on specific services, including HIV testing and counseling, primary care, dental care, and specialist care. This will require legislative action and most likely identifying an additional source of revenue to increase Medicaid appropriations.

It is important to note that governmental inaction in this area has in the past led to successful patient-initiated litigation to achieve this goal. In 1992, a lawsuit was filed in Illinois on behalf of Medicaid-eligible children across the state. In Memisovski v. Maram, a federal district court ruled that Illinois state agencies violated the rights of Medicaid-eligible children to receive adequate healthcare under the Medicaid program. The court found that the state failed to ensure that Medicaid beneficiaries have access to care and services to the extent that such care is available to the general population with private insurance or other public health insurance. The court found that rates paid by the Illinois Medicaid program are insufficient to entice medical providers to provide services to Medicaid patients. They also noted that payment delays exacerbated the problem.

As a result of the court ruling, state agencies were required to amend their reimbursement process, including raising the rates on a number of children’s primary care codes that represented the vast majority of all medical visits. If the General Assembly could find a way to provide more revenue for Medicaid, so that reimbursement rates could be increased and delays in provider payments could be remedied, it would obviate the need for a lawsuit. Without such action, litigation could be one way to try to ensure that the broader Medicaid community is provided access to adequate healthcare under the Medicaid program.
Investigate changing 209(b) status and/or raising Medicaid income-eligibility level

Illinois should explore changing its 209(b) status and instead use SSI eligibility as the standard for Medicaid eligibility for its disabled citizens. The current system creates a significant administrative burden and ongoing cause for concern among existing and future Medicaid beneficiaries. Under the current system, because people who are approved for SSI are not automatically placed on Medicaid, these individuals are required to submit separate applications and documentation to a state administrative agency after being found eligible for SSI. Thus, even though the overwhelming majority of people who submit successful applications for SSI benefits are found eligible for Illinois Medicaid, 2 separate applications are required. This is a duplicative process that is unduly burdensome to the state and the client.

Furthermore, because Illinois Medicaid eligibility is not tied to SSI under its 209(b) status, Medicaid income eligibility is subject to state legislative change at any time. While the state legislature recently raised income eligibility to 100% of FPL, the Illinois General Assembly, with the governor, could reduce income-eligibility requirements at any time. Low-income disabled citizens should not have to worry about changing income requirements. Given the current economic downturn and the state’s struggling economy, 209(b) status could provide the state with the ability to reduce income eligibility and the number of people on Medicaid as a short-term economic fix. As in most states, this vulnerable population’s Medicaid eligibility should not be subject to this potential threat. Instead, Medicaid eligibility should, at a minimum, be tied to the federal SSI eligibility level.

In fact, with or without elimination of 209(b) status, the Illinois General Assembly should consider raising Medicaid income eligibility above the current 100% of FPL for its disabled citizens, for example, to 200% of FPL. Illinois should follow the lead of several other states and expand access to Medicaid to larger numbers of very low-income disabled and uninsured individuals.

Eliminate Medicaid asset test

Illinois should also consider eliminating its asset test for Medicaid. In Illinois, a person who meets the income requirements but has more than $4,000 in assets ($6,000 for a 2-person household) is not eligible for Medicaid. However, many states have found that the asset test is more of an administrative burden than it is worth. Few people who meet the low-income threshold of 100% of FPL own more than $4,000 in assets. Yet, because of the asset test, Medicaid officials are still required to check into every individual’s asset ownership. This takes significant amounts of time, costs additional
money, and results in unnecessary delays. Therefore, eliminating the asset test could free up additional dollars in the Medicaid program that could be used to cover additional clients or expand benefits for those currently on the program.

**Secure 1115 waiver for predisabled HIV-positive individuals**
Illinois should consider applying for an 1115 waiver that would provide Medicaid access to low-income residents living with HIV/AIDS upon diagnosis. Massachusetts and Maine are operating their Medicaid programs with such a waiver, greatly improving health outcomes for those living with HIV. Early access to care has also proven to be highly cost-effective, to reduce avoidable high-cost medical expenses and to dramatically reduce AIDS mortality. In addition, it has been shown to have the significant HIV prevention benefit of reducing HIV transmission by reducing the infectivity of those living with HIV and supporting positive behavior change.

The federal Early Treatment for HIV Act (ETHA), which is modeled on the Breast and Cervical Cancer Prevention and Treatment Act of 2000, would expand on the Maine and Massachusetts examples. ETHA would give all states the option of providing Medicaid coverage to low-income, predisabled people living with HIV, and would provide states with enhanced FMAPs for the program. Advocates should ask Illinois’s members of Congress to cosponsor and actively support ETHA.

**American Recovery and Reinvestment Act**
As part of the 2009 American Recovery and Reinvestment Act (ARRA, also known as the stimulus act), all states will receive a 6.2% increase in base federal medical assistance percentage (FMAP). States with significant changes in unemployment could get an additional FMAP increase. The US Government Accountability Office has estimated that Illinois will receive an additional $2.9B from ARRA for Medicaid costs from FY09-FY11. In order to receive these funds, Illinois may not have Medicaid eligibility or procedures more restrictive than were in effect on July 1, 2008. Additionally, the state must promptly pay doctors, hospitals, and nursing homes providing Medicaid services.
CASE MANAGEMENT SYSTEM

Past success 176

Case management expansion of services offered and targeted clients

In July 1989, a case management consortium, referred to as the Northeastern Illinois HIV/AIDS Case Management Cooperative (“the consortium”) was founded. The model for this consortium was a collection of case managers, connected by centralized support, and governed by providers and consumers. The AIDS Foundation of Chicago was chosen to oversee the funding and administration of the consortium.

In 1990, the consortium obtained a waiver from the federal government that allowed it to receive Medicaid funding for in-home services provided to people who were seriously disabled because of HIV/AIDS. Meanwhile, the number of case manager positions and agencies involved continued to grow over this time period.

The consortium spent the 1990s expanding the case management model to include a larger number of services. For example, in 1992, the consortium established a transportation system for case managed clients; in 1994, it began funding and administering emergency services; and in 1996, it began administering long-term rent subsidies for clients. Consortium case managers also provided access to Ryan White–funded emergency financial assistance for housing, utilities, food vouchers, taxi service, and transit vouchers.

With the creation of the Safe Start Program in 1996, the consortium began focusing attention on the almost 1,500 homeless HIV-positive individuals who needed more intensive case management. The Safe Start Program follows the harm reduction model, which accepts homeless clients “where they are” in relation to substance abuse, and then works with these clients to create a plan to reduce HIV transmission and to work toward sobriety. Safe Start also provides these clients with temporary housing in 22 studio apartments around the Chicago area.

In 1999, the consortium created the Corrections Case Management Initiative, which sought to provide intensive HIV case management to individuals reentering the community after being incarcerated. This program was temporarily suspended, but was reconvened in 2007 with funding from IDPH. Now, case managers in the program contact clients before their release and continue this contact upon release with home visits, office visits, telephone calls, and assistance attending medical appointments. The program served approximately 68 clients in 2008.
Beginning in 2002, the consortium partnered with the University of Chicago’s Children’s Hospital and Mount Sinai Hospital to reduce perinatal HIV transmission. The consortium, in collaboration with the Pediatric AIDS Chicago Prevention Initiative, created an intensive case management system for pregnant women with HIV/AIDS. Clients are referred to an intensive case manager who provides services for them throughout the term of their pregnancy and for 6 months after the child’s birth including primary, prenatal, well-child, substance abuse, and psychological care. Six months after the child’s birth, the mother is referred to nonintensive case management.

Nearly 22% of the case management services are located in collar counties, with the rest being allocated in geographically diverse areas around Cook County.

**Uniqueness of the Chicago model of case management**

Chicago’s case management model, run through the Northeastern Illinois HIV/AIDS Case Management Cooperative, is unique because it ensures centralized, coordinated, and standardized case management services to the clients served. In 2008, approximately $4.3M was made available for Ryan White Part A and B case management services. Today, the consortium funds and coordinates 157 case managers located in 50 agencies.

Despite the broad scope of this case management model, the consortium ensures that clients are assigned only one case manager. From the client’s perspective, the model is beneficial because it reduces gaps in knowledge about the client’s medical history across medical providers when clients engage multiple providers and ensures consistent care. Furthermore, the highly standardized operating procedures and training guarantees clients that case managers will provide them with the same services and knowledge, regardless of who they see. This effectively reduces “case manager shopping” by ensuring that clients get the wide variety of services that is required, all from a single case manager. From a funding perspective, the centralized model also eliminates the unnecessary costs and inefficiencies that come with duplication (a client seeing more than one case manager).

To guarantee the “one client, one case manager” approach, the program is facilitated by a single organization (AIDS Foundation of Chicago), which maintains a centralized database with clients’ medical and support information. The AIDS Foundation of Chicago, as the central administrative body, provides a standardized process of assessment, which allows more accurate reporting to the Chicago and Illinois
part III: successes, challenges, and opportunities for the future

departments of public health (among other investors), fiscal management/oversight of multiple funding streams, established contacts and solid relationships among medical care providers and direct-service agencies, and comprehensive training and technical assistance. Under the consortium policy guide, new case managers must undergo a 40-hour competencies training, and all case managers are required to attend 12 skills-building trainings each year. They also must follow and abide by the standard operating procedures manual, which guarantees standard care across case managers.

The centralized database of clients and their information allows providers and case managers to see a client’s entire prior history if the client chooses to switch case managers. Each year, clients who receive case management from one of the 50 participating agencies sign a release form allowing case managers and supervisors to see their information. This also allows case managers at other agencies to identify case management services already obtained by clients at another agency within the cooperative. Clients always reserve the right to transfer services. Service transfers may be internal or external. It is easy to disenroll from a case manager and/or case management agency, but with some minor exceptions (e.g., perinatal) clients can only have one case manager at a time. By allowing case managers to easily see if their new potential client already has another case manager, duplication of assistance is substantially reduced, and case managers are better able to serve their clients.

In order to continually improve the coordinated case management system, the AIDS Foundation of Chicago requested an evaluation of the case management system in 2003. As a result of this evaluation, the consortium modified its model to provide even better client care. Under the new model, clients belong to one of 3 tiers. In Tier 1, intensive (population-based) case management, the focus is on clients with an exceedingly high level of need such as perinatal, seriously ill, or post-release from correctional facilities. Tier 2 focuses on linkage to primary medical care and other ancillary services. Tier 3 serves clients with low need, and focuses on various services that maintain client access to supportive services such as bus cards and food vouchers.

There are 3 newly created positions, in addition to the intensive case managers, which help clients move from Tier 1 through Tier 3 without a disruption in services: medical case managers (Tier 2), supportive services case managers (Tier 3), and treatment coordinators (oversight).
Medical case managers link clients with healthcare, clinical, psychological, and supportive services if they are having trouble accessing and maintaining adherence to healthcare services. Medical case managers help develop a comprehensive, individualized plan; coordinate services to implement the plan; and perform periodic evaluations to assess and adapt the plan as necessary. These case managers are based in organizations, clinics, health departments, and hospitals, and are responsible for 25-35 clients each.

Supportive services case managers provide advice and assistance in obtaining medical, social, community, legal, financial, and other supportive services for clients who are identified as stable in their clinical care. This does not include coordination and follow-up of medical treatment (that role is left for medical case managers). Supportive services case managers are located in community-based organizations, clinics, health departments, and hospitals, and are responsible for 75-100 clients each.

Treatment coordinators (the newest position that was just started in 2008) have no direct contact with clients, but provide the necessary communication between healthcare providers and case managers regarding clients’ access and adherence to medication and treatment. The treatment coordinators are located at health clinics, and are responsible for reviewing client charts for clinical indicators, and then relaying these indicators to case managers for coordination and follow-up. Treatment coordinators work with a team of 5-10 case managers.

Clients enrolled in the case management system are evaluated at the beginning of service engagement, and every 6 months thereafter. Each case manager is responsible for determining the type of case management the client should be placed in (medical or supportive) based on a set of criteria and what services within this category the client should receive (housing, transportation, legal, etc). The treatment coordinator also performs chart-based medical assessments of the client which allows them to track CD4 and viral load, and to determine a client’s level of disability. The system can use this evaluation to produce 2 types of outcome measures: health outcomes and social determinants of health outcomes.
Opportunities

While Illinois has made great strides in developing and adapting their unique and highly coordinated case management system, there are still opportunities for improvement in the current system.

Seek Medicaid reimbursement for case management services
The primary challenge the consortium may face in the future is its dependence on Ryan White funding. Ryan White funding is discretionary. Should Congress choose to cut funding, or reallocate a large portion of funding away from Illinois, the current case management system would not be sustainable. Thus, one opportunity for change in the system would be to convince Medicaid that the case management system should be a covered service.

In past conversations that HIV/AIDS organizations have had with Medicaid officials, it appears that state Medicaid officials have shown that they are interested in at least considering this option. However, to date, there has been no official action or proposal submitted. Community-based advocates working with Medicaid officials should create and formally submit a request for Medicaid coverage of consortium-based case management services. State government officials should support such a proposal given how uniquely strong the system is, the benefits it provides to its clients, and the number of people still without case management. Advocates should also consider partnering with others, such as maternal and child health organizations that could also benefit from an extensive Medicaid-funded case management system. A coordinated, broad-based advocacy effort could help to convince Medicaid officials of the potential benefits of such a system.

Because of the low reimbursement rates and delayed payments referred to in the Medicaid section above, advocates have expressed some hesitancy about switching the case management system to Medicaid. These advocates fear that case managers will become less involved, or become more hesitant to accept new clients as the case managers get moved from federal funding to a system that has traditionally resulted in significant financial losses to the providers. Therefore, before advocating switching the case management system to a Medicaid reimbursable program, it will be important to work on reforming the current Medicaid system.
Develop “self-support” case management system

A second opportunity for growth in the current case management system is the implementation of a “self-support” level of case management service. By emphasizing an education-based model from the initial intake all the way through the process, clients who have achieved such low need that they are even beyond Tier 3 could then be responsible for their own case management. Allowing these clients to leave the traditional case management structure while still maintaining a minimal amount of supervision and care to ensure that they remain as “low need,” could significantly reduce the cost of the program, increase capacity, and allow resources to be allocated to new clients who are in need, but not currently in case management. Thus, there is a significant opportunity to expand case management coverage by developing the “self-case management” structure. By encouraging education from the very beginning and advancing an ultimate goal of successful passage through the previous tiers based on a reduction of need, clients will no longer require a significant investment or supervision from the system. Officials within the AIDS Foundation of Chicago agree with the recommendation, and plan to develop this fourth tier for self-support.

As a preliminary step, the AIDS Foundation of Chicago collaborated with Test Positive Awareness Network to develop a set of online educational modules for newly diagnosed individuals that are made available to case management agencies to orient their newly enrolled clients. The low-literacy modules, entitled PEERSpeak, are accessible online for anyone to access at www.aidsconnect.net. The recent changes to the program have shifted funding among delegate agencies and required new training and evaluation components. Once these improvements have been evaluated and finalized, the AIDS Foundation of Chicago intends to explore the development of this fourth tier of self-care services. Identifying sustained funding support for treatment coordinators, evaluation, and the development of the self-support components remains an ongoing challenge.

Explore RN/NP degree requirement for treatment coordinators

Another potential opportunity for improvement with the program is to change the requirements for eligibility to be a treatment coordinator. Currently, treatment coordinators must have an RN, NP, PA, LCSW, LCPC, MSW, or MPH and have at least 3 years of experience reading medical records. When this portion of the program was being developed, the consortium wanted to use nurses for the treatment coordinators since they are responsible for analyzing medical records and reporting potential issues to the case managers. However, because of funding issues, the consortium compromised and allowed the treatment coordinators to have one of the previously
mentioned degrees plus experience reading medical records. Given the innovativeness of the treatment coordination system started in late 2008, it is unclear what effect, if any, this compromise will have on case management. However, if it is found that this compromise is having a beneficial effect upon the system, it is possible that if/when Medicaid agrees to cover the case management service, the consortium will have the required funding to hire the nurses they initially sought. More research would be required after the first year of the program, however, to compare the costs of changing the system vs the benefits of having nurses instead of those degrees.

STATE PHARMACEUTICAL ASSISTANCE PROGRAM (ILLINOIS CARES Rx)

Past success

As discussed in the “Medicare” section of Part II, Illinois in 2006 authorized expansion of Illinois Cares Rx, the state pharmacy assistance program, to cover HIV medications for low-income people living with HIV/AIDS under the Rx Basic program. In May 2009, the General Assembly passed HB366, House Floor Amendment 3, which as amended would eliminate the Rx Basic program and bring all beneficiaries up to the level of coverage offered to seniors under the Illinois Cares Rx Plus program (ie, coverage of all medically necessary medications, not just those directly related to the disabling condition, such as HIV). On August 14, 2009, there was a governor’s amendatory veto of HB366, recommending several changes to the bill, mostly concerning financial eligibility and the effective date of the legislation.

The Illinois Cares Rx HIV Benefit has helped hundreds of people transition from ADAP to Medicare Part D. As a result, the state spends approximately $10,500 (or 70%) less on each HIV-positive beneficiary. This cost-shifting leaves the state with additional ADAP dollars to provide care to more people in need. Shifting people living with HIV/AIDS to Illinois Cares Rx also has the advantage of moving people from a program dependent on limited, discretionary funding (Ryan White/ADAP) to a potentially more stable entitlement program (Medicare).
Challenges

In 2008 and 2009, advocates and legislators worked together to improve the Illinois pharmacy assistance program. In 2008, House Bill 4449 would have granted all Illinois Cares Rx Basic beneficiaries the same coverage that seniors receive through Illinois Cares Rx Plus. The bill would also have ensured that all Illinois Medicare beneficiaries with incomes up to 250% of the FPL could get assistance with all of their Part D medications. House Bill 4449 passed the Illinois House and Senate. However, because of disagreements between the House, Senate, and governor regarding an additional provision that would require the governor to submit administrative rules to the legislature General Assembly for approval, the bill did not become law. HB 366, passed by the legislature in May 2009, achieves many of the same goals as HB 4449, but does not link income eligibility for the program to a percentage of FPL. As of the date of publication, the bill awaits action by the governor.

Opportunities

While covering people with HIV/AIDS with Illinois Cares Rx is certainly a great success, there are still a wide variety of opportunities for advocacy and education that could further improve the current program.

**Align Illinois Cares Rx income eligibility with ADAP income-eligibility level**

To more effectively use limited ADAP resources, the state of Illinois should consider raising the Illinois Cares Rx program income-eligibility level to 500% of poverty, the same as the ADAP eligibility level. The Illinois Cares Rx income limit is now $25,532, or about 240% of FPL. By raising Illinois Cares Rx to the same income-eligibility level as ADAP, the state would be able to maximize the benefits realized by helping ADAP beneficiaries through the donut hole and back onto Medicare coverage. Currently, a Medicare-eligible client on ADAP costs ADAP approximately $14,000. A Medicare-eligible client on Illinois Cares Rx costs the program approximately $4,500 to get the person through the donut hole and onto Medicare catastrophic coverage, where the federal government pays 95% of the cost of drug coverage. By shifting the ADAP consumer onto Medicare Part D, the state frees up $9,500 for other ADAP clients or uninsured people with HIV. Increasing Illinois Cares Rx eligibility to 500% of FPL will help guarantee that more people living with HIV are able to receive their life-saving HIV medications as well as all of the other medications available through their Medicare Part D prescription drug plans.
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Change Illinois Cares Rx income eligibility to a percentage of FPL

Regardless of the FPL level agreed on by the Illinois legislature and governor, Illinois should, at a minimum, change Illinois Cares Rx income eligibility from a set number to a percentage of FPL. Currently, the income-eligibility level for Illinois Cares Rx is not connected to the FPL, but is instead set by administrative rule that is adjusted each year for cost of living increases. In other words, the legislature set the baseline income eligibility as a dollar amount when it first created Illinois Cares Rx, and has allowed the executive branch to increase this amount each year, subject to legislative approval. However, advocates state that as tensions mount in the Illinois government, there is always a concern that the executive branch will wait until the last minute to submit the updated income-eligibility amount to the legislature for approval, and it will not pass. Under Illinois state law, should this happen, income eligibility would revert to the dollar amount initially set after the legislation passed in 2005. This amount would be far below the current level given as cost of living increases since the bill’s passage. Changing the income eligibility to a percentage of FPL would guarantee continuity of eligibility and not leave beneficiaries without coverage as the result of inaction or a dispute in any given year. HB 366, as passed by the General Assembly, allows income eligibility to be updated annually to reflect the Social Security cost of living adjustment, but still sets income eligibility at a specific dollar amount, rather than as a percentage of FPL.

Streamline Illinois Cares Rx application process

The application process for Illinois Cares Rx must be simplified. While the program is beneficial for consumers and the state alike, the application process is extremely difficult to navigate. According to community group leaders, the application entails using a number of different Web sites and forms, and cannot be completed accurately without the assistance of specially trained professionals. Furthermore, people on Illinois Cares Rx must reapply every year to remain on the program, even if their circumstances have not changed.

Community-based advocates assert that many of their clients are dealing with numerous, complex issues and without significant outreach and advocacy efforts on their part, hundreds of clients would fail to reapply annually. Advocates also assert that some eligible beneficiaries are dropped from the program due to their failure to reapply, a serious concern given the significance of treatment interruption and subsequent drug resistance on health outcomes. Thus, simplifying and coordinating the application process, as well as allowing for longer than one-year certification periods, present another potential opportunity for the future.
HIV TESTING EXPANSION

Past success

Newly enacted HIV testing legislation
In September 2006, the Centers for Disease Control and Prevention (CDC) issued the “Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings” in which the CDC recommended the routine testing of all adult and adolescent patients for HIV in the United States. These revised recommendations served to update the previous recommendations published by the CDC in 2001.

In response to the CDC’s revised recommendations, IDPH initiated a series of meetings to discuss the need for revising the existing state HIV testing law. A legislator proposed a bill that would have eliminated written informed consent, a requirement of the existing Illinois HIV testing law. Many Illinois advocates and providers opposed the draft legislation and expressed concern that it struck the wrong balance between encouraging routine testing and supporting patients’ right to informed consent prior to HIV testing. Leaders from community-based organizations, community health centers, hospital associations, and IDPH sought modifications of the draft legislation. Their recommendation was to retain informed consent but allow providers significant flexibility in the ways consent can be obtained. Leaders asserted that these modifications addressed concerns about patients’ rights while at the same time significantly reducing barriers to HIV testing, the ultimate goal of the CDC guidelines.

In 2007, a new compromise piece of HIV testing legislation was drafted, approved by the legislature, and signed into law (410 ILCS 305). Under the new law, healthcare providers are required to provide brief pre-test information to patients about HIV and the meaning of HIV test results. Patients are to be given the opportunity to ask questions prior to the test. Testing may only take place with the knowledge and informed consent of the person being tested. As a significant modification to prior HIV testing law in Illinois, consent may now be given either in writing or orally, as long as it is documented in the patient’s medical record. A separate HIV testing consent form is no longer required.

With the new law, healthcare facilities are also permitted to implement opt-out testing. To do so they must inform the patient that opt-out testing will occur unless it is declined, provide the required pre-test information, and give the patient a chance to ask questions and decline testing. (As described in more detail in the following section, healthcare facilities must perform opt-out HIV testing for all pregnant women.)
As part of the new law, healthcare providers must make a good faith effort to tell patients about positive test results through personal contact. They must also make a good faith effort to refer individuals who test positive to counseling and medical services to ensure that they receive follow-up care. Finally, the law doubles the minimum financial damages individuals may collect for violations of the AIDS Confidentiality Act, including testing without informed consent. The penalty for a reckless or intentional violation of the patient protections of the new law carries a minimum civil damages award of $10,000.

Among a broad base of providers, consumers, and advocates, the passage of the new HIV testing law is seen as a great success. Leaders from all interested constituent groups worked closely with lawmakers to draft the new HIV testing law. There appears to be near unanimity of agreement that the new law strikes the proper balance between removing barriers to HIV testing and protecting the rights of patients to informed consent prior to testing.

IDPH is now charged with leading statewide activities to successfully implement the new HIV testing law. Two existing HIV testing initiatives offer insight into how such an initiative can be successful.

**Chicago rapid testing initiative**

As part of a federal HIV testing initiative, the CDC has funded a number of cities to create models for the expansion of rapid testing in identified high-risk communities. The Chicago Department of Public Health (CDPH) received one such grant for approximately $1.9M. Of this amount, about $1.6M was given to the Public Health Institute of Metropolitan Chicago (PHIMC) to develop a rapid HIV test initiative.

The PHIMC funded 4 hospital emergency departments (ED) that are in areas with demographics similar to those identified by the CDC as a high-risk community. The funding in these hospitals went to the hiring and training of “Health Educators/Testers” who are responsible for providing pre-test information and administering the rapid tests. These health educators are provided with carts and test kits so that they are able to go bed-by-bed administering rapid tests to patients in the ED. The health educators are also supervised by a project coordinator who performs all data collection and reporting.

The PHIMC also funded 6 STD/HIV clinics that use an opt-out model for HIV testing.
Individuals who come to these clinics meet with a tester at the start of their clinic visit, meet with a healthcare provider to address the primary purpose of their visit, and then see the tester again for their test results.

Under the PHIMC model, providers are encouraged to refer all individuals who are confirmed HIV-positive to city-funded disease investigation specialists. These specialists work with those newly diagnosed to assist with partner notification, if requested, and assist in linkage to care. Linkage to care services include treatment adherence and health and case management service coordination.

In 2007, approximately 41,000 tests were administered under the Chicago rapid testing initiative at a cost of approximately $500,000. Of these costs, a portion was covered by PHIMC under the federal CDC grant and a portion paid for by the CDPH. CDPH is committed to ensuring that rapid tests are available to funded sites when, or if, the PHIMC runs out of federal funding.

**Perinatal testing legislation and implementation**

According to the CDC, without treatment, there is a 25% chance that a pregnant woman will transmit HIV to her newborn. With treatment, this risk can be reduced to 2% or less. Despite these facts, in 2003, only 72% of women in Illinois who presented in labor had an HIV test prior to delivery.

Beginning in 2003, Illinois passed a series of laws to combat perinatal transmission. Starting with passage of the Perinatal HIV Prevention Act of 2003, all healthcare providers treating pregnant women were required to provide counseling and offer voluntary HIV testing as early as possible in pregnancy. Rapid testing was also required to be offered at labor and delivery to women whose HIV status was not documented in the current pregnancy.

In 2006, the perinatal testing act was amended to require mandatory testing of the newborn if the mother’s HIV status was unknown either because the healthcare provider had missed testing, the mother had not been in care, the mother’s prenatal records were not available, or because the mother declined to be tested. The new law also instituted reporting requirements, mandating monthly reporting on rapid HIV tests given to pregnant women and newborns. Furthermore, under the 2006 law, all hospitals were required to call an established 24-hour perinatal HIV hotline to report women and newborns identified as preliminary HIV-positive within 24 hours of identification.
The hotline links these preliminary HIV-positive women with case managers (which the 2006 law required IDPH to fund) to ensure care during the pregnancy and for the first 6 months after the birth of the child. Case managers linked to HIV-positive pregnant mothers are on-call to the hotline so that they can visit the hospital immediately, and thus ensure that the new mother does not get lost in the system and to ensure receipt of confirmatory testing results.

After the CDC released guidelines calling for opt-out testing in 2007, the Illinois legislature once again enacted new legislation—this time requiring providers to institute opt-out HIV testing for all pregnant women. Under the new legislation, women must be informed not only about testing, but also that they have the right to decline testing. However, if a woman declines, she must also be informed that the hospital is required to then test the newborn child.

While the state has made significant strides in addressing perinatal HIV testing through legislation, many assert that the real success story has been in state efforts to implement the new laws. Beginning in 2004, state funds were set aside to support HIV testing efforts on labor and delivery. Since that time, Illinois has supported the development of a state-of-the-art perinatal testing initiative including offering case management services to all HIV-positive pregnant women and new mothers and the creation of a 24-hour perinatal HIV hotline. The Perinatal Rapid Testing Implementation Initiative in Illinois (PRTII2) has developed standardized scripts for healthcare providers to ensure that consistent and accurate information and counseling are provided to all pregnant women. PRTII2 has also conducted customized trainings and supported the development of perinatal HIV testing implementation plans at all of the 133 birthing hospitals in Illinois. Recently, the 24/7 Perinatal HIV Hotline launched a Web site to ensure that hospitals have access to all rapid testing, case management, and perinatal HIV treatment information (www.hivpregnancyhotline.org).

In recognition of Illinois’s success in implementing a comprehensive perinatal HIV testing initiative, in 2008, the CDC identified Illinois as having an outstanding model for the reduction of perinatal transmission. The state of Illinois has increased perinatal HIV testing from 72% in 2003 to almost 100% (99.99%) in 2008.
Opportunities

Illinois’s successes in greatly expanding ED and HIV/STD clinic testing with its Chicago rapid testing initiative and generating nearly 100% compliance with its perinatal transmission initiative underscore the fact that states’ legislative reforms can be successful if they are matched with meaningful programmatic and financial investments that increase the availability of voluntary counseling and testing services. These initiatives provide strong examples of successful testing programs that must be adapted and adequately funded if Illinois is to now successfully accomplish the goals of its new statewide routine voluntary HIV testing law.

**Fund expanded routine voluntary HIV testing**

While the new HIV testing legislation was widely praised when enacted in June 2008, to date, the General Assembly has failed to appropriate significant funding to support implementation of a statewide HIV testing initiative in keeping with the stated goals of the new law. In the FY08 budget, enacted immediately following passage of the new law, only $500,000 was recommended for implementation of a routine HIV testing initiative by the state legislature. This new funding was ultimately vetoed by the governor. For FY09, despite advocates’ requests of $2M to expand HIV testing through training, technical assistance, and state-sponsored testing grants, the General Assembly appropriated only $500,000 to IDPH for implementation of the new testing law, although the funding was ultimately used for other purposes. This is clearly far short of what is needed to widely expand routine voluntary HIV testing statewide in Illinois. To reverse this current trend, the governor and General Assembly should consider allocating increased funding to IDPH to support the goal of expanded HIV testing. The state should undertake a comprehensive planning process that includes all participants involved in the development and passage of the new law. This HIV testing expansion working group could help to define an implementation plan and measurable goals for implementation.

**Replicate existing HIV testing models for broad-based HIV testing implementation**

Given the significant fiscal constraints brought on by the current economic downturn, it does not make sense for IDPH to “reinvent the wheel” in implementing expanded HIV testing. Instead, IDPH should look to the highly successful Chicago rapid testing and perinatal rapid testing initiatives described above, and use these as a guide for a new HIV testing model. Adopting the best practices of both initiatives can help create an effective, efficient implementation of the new testing law.
In particular, IDPH efforts to promote routine voluntary HIV testing could include modifying materials and procedures employed by PRTII2. A successful implementation plan for the new testing legislation must include the development of standardized tools to help clinicians streamline voluntary HIV testing, the development and promotion of linkage and referral mechanisms, the collection of data and evaluation of activities to closely monitor progress, and the establishment of grants programs to expand HIV voluntary testing. PRTII2 has already created solutions to many of these goals in the perinatal context including the development of standardized tools such as flip-charts and pocket cards for clinicians to use in both pre- and post-testing counseling; the creation of a hotline for providers to call to refer positive results to case managers guaranteeing support from the moment of a positive (or preliminary positive) identification; a data collection, reporting, and feedback process that has drastically reduced the number of untested pregnancies and births; and a successful rapid, opt-out testing campaign.

In addition, the standardized resources created by PRTII2 (eg, flip-charts, pocket cards) are currently being placed on a Web site where healthcare and social service providers across the state will have access to them. This standardization of information and encouragement of rapid testing could be adapted to support HIV testing in the broader community. Also, with additional financial support and staffing, the existing perinatal hotline could be expanded for the larger community outside of the perinatal context. Finally, the PRTII2 focus on training nurses, instead of the primary care and ED physicians, appears to be a key to the success of the program. The lessons learned here may also be important when considering the training component of a broad testing expansion focused on older, adult communities.

**Expand Chicago rapid test initiative**

IDPH should also consider expanding the Chicago rapid test initiative into the inpatient areas of the current hospitals in which they work; additional EDs and STD clinics, and hospitals and clinics in areas of the state outside of the Chicago metropolitan area where high numbers of individuals with undiagnosed HIV are likely to receive healthcare. While fiscal constraints may preclude the hiring and training of a large number of health educators/testers who are responsible for providing pre-test information and administering the tests, the model could be adapted to train and promote buy-in of existing hospital and clinic staff to administer rapid HIV tests. While existing work loads of healthcare staff and low HIV-testing reimbursement rates will represent challenges, this model may be a cost-effective option. (HIV-testing reimbursement rates...
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should also be addressed by the state given the current Illinois Medicaid HIV-testing reimbursement rate of $11/test, as compared, for example, with the New York HIV-testing reimbursement rate of $120/test in certain hospitals.)

SUPPORTIVE HOUSING

Past success

Housing first models

An estimated 3.5 million people in the US experience homelessness in any given year, and approximately 40% of homeless individuals have chronic medical illnesses. Without access to primary or preventive care, homeless individuals often use more costly medical care, such as ED care and hospitalizations. The Chicago Housing for Health Partnership (CHHP) is an innovative program that addresses the health needs of the homeless by providing housing and intensive case management to homeless individuals with chronic medical illnesses, including HIV/AIDS.

CHHP uses a “housing first” model, which identifies chronically ill homeless adults at hospitals and emphasizes quickly moving them into permanent housing after discharge while concurrently providing intensive case management to improve health status and ensure long-term housing stability. CHHP is a collaborative initiative between hospitals and supportive housing organizations.

CHHP began as a 4-year study to examine the effectiveness of a housing first/intensive case management model vs the “usual care” system of emergency shelters and transitional housing. The groundbreaking study of 405 participants (more than one-third of whom were HIV-positive), published in the May 6, 2009 *Journal of the American Medical Association*, found that participants in the housing first group had a 29% reduction in hospitalizations, a 29% reduction in number of hospital days, and a 24% reduction in ED visits, compared with participants in the usual care group. The study found that for every 100 homeless individuals offered a CHHP intervention, the expected benefits over the course of a year would be 49 fewer hospitalizations, 270 fewer hospital days, and 116 fewer emergency room visits. At the end of the study period, 60% of the intervention group remained in permanent housing, while 15% of the group receiving usual care were permanently housed.
A study published in the June 2009 American Journal of Public Health reported that participants living with HIV/AIDS who were randomly assigned to the intervention group (permanent housing and case management) had statistically significant health improvements as compared with those assigned to the control group, which received usual care—a piecemeal system of emergency shelters, family, and recovery programs. For this subanalysis, intended to evaluate the health impact of the intervention, researchers selected HIV/AIDS because CD4 and viral-load counts provide clear clinical endpoints of health status to evaluate. After one year, 55% of the group receiving permanent, supportive housing and 34% of the usual care group were still alive and had intact immunity (i.e., CD4>200 and viral load<100,000). Moreover, 17 study participants in the intervention group (35%) and 9 participants in the usual-care group (19%) achieved undetectable viral loads, and median viral loads were significantly lower in the intervention group as compared with the control group. The variance between the intervention group and the usual-care group was statistically significant, demonstrating that housing interventions improved the health of HIV-positive people.

In the summer of 2007, CHHP evolved from a study into a permanent partnership that provides more than 230 permanent housing subsidies for homeless people living with chronic medical illnesses. Led and coordinated by the AIDS Foundation of Chicago, CHHP is funded through the federal Department of Housing and Urban Development and private foundations.

**IDPH housing funding**

For 2 years (FY08 and FY09), IDPH has invested approximately $2M in state funds in AIDS housing programs throughout the state. This funding has allowed agencies to expand programs, stabilize their finances, and house additional people living with HIV. IDPH targeted funding to agencies in downstate Illinois, where AIDS housing resources are particularly scarce. Funding these programs has been a significant, first-time investment of state dollars in AIDS housing, and demonstrates that IDPH prioritizes safe, affordable housing for people living with HIV/AIDS.

**Opportunities**

CHHP has demonstrated that a housing first approach with intensive supportive services is a cost-effective (and in some cases, cost-saving) way to improve the health and quality of life of homeless individuals living with chronic medical conditions. The costs of providing housing and case management are more than offset by the savings resulting from decreased hospitalizations, use of nursing homes, and use of ED care. The CHHP model integrates delivery of housing and other supportive services with
medical care to optimize the health of low-income people with HIV/AIDS. Policymakers should consider replicating the CHHP example in other parts of the state and beyond.

Advocacy is needed to establish a dedicated state funding line for AIDS housing in IDPH. The funding could be eliminated by a change in IDPH leadership or a new governor.

**ISSUES SPECIFIC TO AREAS OUTSIDE COOK COUNTY**

Advocates from community-based organizations outside of Cook County have identified a number of issues that are specific to the nonmetropolitan population of people living with HIV/AIDS. One of the biggest concerns raised by these members is the lack of specialized care providers for non-HIV-related problems (e.g., dental, optical, gastrointestinal). Advocates assert that their clients have to travel significant distances to get the specialized care they need. Traveling to these appointments is difficult for many clients and can be prohibitively expensive. Additionally, advocates assert that even if they can assist their clients with getting to appointments, many specialized providers refuse to accept Medicaid because of the low reimbursement rates.

Advocates from downstate agencies also expressed concerns about the availability of on-site or local training opportunities to ensure their familiarity with ongoing implementation of state care and prevention programs, as well as new laws and policies. Advocates specifically identified a lack of training on the new testing law and healthcare coverage options available for people living with HIV. To remedy this problem, the state could consider funding a mentoring program, which would provide downstate organizations with ongoing access to up-to-date programmatic and policy information. In addition to educating providers, advocates assert a need for increased capacity for consumer education on such topics as prevention for people living with HIV, healthcare access options, HIV and pregnancy, and stigma and discrimination.

One resource to consider in expanding consumer education is the PEERSpeak application available through the AIDS Foundation of Chicago. PEERSpeak is a series of 15-20-minute interactive online modules that provide information to people with HIV/AIDS on topics such as “Getting into Care,” “Navigating the System,” and “Staying Healthy.” While using the modules, a person with HIV/AIDS plays the role of a social worker, case manager, or the like, and responds to fictional clients with HIV/AIDS. The modules then explain which responses and approaches are appropriate, and provide further information on the given topic area. The PEERSpeak Web site currently has 5 modules available, but this application could be expanded to cover additional areas.
Finally, downstate consortia members have expressed concern with IDPH contracting and reimbursement policies for Ryan White–funded programs. Under these policies, IDPH requires each consortia member to have individual contracts with each provider of Ryan White reimbursable services. One consortium member tried to create a “clearinghouse” model by using an Illinois organization to create and manage provider contracts. However, IDPH did not permit this clearinghouse model. There is an opportunity to advocate with IDPH to allow use of a clearinghouse model for Ryan White provider contracts. This model could function in a way similar to the way AIDS Foundation of Chicago administers the case management program. This would create a coordinated, more efficient system, rather than having each individual consortium member manage multiple contracts. It would alleviate the significant administrative burdens on individual agencies with limited resources, and allow more time for these agencies to work with their clients.

**OTHER CHALLENGES AND OPPORTUNITIES**

An additional challenge is the criminal transmission statute, discussed in “Description of Relevant State Laws, Regulations, and Policies,” which makes a person guilty of a class 2 felony if that person knows that he/she is HIV-positive and engages in intimate contact with another. The broad scope of “intimate contact”—which could include merely kissing—is problematic. Additionally, the knowledge element in the statute actually discourages people from being tested for HIV/AIDS and finding out their status.

Another challenge is the inability of people with HIV/AIDS to find specialty care. Often people with HIV/AIDS are better off going to the ED than trying to get on a specialist wait-list. Many clients in rural areas have to travel either significant distances or even into another state (such as Iowa/Missouri/Kentucky) in order to receive specialty care. This challenge also implicates a transportation issue.

Finally, housing is also a challenge. The HRSA cap of 24 months for housing coverage has significantly hurt the HIV/AIDS community in areas outside of Chicago, where large apartment complexes are not readily available.
Despite a sometimes contentious and challenging political environment, Illinois has made impressive progress in advancing access to healthcare for its residents living with HIV/AIDS. The “Chicago model” case management system and the rapid and perinatal testing programs are clear successes and can serve as models for other states. The Illinois Cares Rx HIV program has helped many people living with HIV/AIDS to access life-saving medications.

Nevertheless, there are still areas for improvement. Illinois’s Medicaid program frustrates providers and consumers alike, with long delays for payment, low reimbursement rates, burdensome administrative requirements, and a low financial-eligibility level. The case management consortium depends heavily on annually appropriated Ryan White funding—a risky strategy in difficult economic times. The recently-passed HIV testing law has yet to be widely implemented.

Some opportunities to expand access to care may be more challenging to achieve in a time of shrinking resources. Some, however, would not be that expensive to implement and could ultimately save Illinois money. With a talented and resourceful community of consumers and providers, the state is well-positioned to build on past successes and bring healthcare access to more Illinoisans living with HIV/AIDS in the future.
ADDITIONAL MANDATORY SERVICES COVERED BY ILLINOIS MEDICAID

- Inpatient hospital care (except for psychiatric)
- Outpatient hospital care
- Other laboratory and x-ray services
- Ambulatory services provided by rural health clinics and federally qualified health centers
- Nursing facility and home health services for individuals older than 21
- Family planning services and supplies
- Physician services
- Nurse-midwife services
- Nurse practitioner (pediatric and family only)
- Home health (including nursing, aide, medical supplies and equipment, and therapy)
- Ambulatory services to presumptively eligible pregnant women
- Pregnancy-related services and services for other conditions that may complicate pregnancy
- Emergency services to illegal immigrants
- Medical and surgery services performed by a dentist
ADDITIONAL OPTIONAL SERVICES COVERED BY ILLINOIS MEDICAID (cont’d)

- Prescribed medications
- Dental services for dentures and emergencies
- Podiatric services
- Optometric services
- Chiropractic services
- Other practitioner services
- Therapy services
- Eyeglasses
- Screening services
- Medicaid clinic services
- Physical therapy
- Occupational therapy
- Inpatient psychiatric services for individuals under 21
- Intermediate care facility services for the mentally retarded
- Prosthetic devices
- Diagnostic services
- Preventive services
- Care of individuals over 65 in institutions for mental disease
- Home- and community-based services through federal waivers
- Services provided through a health maintenance organization or a prepaid health plan
- Special tuberculosis-related services
- Medicaid rehabilitative services
- Religious nonmedical healthcare institution services
- Nurse anesthesia services
ADDITIONAL OPTIONAL SERVICES COVERED BY ILLINOIS MEDICAID (cont’d)

- Hospice care
- Transplants
- Transportation
- Targeted case management services for infants and pregnant women
- Nursing facility services for people under 21
- Program for all-inclusive care for the elderly
- Emergency hospital services
appendix B: Map of Illinois Counties
## The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

<table>
<thead>
<tr>
<th>Persons in family</th>
<th>Poverty guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$10,830</td>
</tr>
<tr>
<td>2</td>
<td>$14,570</td>
</tr>
<tr>
<td>3</td>
<td>$18,310</td>
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<tr>
<td>4</td>
<td>$22,050</td>
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<tr>
<td>5</td>
<td>$25,790</td>
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<td>6</td>
<td>$29,530</td>
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<td>7</td>
<td>$33,270</td>
</tr>
<tr>
<td>8</td>
<td>$37,010</td>
</tr>
</tbody>
</table>

For families with more than 8 persons, add $3,740 for each additional person.

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notes and references

1. Information obtained from: US Census Bureau, American FactFinder, IL Population Estimates (Table 1), http://factfinder.census.gov.


10. Id.


12. Id.


15. Id.


19. Id.


21. Id.

22. “Value added” refers to the additional value of a commodity over the cost of commodities used to produce it from the previous stage of production. http://business.illinois.gov/io_keyIndustries.cfm.

notes and references

24. Id.
25. Id.
26. Id.
27. Id.
28. Id.
29. Id.
30. Id.
34. Id.
35. Id.
38. Id.
39. Id.
40. Id.
43. Id.
45. Id.
50. Id.
51. Id.


53. Information obtained from: Illinois General Assembly, Public Act 095-0674, http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=095-0674. Organizations with budgets less than $300,000 will compete for 50% of revenues; organizations with budgets between $300,000 and $700,000 will compete for 25%; and organizations with budgets larger than $700,000 will compete for the final 25%.


55. Information obtained from: US Census Bureau, American FactFinder, IL Population Estimates (Table 1), http://factfinder.census.gov/; see also Kaiser Family Foundation, statehealthfacts.org.


58. Id.


64. Id.

65. Id.


67. Id.

68. Id.


71. Id.

72. Id.


76. A “nonfederal physician” is one who is not employed by the federal government, ie, one who does not work for the military, the US Public Health Service, or the Veterans’ Administration. Illinois Department of Commerce and Economic Opportunity, Health Care in Illinois, http://www.commerce.state.il.us/NR/rdonlyres/04BB5BF3-E11E-404B-AEC1-7C73993BD7E4/0/HealthCareinIllinois.pdf.


78. Id.


85. Id.

87. Information obtained from: Illinois Compiled Statutes, Hospital Uninsured Patient Discount Act, 210 ILCS 89, http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=3001&ChapAct=210%26nbsp%3BILCS%26nbsp%3B89%26nbsp%3B%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbs


95. Id.

96. Id.

97. Id.


104. Information obtained from: “When Do Young Adults (Age 18 and Older) Qualify for Medicaid?” Illinois Legal Aid, http://www.illinoislegalaid.org/index.cfm?fuseaction=home.dsp_content&contentID=1380.

105. Information obtained from: "When Do Young Adults (Age 18 and Older) Qualify for Medicaid?" Illinois Legal Aid, http://www.illinoislegalaid.org/index.cfm?fuseaction=home.dsp_content&contentID=1022.
An Analysis of the Successes, Challenges, and Opportunities for Improving Healthcare Access

106. Id.
108. Id.
111. Id.
112. Id.
117. Id.
118. Id.
121. Id.
122. Id.
128. Id.
130. Id.
131. Id.
132. Id.


136. Id.


142. Id.


150. 720 Ill. Comp. Stat. 5/1216.2 Section (c).


153. Id.
notes and references

155. Id.


160. Id.


162. 410 ILCS 315/,Communicable Disease Prevention Act, http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1552&ChapAct=410%26nbsp%3BLCS%26nbsp%3B315%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26n

163. House Representative Sara Feigenholtz (D-Chicago) sponsored the Protect Privacy of HIV-positive School Children Bill (HB 4314), which eliminated Illinois’s requirement of school notification. This legislative change was supported by AIDS Foundation of Chicago in coalition with ACLU of Illinois, AIDS Legal Council of Chicago, Children’s Place Association, and FCAN, the Families and Children’s AIDS Network. However, the Illinois House defeated HB 4314 on March 4, 2008.

164. 720 ILCS 635/2, Sale of hypodermic syringes and needles. http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1954&ChapAct=720%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26nbsp%26n


166. Information obtained from: Sterile Syringe Access in Illinois, AIDS Foundation of Chicago, http://www.aidschicago.org/prevention/syringes.php. The organizations providing these services are Chicago Recovery Alliance, Community Outreach Intervention Projects, Carepoint, Safety Wellness and Prevention Foundation, Sisters and Brothers Helping Each Other, Test Positive Awareness Network, Total Health Awareness Team.


172. It should be noted that in considering changing 209(b) status, or otherwise increasing income eligibility, Illinois should retain its current monthly spend-down policy until additional research is conducted to determine if it successfully supports Medicaid access and is not unduly administratively burdensome. Under the current system in Illinois, an individual’s monthly spend-down is equal to his or her monthly income that is above 100% of FPL. When individuals can document that they have incurred medical expenses equal to or above their spend-down during any given month they are eligible for Medicaid during that month. Many states have adopted a 6-month spend-down rule, which requires incurring medical expenses during a 6-month period to be eligible for the same 6 months of Medicaid coverage. While there appear to be advantages and disadvantages to each system, Illinois should determine which protocol works best for its Medicaid beneficiaries before instituting a change.


175. Id.


177. It should be noted that the proposal could include seeking coverage of consortium-based case management services or specific tiers of services such as intensive case management.


182. Information in this section from the following sources:


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