

Illinois Continuity of Care & Administrative Simplification 1115 Waiver

Purpose, Goals, and Objectives:

As Illinois continues to develop and improve its statewide Medicaid managed care infrastructure, grounded in care coordination, it has identified three administrative barriers that it seeks to address through a Section 1115 Demonstration Waiver:

1. Coverage for pregnant women ending 60 days postpartum;
2. Churning between Medicaid Fee-for-Service (FFS) and Medicaid managed care due to late redetermination paperwork; and
3. Implementing hospital presumptive eligibility (HPE).

The three proposals in this waiver application directly address the administrative barriers above and will allow the state to more strategically achieve the three-part aim of better care for individuals, better health for populations, and lower costs. The problems created by these three barriers within Medicaid and the Children's Health Insurance Program (CHIP) are described in detail below:

Coverage for pregnant women ending 60 days postpartum

The maternal mortality rate in the United States has doubled over the past two decades, and the United States is the only developed nation with an increasing maternal mortality rate.¹ According to the federal Centers for Disease Control and Prevention (CDC), the rate of maternal mortality in the United States also includes vast disparities between racial and ethnic groups, with pregnancy-related mortality ratios more than three times higher for non-Hispanic black women than non-Hispanic white women from 2011-2016.² The CDC, which defines the full postpartum period as 12 months after delivery, also has found that 60% of pregnancy-related deaths occurring up to one year after delivery are preventable

In Illinois, the maternal mortality statistics are even more alarming. The Illinois Department of Public Health (DPH) released an Illinois Maternal Morbidity and Mortality Report in October 2018 which found that in Illinois, non-Hispanic black women are six times as likely to die of a pregnancy-related condition as non-Hispanic white women.³ The DPH Maternal Mortality Review Committee and the DPH Maternal

¹ Mayer R, Dingwall A, Simon-Thomas J, et al. (2019, February 4) The United States Maternal Mortality Rate Will Continue To Increase Without Access To Data, *Health Affairs Blog*, Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20190130.92512/full/>

² Centers for Disease Control and Prevention. (2019, October 10). Pregnancy Mortality Surveillance System. Retrieved from https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Freproductivehealth%2Fmaternalinfanthealth%2Fpregnancy-mortality-surveillance-system.htm

³ Illinois Department of Public Health. (2018, October). Illinois Maternal Morbidity and Mortality Report. Retrieved from <http://dph.illinois.gov/sites/default/files/publications/publicationsowhmaternalmorbiditymortalityreport112018.pdf>

Mortality Review Committee for Violent Deaths also deemed 72% of all pregnancy-related deaths and 93% of all violent pregnant-associated deaths in Illinois to be preventable.⁴

Additionally, the Illinois Maternal Morbidity and Mortality Report notes that women with Medicaid coverage at delivery were two and a half times as likely to die within one year of pregnancy than women with private insurance for delivery and were nearly five times as likely to die from a pregnancy-related cause than women with private insurance for delivery.⁵ According to the DPH Office of Women's Health and Family Services, women on Medicaid at delivery were nearly seven times as likely to die from a drug overdose within one year of pregnancy as women with private insurance.⁶

The state is seeking to extend postpartum coverage from 60 days to 12 months to address five issues:

1. *A significant portion of maternal deaths are occurring 61-364 days postpartum.* While Illinois Medicaid covers 44 percent of births in Illinois,⁷ a large proportion of maternal deaths occurred more than 60 days after pregnancy, which is when coverage under the pregnant women category of Medicaid eligibility currently ends and is a medically vulnerable time. According to data provided by the DPH Office of Women's Health and Family Services, 51% of pregnancy-associated deaths occurred 61-364 days postpartum and 79% of the deaths due to suicide or unintentional drug overdose occurred 61-364 days postpartum.⁸

Additionally, 34% of pregnancy-related deaths occurred 61-364 days postpartum, and the state Maternal Mortality Review Committees found 71% of pregnancy-related deaths that occurred 61-364 days postpartum to be potentially preventable. Of the pregnancy-related deaths that occurred 61-364 days postpartum, 33% were due to behavioral health conditions (e.g., depression, substance use disorder) and 24% were due to postpartum cardiomyopathy, which typically emerges about two months after pregnancy, around the same time some women are losing Medicaid coverage at 60 days postpartum. Poor continuity of care and/or a lack of care

⁴ Illinois Department of Public Health. (2018, October). Illinois Maternal Morbidity and Mortality Report. Retrieved from <http://dph.illinois.gov/sites/default/files/publications/publicationsowhmaternalmorbiditymortalityreport112018.pdf>

⁵ Illinois Department of Public Health. (2018, October). Illinois Maternal Morbidity and Mortality Report. Retrieved from <http://dph.illinois.gov/sites/default/files/publications/publicationsowhmaternalmorbiditymortalityreport112018.pdf>

⁶ Illinois Department of Public Health, Office of Women's Health and Family Services. (2019, December) Data Summary: Later Postpartum Maternal Deaths in Illinois. Updated data pull for the Illinois Department of Healthcare and Family Services. Data points that reference pregnancy-related deaths refer to data from 2015-2017 and data points that reference pregnancy-associated deaths refer to data from 2015-2016.

⁷ Retrieved from <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁸ DPH defines pregnancy-related deaths as the death of a woman during pregnancy or within one year of the end of a pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. DPH defines pregnancy-associated deaths occur within one year of the end of a pregnancy from any cause; during 2014-2016, 59% were related to medical causes (e.g., hemorrhage, infection, cardiac conditions, or cancer) and 29% were deemed "violent deaths" (e.g., suicide, homicide, drug overdose, or care accident).

coordination were identified as factors that contributed to death in 93% of preventable pregnancy-related deaths during the late postpartum period (61-364 days postpartum).⁹

2. Women need continuity of care for medical and behavioral health services during the postpartum period. The Illinois Maternal Morbidity and Mortality Report highlights the impact of severe maternal morbidity¹⁰ in conjunction with common chronic health conditions affecting pregnant women. Among Illinois women with severe maternal morbidity during 2016-2017, 45.1% had hypertension, 13.1% had diabetes, and 8.3% had both diabetes and hypertension. This is much higher than women without severe maternal morbidity (12.1% had hypertension, 8.2% had diabetes, and 1.8% had both conditions). A report from nine maternal mortality review committees found that nearly 50% of pregnancy-related deaths overall were caused by hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, or infection, with the leading causes varying by race (i.e., preeclampsia, eclampsia, and embolism for non-Hispanic black women and mental health conditions for non-Hispanic white women).¹¹

The Illinois Maternal Morbidity and Mortality Report found that of the violent pregnancy-associated deaths reviewed, 93% were preventable, mental health conditions contributed to 75%, substance use contributed to 61%, and the majority occurred at least six months postpartum.¹² According to the American Society of Addiction Medicine notes that the first year after delivery is stressful and, due to stress being a relapse risk factor, women are at an increased risk of relapse and overdose during this time.¹³ Additionally, according to an American Academy of Pediatricians (AAP) 2010 clinical report, perinatal depression is the most under-diagnosed obstetric complication in America, as many as 12% of all pregnant or postpartum women experience depression in a given year, and for low-income women, the prevalence is doubled. The AAP clinical report also notes that the peaks for depression are six weeks after birth of a child for major depression, two to three months after birth for minor depression, and six months after birth of a child.¹⁴

⁹ Illinois Department of Public Health, Office of Women's Health and Family Services. (2019, December) Data Summary: Later Postpartum Maternal Deaths in Illinois. Updated data pull for the Illinois Department of Healthcare and Family Services. Data points that reference pregnancy-related deaths refer to data from 2015-2017 and data points that reference pregnancy-associated deaths refer to data from 2015-2016.

¹⁰ DPH defines severe maternal morbidity as a complication related to pregnancy experienced during a delivery hospitalization, based on a standard set of 21 conditions defined by the CDC at <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>.

¹¹ Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs

¹² Illinois Department of Public Health. (2018, October). Illinois Maternal Morbidity and Mortality Report. Retrieved from <http://dph.illinois.gov/sites/default/files/publications/publicationsowhmaternalmorbiditymortalityreport112018.pdf>

¹³ American Society of Addition Medicine. (2017, January). Public Policy Statements: Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids. Retrieved from <https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2017/01/19/substance-use-misuse-and-use-disorders-during-and-following-pregnancy-with-an-emphasis-on-opioids>

¹⁴ American Academy of Pediatricians. (2010, October). Clinical Report—Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice. Retrieved from <https://pediatrics.aappublications.org/content/pediatrics/early/2010/10/25/peds.2010-2348.full.pdf>

Additionally, the American College of Obstetricians and Gynecologists (ACOG) Illinois section submitted examples of challenges created by Medicaid coverage ending 60 days postpartum to the Illinois Department of Healthcare and Family Services. The examples of challenges for their patients include: patients with cardiomyopathy, which is caused by pregnancy, needing close follow-up with a cardiologist to monitor heart function and manage medications postpartum, patients not having coverage when they are in need of mental health services, patients who began treatment prior to 60 days postpartum needing six weeks of monitoring to determine if anti-depressant drugs are effective, and patients who request tubal ligation for permanent contraception not being able to receive the service due to scheduling challenges between the postpartum follow-up appointment and the end of the 60 day postpartum coverage window, and patients needing access to all forms of postpartum contraception, which are critical for birth spacing and preventing undesired pregnancies within the following year as closely timed pregnancies are associated with preterm birth and placental abruption.

Having to switch coverage at 60 days postpartum adds new risks onto an already medically vulnerable time. For example, it may: require a new mother to switch from providers who have an understanding of her health history to providers she does not already have an established or trusted relationship with during a medically vulnerable time due to different health plan provider networks; create gaps in coverage from switching health plans (a 2019 Health Affairs article on perinatal insurance churn notes that 57.4% of insurance disruptions included a period of un-insurance¹⁵); result in coverage loss for mothers who do not have the capacity or resources to seek out alternative coverage; and result in missed treatments for follow-up appointments due to coverage gaps or loss.

A 2013 Health Affairs article notes that even brief gaps in coverage can lead otherwise preventable or treatable health problems, such as asthma, diabetes, and behavioral disorders, resulting in costly hospital admissions and emergency department visits.¹⁶ Additionally, a March 2014 Medicaid and CHIP Payment and Access Commission (MACPAC) report also noted that reducing movement in and out of Medicaid lowers average monthly per capita spending in Medicaid, increases utilization of preventive care, reduces the likelihood of inpatient hospital admissions and emergency room visits, and prevents disruption for enrollees, health plans, and providers.¹⁷ The churn from losing Medicaid coverage 60 days postpartum not only may result in unaddressed health conditions for mothers, but also more broadly impacts Medicaid in that the mothers will become eligible for Medicaid again if they become pregnant again and their children remain covered through CHIP, which has a higher income threshold, but with

¹⁵ Daw, J.R., Backes Kozhimannil K., Admon, L.K.. (2019, September). High Rates of Perinatal Insurance Churn Persist After The ACA. *Health Affairs Blog*. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20190913.387157/full/>

¹⁶ Ku, L., Steinmetz, E., Bruen, B. (2013, September), Continuous-Eligibility Policies Stabilize Medicaid Coverage For Children And Could Be Extended To Adults With Similar Results, *Health Affairs*, Vol. 32., No. 9: *Navigating the Thorns that Await the ACA*. Retrieved from <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0362>

¹⁷ Medicaid and CHIP Payment and Access Commission. (2014, March) Report to the Congress on Medicaid and CHIP Chapter 2: Promoting Continuity of Medicaid Coverage among Adults under Age 65. Retrieved from https://www.macpac.gov/wp-content/uploads/2015/01/Promoting_Continuity_of_Medicaid_Coverage_among_Adults_under_65.pdf

potentially increased long-term costs due to the impact of the mother's untreated conditions on her children.

3. Women need care coordination and support addressing Social Determinants of Health during the postpartum period. The Illinois Maternal Morbidity and Mortality Report notes several overarching themes that emerged from the factors that contributed to Illinois maternal deaths in 2015, including a lack of care coordination; hospitals missing opportunities for screening and assessments of physical, mental health conditions, and social issues; providers not knowing where to refer pregnant and postpartum women with mental health and substance use disorders; providers lacking resources for ensuring patient follow-up; access to specialty and behavioral health services; and poor communication between providers. These findings demonstrate a need for care coordination during the postpartum period. While women who lose Medicaid coverage after 60 days may qualify to enroll in Qualified Health Plans (QHPs) through the Health Insurance Marketplace, QHPs do not include care coordination support as a covered benefit.

Additionally, the Illinois Maternal Morbidity and Mortality Report concludes that while health insurance and availability of services can remain major barriers for women, the persistent racial disparities in maternal health outcomes nationally and in Illinois are also the result of many social and systemic issues that profoundly affect women's health. These factors, often referred to as the Social Determinants of Health (SDOH) include poverty, quality of education, health literacy, employment, housing, availability of childcare, and neighborhood safety, and affect a woman's ability to seek and receive health care, in addition to affecting her underlying health status.¹⁸ Unlike Medicaid managed care, QHPs offered through the Marketplace do not include additional support services through care coordination or referrals to assist with SDOHs within personalized care plans, limiting the ability of QHPs to fully address factors contributing to Illinois maternal deaths.

4. The mother's health is directly impacting the health of children covered by CHIP. A mother's health and well-being have significant impacts on the health of her children. Research shows that when adults have coverage, their children are more likely to access preventive care.¹⁹ A study published in Pediatrics in 2017 found that parental enrollment in Medicaid was associated with a 29 percentage point higher probability that their child received an annual well-child visit; children who receive well-child visits are more likely to complete immunization schedules and are less likely to have avoidable hospitalizations.²⁰ Well-child visits occur more frequently for infants and are also used to engage caregivers about parenting and healthy development as well as identify parent or family circumstances, such as parental depression which can negatively affect a child's trajectory if unaddressed.²¹

¹⁸ Illinois Department of Public Health. (2018, October). Illinois Maternal Morbidity and Mortality Report. Retrieved from <http://dph.illinois.gov/sites/default/files/publications/publicationsowhmaternalmorbiditymortalityreport112018.pdf>

¹⁹ Wright Burak, El, Clark, M. Roygardner, L. (2019, December). Nation's Youngest Children Lose Health Coverage at an Alarming Rate. *Georgetown University Health Policy Institute Center for Children and Families*. <https://ccf.georgetown.edu/wp-content/uploads/2019/12/Uninsured-Kids-under-6-final-1.pdf>

²⁰ Retrieved from <https://pediatrics.aappublications.org/content/pediatrics/140/6/e20170953.full.pdf>

²¹ <https://ccf.georgetown.edu/wp-content/uploads/2019/12/Uninsured-Kids-under-6-final-1.pdf>

An AAP 2010 clinical report notes that postpartum depression leads to increased costs of medical care, inappropriate medical care, child abuse and neglect, discontinuation of breastfeeding, and family dysfunction and adversely affects early brain development.²² A Georgetown University Health Policy Institute Center for Children and Families paper notes that the neural networks that enable children’s brains to take in vast amounts of information also make them especially vulnerable.²³ For example, the AAP report notes that as early as two months of age, an infant of a depressed mother will look at the mother less often, shows less engagement with objects, have a lower activity level, and have poor state regulation, with developmental and attachment issues not only persisting, but being less likely to respond to interventions over time.

Research also has found that parents who live with temporary or chronic health challenges have limited resources for childrearing, which can lead to increased stress and add to other adverse childhood experiences (ACEs) that negatively impact a child’s life trajectory. ACEs are linked to an increased risk for physical and mental health problems, poorer school readiness and educational outcomes, and involvement with the juvenile justice system; stressors on parents, including financial, mental health, substance use, and other health conditions prevent them from fully responding to their own health needs as well as their children’s health needs, which then impedes their children’s development.²⁴

While the AAP 2010 clinical report notes that treating a mother’s depression also is associated with improvement of depression and other disorders in her child,²⁵ a multi-site, multi-year review of postpartum depression found that because of 60 day postpartum limit on Medicaid benefits, many screened mothers were not able to access the postpartum depression care.²⁶ Research on the impact of the mother not accessing care for mental health, substance use, and other medical conditions demonstrate the need for systemic changes to increase affordable access to medically appropriate care.

5. *Systemic change is needed in Illinois to improve health outcomes during the postpartum period.* According to the United States Census data, Illinois is the fifth most populous state, including 2.5

²² American Academy of Pediatricians. (2010, October). Clinical Report—Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice. Retrieved from <https://pediatrics.aappublications.org/content/pediatrics/early/2010/10/25/peds.2010-2348.full.pdf>

²³Wright Burak, E. and Rolfes-Haase, K., (2018, November). Using Medicaid to Ensure the Healthy Social and Emotional Development of Infants and Toddlers. Retrieved from https://ccf.georgetown.edu/wp-content/uploads/2018/12/Medicaid-and-IECMH_FINAL.pdf

²⁴ Wright Burak, E. and Rolfes-Haase, K., (2018, November). Using Medicaid to Ensure the Healthy Social and Emotional Development of Infants and Toddlers. Retrieved from https://ccf.georgetown.edu/wp-content/uploads/2018/12/Medicaid-and-IECMH_FINAL.pdf

²⁵ American Academy of Pediatricians. (2010, October). Clinical Report—Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice. Retrieved from <https://pediatrics.aappublications.org/content/pediatrics/early/2010/10/25/peds.2010-2348.full.pdf>

²⁶ Bobo, WV, Wollan P., Lewis G., Bertram S., Kurland, M.J., Vore, K., Yawn, B.P. (2014, September). Depressive symptoms and access to mental health care in women screened for postpartum depression who lose health insurance coverage after delivery: findings from the Translating Research into Practice for Postpartum Depression (TRIPPD) effectiveness study, *Mayo Clinic Proc. Vol 89, No. 9: 1220-8*. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/25091871>

million women of reproductive age (15-44 years), and also is fifth in the nation for total number of births each year, with approximately 148,000 births occurring from July 1, 2017 to July 1, 2018.^{27,28,29} According to America's Health Rankings, the Illinois maternal mortality rate is 21.4 per 100,000 live births (13th in the country),³⁰ the Illinois infant mortality rate is 6.2 per 1,000 live births (29th in the country),³¹ 8.5% of live birth newborns have a low birthweight (29th in the country),³² and the neonatal mortality rate is 4.4 per 1,000 live births (35th in the country).³³

Additionally, the Illinois Maternal Morbidity and Mortality Report found that the maternal mortality and morbidity crisis is occurring throughout the state. The report found that the Chicago/Bellwood region, an area in northeastern Illinois, had the highest rate of severe maternal morbidity and the Marion region, located in southern Illinois, ranked second.³⁴ Additionally, the Chicago Department of Public Health Maternal Morbidity & Mortality in Chicago Report found that women living in communities with high economic hardship had the highest maternal morbidity rates (91.5 per 10,000 deliveries) and the highest pregnancy-associated mortality rates (62.7 per 100,000 births).³⁵

Compared to other states, Illinois also has a higher proportion of pregnancy-related deaths occurring in the later postpartum period (42-364 days postpartum) than other states, with Illinois at 39% compared to an 18% average for nine states in a CDC study.³⁶ Illinois also has a higher rate of severe maternal morbidity than the national average: Illinois has 168 severe

²⁷ United States Census Bureau (2018, December), Estimates of the Components of Resident Population Change: April 1, 2010 to July 1, 2018. *2018 Population Estimates*. Retrieved from

<https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t>

²⁸ United States Census Bureau (2018, April), Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018. *2018 Population Estimates*. Retrieved from

<https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t>

²⁹ United States Census Bureau, Population Division (2019, June), Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2018. *2018 Population Estimates*. Retrieved from

<https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t>

³⁰ American's Health Rankings. (2019 Edition). Public Health Impact: Maternal Mortality. Retrieved from

https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_a/state/IL

³¹ American's Health Rankings. (2019 Edition). Public Health Impact: Infant Mortality. Retrieved from

https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/IMR_MCH/state/IL

³² American's Health Rankings. (2019 Edition). Public Health Impact: Low Birthweight. Retrieved from

<https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/birthweight/state/IL>

³³ American's Health Rankings. (2019 Edition). Public Health Impact: Neonatal Mortality. Retrieved from

https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/neonatal_mortality/state/IL

³⁴ Illinois Department of Public Health. (2018, October). Illinois Maternal Morbidity and Mortality Report. Retrieved from

<http://dph.illinois.gov/sites/default/files/publications/publicationsowhmaternalmorbiditymortalityreport112018.pdf>

³⁵ Chicago Department of Public Health. (2019) CDPH Data Report: Maternal Morbidity & Mortality in Chicago.

https://www.chicago.gov/dam/city/depts/cdph/statistics_and_reports/CDPH-002_MaternalMortality_Databook_r4c_DIGITAL.pdf

³⁶ Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs

maternal morbidity events per 10,000 delivery hospitalizations compared to national average of 144 severe maternal morbidity events per 10,000 delivery hospitalizations.^{37, 38} Additionally, in Illinois the rate of opioid-related pregnancy associated deaths has increased more than 10-fold over a 9 year period: from 1.1 per 100,000 in 2008 to 12.0 per 100,000 in 2017. The number of Illinois pregnancy-associated deaths related to opioid poisonings also doubled from 2016 to 2017.³⁹

According to Centers for Medicare & Medicaid Services (CMS) data, Illinois women with Medicaid coverage also are less likely to have a postpartum visit than the national average. Only 56% percent of Medicaid women delivering a live birth had a postpartum care visit on or between 21 and 56 days after delivery during federal fiscal year 2018, but the national average was 61%. Out of the 37 states reporting on this Medicaid measure, Illinois had the 9th lowest rate.⁴⁰

Additionally, as noted earlier, compared to other states, Illinois has worse outcomes for non-Hispanic black women, who are six times as likely to die of a pregnancy-related condition as non-Hispanic white women in Illinois⁴¹ compared to three times more likely nationally.⁴² Additionally, 72% of all pregnancy-related deaths in Illinois were deemed preventable⁴³ compared to 60% nationally.⁴⁴ In Illinois, poor continuity of care and/or a lack of care coordination were identified as factors that contributed to death in 93% of preventable pregnancy-related deaths during the late postpartum period (61-364 days postpartum), and 93% of all violent pregnant-associated deaths also were deemed preventable.⁴⁵

³⁷ Illinois Department of Public Health. (2016, January). Health Data: Core Indicators. Healthy Illinois 2021.

Retrieved from <http://www.idph.state.il.us/ship/icc/documents/Data-Book-final-091216.pdf>

Centers for Disease Control and Prevention. (2017, November). Rates in Severe Morbidity Indicators per 10,000 Delivery Hospitalizations, 1993–2014. Retrieved from

<https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/rates-severe-morbidity-indicator.htm>

³⁹ Illinois Department of Public Health. (2019, March). Data Snapshot: Opioid Poisoning Deaths among Illinois

Women of Reproductive Age. Retrieved from http://www.dph.illinois.gov/sites/default/files/publications/opioid-deaths-among-women-repro-age_0.pdf

⁴⁰ Medicaid.gov. (2019, December). Prenatal & Postpartum Care: Postpartum Care. Medicaid & CHIP Scorecard.

Retrieved from <https://www.medicaid.gov/state-overviews/scorecard/postpartum-care/index.html>

⁴¹ Illinois Department of Public Health. (2018, October). Illinois Maternal Morbidity and Mortality Report. Retrieved from

<http://dph.illinois.gov/sites/default/files/publications/publicationsowhmaternalmorbiditymortalityreport112018.pdf>

⁴² Centers for Disease Control and Prevention. (2019, October 10). Pregnancy Mortality Surveillance System.

Retrieved from https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Freproductivehealth%2Fmaternalinfanthealth%2Fpregnancy-mortality-surveillance-system.htm

⁴³ Illinois Department of Public Health. (2018, October). Illinois Maternal Morbidity and Mortality Report. Retrieved from

<http://dph.illinois.gov/sites/default/files/publications/publicationsowhmaternalmorbiditymortalityreport112018.pdf>

⁴⁴ Centers for Disease Control and Prevention. (2019, May). Pregnancy-related deaths: Saving women's lives before, during and after delivery. *CDC Vital Signs*. Retrieved from <https://www.cdc.gov/vitalsigns/maternal-deaths/pdf/vs-0507-maternal-deaths-H.pdf>

⁴⁵ Illinois Department of Public Health, Office of Women's Health and Family Services. (2019, December) Data Summary: Later Postpartum Maternal Deaths in Illinois. Updated data pull for the Illinois Department of

Based on data and research nationally and in Illinois, the state must take systemic action to improve outcomes for women in Illinois during the postpartum period. However, the current federal policy that ends categorical eligibility for pregnant women 60 days postpartum limits the state's ability to leverage its Medicaid managed care infrastructure to strategically address the state's maternal morbidity and mortality crisis through the care coordination and performance improvement reporting by the Medicaid managed care plans.

Churn between Medicaid Fee-for-Service and Medicaid managed care due to late redetermination paperwork

The timely submission of redetermination paperwork continues to be a challenge in Illinois. While 42 CFR 435.916(a)(3)(iii) allows for reconsideration without a new Medicaid application if the individual submits their renewal form within 90 days of the termination date, 42 CFR 438.56(g) limits reinstatement into the prior Medicaid MCO to 60 days. In Illinois, about 80% of Medicaid enrollees are enrolled in managed care, so late redetermination paperwork that is not processed within 60 days requires individuals to be reinstated into Medicaid Fee-for-Service (FFS) prior to going through the Medicaid managed care enrollment process again to enroll in a managed care health plan.

Illinois is seeking an 1115 waiver to allow managed care reinstatements when a Medicaid beneficiary submits late redetermination paperwork within 90 days to address two issues:

1. Care disruptions within the Medicaid managed care system. The current process creates additional "churn" at a systemic level as well as challenges for beneficiaries and MCOs managing their individual care needs, such as disrupted communication with care coordinators, potential confusion at the beneficiary and provider level over standing prior authorizations and transportation arrangements, and gaps in claims history for MCOs monitoring their members' care.
2. Churning between Medicaid FFS and managed care prevents more complete HEDIS quality reporting. A Center for Health Care Strategies (CHCS) report notes, "Managed care is seen not only as a vehicle for controlling costs in Medicaid, but also as a way to improve quality of care for recipients and to hold health plans accountable for delivery of services. However, serious questions need to be raised about how well health plans can manage care and improve health outcomes of the Medicaid population as a whole if most individual Medicaid recipients are health plan members for less than a year."⁴⁶ The report goes on to highlight the 12 month continuous enrollment standard for HEDIS reporting and the challenges the Medicaid redetermination process, including the churn it creates between Medicaid managed care and Medicaid FFS, which lead to a smaller number of MCO enrollees being reflected in HEDIS measure results. The report recommends that states look to, "eliminate gaps in plan enrollment resulting from the recertification process."⁴⁷ Not allowing managed care reinstatements when a

Healthcare and Family Services. Data points that reference pregnancy-related deaths refer to data from 2015-2017 and data points that reference pregnancy-associated deaths refer to data from 2015-2016.

⁴⁶ Fairbrother, G, Park H, Haivderv, et al. (2004, July). Policies and Practices that Lead to Short Tenures in Medicaid Managed Care. *Center for Health Care Strategies, Inc.* Retrieved from <http://www.chcs.org/media/churning.pdf>

⁴⁷ Fairbrother, G, Park H, Haivderv, et al. (2004, July). Policies and Practices that Lead to Short Tenures in Medicaid Managed Care. *Center for Health Care Strategies, Inc.* Retrieved from <http://www.chcs.org/media/churning.pdf>

Medicaid beneficiary submits late redetermination paperwork within 90 days will continue to limit the state's ability to more fully measure the quality of care being provided by its Medicaid managed care plans.

Implementing Hospital Presumptive Eligibility

Illinois has analyzed its options for implementing HPE and determined that we must continue to delay implementation. Waiving HPE is necessary to promote the continuity of care and MCO coverage that follows a full Medicaid application as well as to avoid the administrative burdens of HPE, which are particularly risky for the state at this point in time as it works to reduce backlogs of applications and determinations.

HPE coverage is, at its essence, temporary coverage and does not align with Illinois' promotion of continuity of care. While HPE applications may be followed by a full Medicaid application, the state is concerned that both the hospital and the client will fail to submit the follow-up application once the initial hospital stay has been covered through HPE.

Additionally, payments for services during an HPE segment occur through Medicaid FFS. A large part of Illinois' efforts to improve continuity of care revolve around getting clients into an MCO that is responsible for working with providers and coordinating the client's health care. Creating an entirely new type of application which results in coverage that exists outside of that MCO framework does not align with the state's goals.

The state also determined the implementation of HPE to be overly administratively burdensome at this time because it creates three issues:

1. Increased application volumes. HPE implementation means the state will receive two applications for each client who uses HPE as their access point for Medicaid. Initially the hospital submits an HPE application on behalf of the client which the state must promptly review. At a later date either the hospital or the client may follow that application with a full Medicaid application. Illinois is currently facing a backlog in its processing of Medicaid applications, and adding a large volume of additional HPE applications would move the state in the wrong direction. Additionally, the substantial programming efforts, changes to the Integrated Eligibility System (IES), that would be required to implement HPE in Illinois would postpone high priority efforts to reduce IES system delays. Those system performance improvements are another important mechanism by which the state is working to reduce backlogs.
2. Expansion of time-consuming manual casework. Administering an HPE program requires that the state change the end date of an HPE enrollment based on the results of a full Medicaid application submitted for the same individuals. The association process to match an HPE application with a regular Medicaid application is administratively complex. While Illinois can control how hospitals submit HPE applications, the state accepts full Medicaid applications in a wide variety of methods and locations. A full application that is associated with an HPE application could be submitted online by the hospital, online by the client, on paper by the client, or over the phone by the client. Those applications then could be routed to any local office across the state. Additionally, the full Medicaid application could be submitted at the same time as the HPE application or at any later date during the HPE enrollment period. Illinois' current backlogs make this attempt to match applications even more complicated because the

state could already have a full application pending for the same client who applies for HPE. The numerous combinations of application sources and timeframes necessitate making the association between HPE and full applications a manual process. The state's eligibility and enrollment system is sophisticated enough to suggest potential matches to a caseworker, but it cannot fully perform the association task. The need to match HPE applications with full applications therefore creates a large volume of additional work for casework staff. Each HPE application or full Medicaid application the state receives would go through an additional time-consuming manual step to check for an existing application to associate with the new application.

3. *Monitoring and enforcement.* Because HPE allows a hospital to make an eligibility determination that directly results in payments to the hospital for services for a patient, the state would need to be diligent in monitoring the hospitals' determinations in order to prevent fraud or abuse of the system. HPE would therefore require a new layer of administration that does not exist in Illinois today. The state would need to find staff to monitor and enforce HPE performance standards, to create new reports detailing each hospital's HPE applications, and to work with underperforming hospitals on their corrective actions or expulsion from the HPE program. Waiting HPE to continue traditional Medicaid application processes would avoid these additional bureaucratic steps and instead would promote administrative simplicity.

Proposed Solutions to Administrative Barriers

To address the administrative barriers to continuity of care described above, the Illinois Department of Healthcare and Family Services (HFS) is seeking a five-year Medicaid Section 1115 Research and Demonstration Waiver that promotes continuity of care and administrative simplification. The Demonstration is designed to provide quality healthcare and improve health outcomes through continuity of care and care coordination to Medicaid beneficiaries while reducing unnecessary administrative burdens. The following three initiatives will help the Department achieve these goals:

- 1) Extending postpartum coverage from 60 days to 12 months;
- 2) Managed care reinstatements when a Medicaid beneficiary submits late redetermination paperwork within 90 days; and
- 3) Waiving Hospital Presumptive Eligibility (HPE).

Each proposal is explained in more detail below:

Extending postpartum coverage from 60 days to 12 months

Illinois proposes to extend eligibility for pregnant women from 60 days postpartum to 12 months postpartum, implement continuous eligibility for the entire postpartum period, and enroll women in the pregnant women category of eligibility throughout the entire 12 month postpartum period. The goal of this proposal is to reduce maternal morbidity and mortality in Illinois by providing additional health care access and care coordination support to new mothers during the entire medically vulnerable postpartum period. This demonstration proposal directly addresses the five identified problems that were outlined in the previous section of this waiver request based on national and state research.

Based on the findings of the DPH Illinois Maternal Morbidity and Mortality Report that the majority of maternal deaths reviewed occurred late in the postpartum period and were preventable, and the report's corresponding recommendations, the Illinois General Assembly amended 305 ILCS 5/5-2 to extend Medicaid coverage for pregnant women from 60 days to 12 months postpartum, effective January 1, 2020, and the Governor of Illinois signed it into law on June 5, 2019. This state law also aligns with the recommendations of maternal mortality review committees around the country, ACOG,⁴⁸ and the American Medical Association (AMA).⁴⁹ The recommendation to extend Medicaid coverage from 60 days to 12 months postpartum is also listed as a systemic recommendation in the CDC Vital Signs report, which is based on a compilation of findings from state maternal mortality review committees across the nation that researched pregnancy-related deaths within their states to determine if the deaths were preventable and recommend actions to prevent maternal mortality based on their findings.⁵⁰

The extended postpartum coverage under Public Act 101-0010 is full Medicaid benefits for women at or below 213% of the federal poverty level (FPL), which is the income threshold for the pregnant women category of Medicaid eligibility in Illinois (208% FPL with a 5% income disregard). Providing full benefit coverage aligns with the research that maternal morbidity and mortality are caused by a combination of medical and behavioral health conditions during the postpartum period.

To further promote continuity of coverage and administrative simplification, the state's 1115 waiver proposal seeks to align continuous eligibility for the mom and baby so that both are eligible through 12 months after delivery. Continuous eligibility for the postpartum period will prevent mothers from having to switch providers during a medically vulnerable time due to different provider networks, will prevent disruption in courses of treatment during the postpartum period, and will increase access to needed care, follow-up visits, and medications when health issues arise during the postpartum period. It will prevent churning between different types of health insurance that can lead to gaps in care or a loss of coverage. Additionally, allowing women to enroll in the pregnant women category of eligibility throughout the entire 12 month postpartum period ensures their health care needs are met throughout the postpartum period regardless of the source of coverage at delivery.

The Illinois proposal also will leverage the state's Medicaid managed care system to provide care coordination for women during the postpartum period and provide support and appropriate referrals for SDOHs during the postpartum period. The Illinois Maternal Morbidity and Mortality Report identified poor continuity of care and/or a lack of care coordination as factors that contributed to death in 93% of preventable pregnancy-related deaths 61-364 days postpartum, and it recommended that the state require coverage of case management and outreach for postpartum high-risk women for up to one year after delivery.⁵¹

⁴⁸ The American College of Obstetricians and Gynecologists. (2019, June 12). ACOG Statement on AMA Support for 12 Months Postpartum Coverage under Medicaid. Retrieved from <https://www.acog.org/About-ACOG/News-Room/Statements/2019/AMA-Support-for-12-Months-Postpartum-Medicaid-Coverage?IsMobileSet=false>

⁴⁹ American Medical Association. (2019, June 12) AMA adopts new policies at 2019 Annual Meeting. Retrieved from <https://www.ama-assn.org/press-center/press-releases/ama-adopts-new-policies-2019-annual-meeting>

⁵⁰ Petersen EE, Davis NL, Goodman D, et al. (2019, May 7) *Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 14 States, 2013-2017. Morbidity and Mortality Weekly Report (MMWR)*. DOI: <http://dx.doi.org/10.15585/mmwr.mm6818e1>

⁵¹ Illinois Department of Public Health. (2018, October). Illinois Maternal Morbidity and Mortality Report. Retrieved from <http://dph.illinois.gov/sites/default/files/publications/publicationsowhmaternalmorbiditymortalityreport112018.pdf>

Care coordination is built into the Illinois Medicaid managed care infrastructure and goes beyond what QHPs on the Marketplace provide. The Illinois Medicaid MCOs also have been expanding their partnerships with providers and increasingly incorporating SDOHs into their risk stratification algorithms, health risk assessments, person-centered care plans, and overall care coordination approach, allowing coordination with providers and social determinants of health to be addressed in managed care beyond what is possible in traditional Medicaid FFS.

Additionally, in Illinois, women eligible for Medicaid benefits under the pregnant women category generally are enrolled in Medicaid MCOs and their newborns are auto-assigned to the mother's MCO with a 90-day switch period. As a result, extending coverage from 60 days to 12 months postpartum not only provides the mother with access to care coordination and health care services, but also allows for comprehensive, person-centered care plans supporting both the mother and the new baby. Research shows that the mother's health directly impacts the health of her children; having both enrolled with a Medicaid MCO with 12 months continuous eligibility further provides incentives and opportunity for the Medicaid MCO to improve health outcomes for the mother and baby.

Systemic change is needed in Illinois to improve health outcomes during the postpartum period. Illinois is committed to investing state resources to address the maternal morbidity and mortality crisis in the state and is seeking an 1115 waiver to demonstrate that extending postpartum coverage under Medicaid managed care will improve health outcomes for Illinois mothers and their children. Implementing the postpartum extension within the Illinois Medicaid managed care infrastructure not only provides care coordination and assistance with SDOHs for mothers during a medically vulnerable time, but also provides the state with additional oversight and performance management opportunities to reduce preventable pregnancy-related deaths. The state will set clear expectations for Medicaid MCOs to improve outcomes for both mothers and their newborns through its MCO performance management oversight structure, including the number of women who receive a second postpartum depression screening. Illinois also will continue to monitor the findings of the Illinois Department of Public Health (DPH) Maternal Mortality Review Committee and Maternal Mortality Review of Violent Deaths Committee.

Managed care reinstatement when a Medicaid beneficiary submits late redetermination paperwork within 90 days

Illinois proposes to allow Medicaid beneficiaries to be retro-enrolled into their prior Medicaid MCO within 90 days of losing Medicaid coverage due to late submission of a renewal form, also known in Illinois as Medicaid redetermination paperwork. While current federal Medicaid regulations allow for reconsideration without a new Medicaid application if the individual submits their renewal form within 90 days of the termination date, they also limit reinstatement into the prior Medicaid MCO to 60 days. This creates a gap where individuals are reinstated into Medicaid FFS and then need to go through the Medicaid managed care enrollment process again to enroll in a managed care health plan.

The goal of this proposal is to increase continuity of coverage and improve MCO quality oversight by minimizing churn between Medicaid FFS and Medicaid managed care. In Illinois, about 80% of Medicaid beneficiaries are enrolled in Medicaid managed care, so this proposal will prevent unnecessary care disruptions for a significant number of Illinois Medicaid beneficiaries by re-connecting them to their care coordinators without delay and reducing confusion at the beneficiary and provider level over standing prior authorizations and transportation arrangements. The proposal also will reduce gaps in claims history for MCOs monitoring their members' care.

This proposal also will also allow for more complete HEDIS quality reporting, due to the 12 month continuous eligibility requirements within HEDIS, which will give the state a more complete picture of the care Medicaid beneficiaries are receiving. This also will allow for improved contract oversight and more accurate evaluation of Medicaid MCO performance and improvement initiatives.

Additionally, this proposal results in administrative simplifications for the state's managed care enrollment staff as well as the state's Client Enrollment Broker contractor, who currently send Medicaid beneficiaries through the full managed care enrollment process solely because their redetermination paperwork was submitted soon enough to be reinstated, but not soon enough to be eligible for automated retro-enrollment into their prior MCO.

This policy will not have an impact on the number of individuals eligible for Medicaid; it only impacts the number of months Medicaid beneficiaries are enrolled in Medicaid MCOs in place of Medicaid FFS. The state will monitor and evaluate the impact of this policy change by working collaboratively with the Medicaid managed care health plans, the state's managed care enrollment and quality staff, and the state's eligibility policy staff.

Waiving Hospital Presumptive Eligibility

Illinois seeks to delay the HPE requirement until IES performance issues and eligibility backlogs are resolved. The only way to delay is to waive the requirement to permit hospitals to make presumptive eligibility determinations as laid out in 42 CFR 435.1110. The waiver request will include the removal of all six HPE groups from the HPE requirement: children, pregnant women, former foster care, parent or caretaker relatives, breast and cervical cancer, and single adults made eligible under the Affordable Care Act.

Removal of HPE requirements would not impact Medicaid eligibility requirements for these six groups; they all would remain eligible with the same requirements that exist today. Hospitals also would still be permitted to assist patients with the completion of a full Medicaid application.

The goal of this proposal is to promote continuity of care with full benefit Medicaid applications and reduced processing times by avoiding the administrative complexities involved with HPE. Illinois has yet to fully implement HPE, but during its analysis and design of an HPE program, it has determined HPE to be overly administratively burdensome.

Core Features and Components of the Demonstration to Test

Under this Demonstration, HFS requests:

- Waiver of § 1902(a)(10)(A) and 1902(e)(5) and (6), to the extent necessary, to extend eligibility for pregnant women from 60 days postpartum to 12 months postpartum, implement continuous eligibility for the entire postpartum period, and enroll women in the pregnant women category of eligibility throughout the entire 12 month postpartum period.
- Waiver of § 1902(e)(2), to the extent necessary, to reinstate Medicaid beneficiaries into their prior Medicaid MCO within 90 days of losing Medicaid coverage due to late submission of Medicaid redetermination paperwork.

- Waiver of § 1902(a)(47), to the extent necessary, to waive hospital presumptive eligibility.

Under this Demonstration, HFS also requests expenditure authority for women up to 213% FPL in the pregnant women category of eligibility through the full 12 month postpartum period. Illinois is requesting a federal match for citizens as well as qualified immigrants who meet the five year waiting period. Illinois proposes using Health Services Initiative (HSI) funding to fully fund the coverage extension for qualified immigrants who have not met the five year waiting period for Medicaid.

The core features and components of the demonstration that the state intends to test with section 1115 authority are described in detail below:

Extending postpartum coverage from 60 days to 12 months

For this proposal, Illinois requests to waive §1902(a)(10)(A) (*Eligibility Group*) and 1902(e)(5) and (6) (*Pregnant Women, Continuous Eligibility, and 60-Day Post-Partum Eligibility*) of the Social Security Act (SSA) to the extent necessary. The corresponding federal regulation citations Illinois is seeking a waiver from are:

- 42 CFR 435.4, as Illinois seeks to define pregnant women through 12 months postpartum instead of 60 days postpartum;
- 42 CFR 435.170, as Illinois seeks to extend eligibility for pregnant women from 60 days to 12 months postpartum, extend continuous eligibility for pregnant women from 60 days to 12 months postpartum, and allow coverage under the pregnant woman category of eligibility when the woman applies during the postpartum period more than three months after delivery; and
- 42 CFR 435.916(a), as Illinois seeks to extend the renewal of MAGI-based income to the end of the 12 month postpartum period.

Illinois is seeking an 1115 waiver to implement this proposal with a federal match because extending eligibility for pregnant women from 60 days to 12 months postpartum, as well as continuous eligibility during this extension, is currently not an option available to states through a State Plan Amendment or other federal waiver authority.

The state is requesting waiver and expenditure authority for this proposal to reduce maternal morbidity and mortality in Illinois by providing additional health care access and care coordination support to new mothers during the entire medically-vulnerable postpartum period. Currently, coverage under the pregnant women category of eligibility ends at 60 days postpartum under 42 CFR 435.4 and 42 CFR 435.170.

Illinois seeks to test whether extending coverage from 60 days to 12 months postpartum gives Medicaid MCOs the ability to provide care coordination and support for both the mother and baby during the pregnancy, labor and delivery, and the entire postpartum period, which is defined as 12 months after delivery by the Centers for Disease Control and Prevention (CDC).⁵²

⁵² Centers for Disease Control and Prevention. (2019, May). Pregnancy-related deaths: Saving women’s lives before, during and after delivery. *CDC Vital Signs*. Retrieved from <https://www.cdc.gov/vitalsigns/maternal-deaths/pdf/vs-0507-maternal-deaths-H.pdf>

Illinois seeks to align continuous eligibility for the mom and baby to be 12 months after delivery. A national study published in Health Affairs in April 2017 notes that “churn” before and after childbirth can adversely affect continuity and quality of care, and cites having Medicaid or CHIP coverage as one of the risk factors associated with insurance loss after delivery.⁵³ Waiving 42 CFR 435.170 to extend continuous eligibility for pregnant women from 60 days to 12 months postpartum will allow Illinois to test whether allowing the mother’s healthcare needs to continue uninterrupted within the Medicaid managed care system will improve maternal health outcomes, as late redetermination paperwork often creates gaps in coverage that are then filled retroactively through a mix of Medicaid FFS and managed care. It also will allow Illinois to test whether redetermining the mother and newborn at the same time creates administrative efficiencies for caseworkers.

Additionally, waiving 42 CFR 435.170(b) to allow coverage under the pregnant women category of eligibility when the mother applies during the postpartum period more than three months after delivery will allow the state to test whether if this policy creates administrative simplicity for the state and a simplified understanding of eligibility policy for beneficiaries and stakeholders. Today, if a woman applies during the 60 day postpartum period, the three months of retroactive coverage include the time she was pregnant. An extension of the postpartum period to 12 months allows for the possibility of receiving applications from women in the 12 month postpartum period whose retroactive coverage for the three prior months would not include a month she was pregnant. Allowing mothers to be in the pregnant women category of eligibility through 12 months postpartum would simplify caseworker policy instructions, guidance to new mothers and stakeholders, and enhance the state’s ability to address postpartum coverage needs, including the violent pregnancy-associated deaths from mental health conditions and substance use occurring in the second half of the postpartum period.

Managed care reinstatement when a Medicaid beneficiary submits late redetermination paperwork within 90 days

For this proposal, Illinois requests to waive §1902(e)(2) (*MCO Enrollees*) of the Social Security Act, to the extent necessary. The corresponding federal regulation citation Illinois is seeking a waiver from is:

- 42 CFR 438.56(g) (*Mandatory Managed Care Enrollment and Disenrollment*), as Illinois seeks to allow reinstatement in a Medicaid MCO within 90 days, rather than 60 days of late renewal paperwork. This creates alignment with the Medicaid coverage reinstatement policy in 42 CFR 435.916(a)(3)(iii).

The state is requesting 1115 waiver authority for this proposal to increase continuity of coverage and improve MCO quality oversight by minimizing churn between Medicaid FFS and Medicaid managed care. The state is not aware of this reinstatement policy alignment being possible through a State Plan Amendment or other federal waiver authority.

Waiving 42 CFR 438.56(g) to allow reinstatement in a Medicaid MCO within 90 days, rather than 60 days, of late renewal paperwork, will create alignment with the reinstatement policy in 42 CFR 435.916(a)(3)(iii). It will allow the state to test whether reinstatement into the beneficiary’s prior Medicaid MCOs instead of Medicaid FFS reduces disruption for beneficiaries and providers and allows for more complete quality reporting and oversight by the state.

⁵³ Daw R, Hatfield L, Swartz K, et al. (2017, April). Women in The United States Experience High Rates of Coverage ‘Churn’ In Months Before and After Childbirth, *Health Affairs*, vol. 36, no. 4. Retrieved from <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.1241>

Additionally, it will allow the state to test whether this policy also creates efficiencies for state eligibility and enrollment staff who currently send Medicaid beneficiaries through the full managed care enrollment process solely because their redetermination paperwork was submitted soon enough to be reinstated, but not soon enough to be eligible for automated retro-enrollment into their prior MCO under 42 CFR 438.56(g).

Waiving HPE

For this proposal, Illinois requests to waive §1902(a)(47) (*Presumptive Eligibility*) of the Social Security Act (SSA) to the extent necessary. The corresponding federal regulation citation Illinois is seeking a waiver from is:

- 42 CFR 435.1110, as Illinois seeks to waive the requirement to permit hospitals to make presumptive eligibility determinations.

The state cannot use a State Plan Amendment or other federal waiver authority to waive HPE, so it is requesting 1115 waiver authority. The state wishes to encourage applications for full Medicaid which would allow a client to have coverage as long as they remain eligible, and the state will test both its intake and processing of those full Medicaid applications to determine if waiving HPE does in fact allow for more effective processing of Medicaid applications by avoiding the duplicate applications and other administrative complexities of HPE.

The Demonstration Proposals Support the Core Objectives of the Medicaid and CHIP Programs

The three proposals within the state's continuity of care and administrative simplification waiver request are designed to promote Medicaid objectives by serving the health and wellness needs of vulnerable and low-income individuals and families. More detailed examples are provided under each proposal below:

Extending postpartum coverage from 60 days to 12 months

The proposal to extend postpartum coverage from 60 days to 12 months postpartum will improve access to high-quality, person-centered services that produce positive health outcomes for individuals by leveraging the Illinois Medicaid managed care infrastructure. Keeping women covered through their Medicaid MCO during the full postpartum period will prevent the need to change providers due to network differences during a medically vulnerable time, prevent gaps in care, and allow the state to leverage the care coordination benefit built into its Medicaid MCOs to help mothers navigate the health system to receive follow-up care and provide support and referrals for SDOHs that also impact health outcomes, as discussed in detail in previous sections of this waiver request. Requiring mothers to switch to QHPs on the Marketplace 60 days postpartum risks disrupting coverage mid-treatment, requires mothers to find new providers that do not have relationships with them or an understanding of their health history at a medically vulnerable time, and in many cases will result in gaps in coverage or coverage loss. QHPs also do not have built in care coordination benefits to address the key factors that are leading to poor health outcomes for mothers during the postpartum period.

This proposal also supports coordinated strategies to address health determinants to promote upward mobility and improved quality of life among individuals while promoting efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term. The Illinois Medicaid managed care infrastructure includes strategies to address SDOHs through care coordination support, which is not a component of QHPs on the Marketplace. As discussed previously, research shows that the ability to

treat the mother during the postpartum period not only has the ability to improve the health outcomes for the mother, but also reduces costs for the Medicaid and CHIP program by improving health outcomes for her children, increasing the use of and access to care in the right settings at the right time, including early interventions, and supporting improved birth spacing and better birth outcomes for future pregnancies.

This proposal also has the ability to advance innovative delivery system and payment models to drive greater value for Medicaid. In addition to providing continuity of care for mothers during the full postpartum period by keeping them with their Medicaid MCOs, providing continuous eligibility during the full postpartum period and allowing mothers to apply for coverage during the full 12 month postpartum period ensures that mothers have access to treatment and follow-up appointments and allows the state to hold Medicaid MCOs accountable for health outcomes while driving performance improvement.

Managed care reinstatements when a Medicaid beneficiary submits late redetermination paperwork within 90 days

The proposal to allow reinstatements into the beneficiary's prior Medicaid MCO within 90 days of late redetermination paperwork improves access to high-quality, person-centered services that produce positive health outcomes for individuals and promotes efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term. As discussed previously, the current process creates "churn" between Medicaid FFS and Medicaid managed care, which adds inefficiencies into the Illinois Medicaid managed care system, which now serves about 80% of Medicaid beneficiaries. Churning between Medicaid FFS and Medicaid managed care because of late redetermination paperwork results in disrupted communication with care coordinators, potential confusion at the beneficiary and provider level over standing prior authorizations and transportation arrangements, and results in gaps in claims history for MCOs monitoring their members' care. This churning also restricts the state's ability to access the health outcomes for Medicaid beneficiaries in managed care due to the 12 months continuous enrollment requirements in HEDIS quality reporting. Maintaining the relationship with the Medicaid beneficiary's MCO and care coordination, reducing provider confusion and burden to ensure beneficiaries are getting care in the right place at the right time, and more complete quality results are also examples of efficiencies that will help ensure Medicaid's sustainability for beneficiary's in the long term.

Waiving Hospital Presumptive Eligibility (HPE)

Waiving HPE requirements is important to improve the state's ability to better serve the health and wellness of Illinois' low-income individuals and families. While Illinois has yet to implement HPE, the act of delaying implementation is itself an important approach to promote the state's objectives. Illinois' eligibility and enrollment system went through a significant overhaul and continues to undergo consistent fixes and improvements. Illinois must prioritize changes to the system that improve the performance of the system rather changes that introduce new and complex functionality like HPE that could increase the risks of new defects or performance issues. By waiving HPE and thus allowing more time for priority system improvements, the state will be able to continue its progress to reduce system defects and eligibility backlogs which will allow Medicaid applicants to have better and faster access to health coverage.

Promotion of the State's Medicaid and CHIP Program Goals

The primary goals of the demonstration are the promotion of continuity of care and administrative simplicity. The components of the proposed demonstration, how they are intended to promote Medicaid and CHIP program goals, and the identification of the requested waiver authorities are described in previous sections of this application.

In regards to waiver expenditure authority, through this 1115 demonstration waiver, Illinois seeks to receive a federal match for women in the pregnant women category of eligibility through 12 months postpartum. Illinois will use General Revenue Funds for the state share and has funding authorized through the budget implementation act that includes the postpartum coverage extension.

Additionally, Illinois seeks to use Health Services Initiative (HSI) funding to extend coverage for qualified immigrants in their five-year waiting period from 60 days to 12 months postpartum. This funding source is currently used for their expenditures through 60 days postpartum.

Illinois is not requesting new expenditure authority for the proposal to allow managed care reinstatements when Medicaid beneficiaries submit late redetermination paperwork. This policy does not impact the number of individuals enrolled in Medicaid coverage; it only impacts the number of months Medicaid beneficiaries are enrolled in Medicaid MCOs instead of Medicaid FFS.

Illinois also is not requesting new expenditure authority to waive HPE. Illinois has not yet implemented HPE so waiving it does not result in additional expenditures.

Eligibility, Enrollment, and Delivery System:

HFS proposes to implement the following Demonstration initiatives across all eligibility groups:

- Managed care reinstatement when a Medicaid beneficiary submits late redetermination paperwork within 90 days; and
- Waiving HPE.

The proposal to extend postpartum coverage from 60 days to 12 months will only be implemented for the eligibility groups noted in the tables below; this is also the only proposal in the Demonstration that impacts Medicaid eligibility. The policy to reinstate Medicaid beneficiaries into their previous managed care plan when late redetermination paperwork is submitted within 90 days does not have an impact on the number of individuals eligible for Medicaid; it only impacts the number of months Medicaid beneficiaries are enrolled in Medicaid managed care in place of Medicaid FFS. Additionally, waiving HPE requirements would not change Medicaid eligibility for anyone; it merely promotes the use of traditional application methods.

**Eligibility Chart
Mandatory State Plan Groups***

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Qualified Pregnant Women and Children	42 CFR 435.116 - old 1902(a)(10)(A)(i)(III) 1905(n)	Up to 213% FPL (208% plus standard 5% disregard)

Mandatory Poverty Level Related Pregnant Women	1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	Up to 213% FPL (208% plus standard 5% disregard)
Medically Needy Pregnant Women	1902(a)(10)(C)(ii)(II) 42 CFR 435.301(b)(1)(i) and (iv)	Up to 213% FPL (208% plus standard 5% disregard)

Optional State Plan Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Optional Poverty Level Related Pregnant Women and Infants	1902(a)(10)(A)(ii)(IX) 1902(l)(2)	Up to 213% FPL (208% plus standard 5% disregard)

Expansion Populations

Eligibility Group Name	N/A	Income Level
Qualified Pregnant Women Immigrants in their Five Year Waiting Period	N/A	Up to 213% FPL (208% plus standard 5% disregard)

**For individuals enrolled in the AABD eligibility group, the income threshold is 100% FPL and clients with a spenddown would still need to spenddown to 100% FPL. However, if a woman in the AABD category became pregnant, she could move to the pregnant women category of eligibility with the 213% FPL income threshold and no asset test.*

In regards to extending postpartum coverage, Illinois seeks to align continuous eligibility for the mother and baby to be 12 months after delivery. Waiving 42 CFR 435.170 to extend continuous eligibility for pregnant women from 60 days to 12 months postpartum allows the mother's healthcare needs to continue uninterrupted, as late redetermination paperwork often creates gaps in coverage that are then filled retroactively through a mix of Medicaid FFS and Medicaid managed care. Additionally, continuous eligibility for 12 months postpartum allows Illinois to redetermine the mother and newborn at the same time, creating administrative efficiencies.

Under the Demonstration, HFS proposes to waive 42 CFR 435.170(b) to allow coverage under the pregnant women category of eligibility when the mother applies during the postpartum period more than three months after delivery. An extension of the postpartum period to 12 months allows for the possibility of receiving applications from women in the 12 month postpartum period whose retroactive coverage for the three prior months would not include a month she was pregnant. Allowing mothers to be in the pregnant women category of eligibility through 12 months postpartum simplifies caseworker policy instructions and guidance to new mothers and stakeholders, and it enhances the state's ability to address postpartum coverage needs, including the violent pregnancy-associated deaths from mental health conditions and substance use occurring in the second half of the postpartum period.

There are no enrollment limits under any of the three Demonstration proposals. The Demonstration also does not change HFS policies on post-eligibility treatment of income for long term services and supports or spousal impoverishment rules. Additionally, this Demonstration is not undertaking eligibility changes based on specific standards or changes in 2014.

All proposals within the Demonstration will operate statewide. Additionally, the Demonstration will not affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

This Demonstration also does not change the Medicaid benefit package design; there is no new cost-sharing, copayments, or coinsurance for any benefit provided under the waiver. State Plan benefits will continue to be applied in accordance with the State Plan and all eligibility groups will continue to receive all State Plan benefits.

The delivery system used to provide benefits to Demonstration participants does not differ from the Medicaid and/or CHIP State plan. To the extent Medicaid FFS payments are made for any services, the Demonstration will not cause a deviation from State Plan provider payment rates. Additionally, to the extent payment is being made through managed care entities on a capitated basis, the Demonstration does not change the methodology for setting capitation rates or cause any deviations from the payment and contracting requirements under 42 CFR Part 438. The Demonstration also does not dictate quality-based supplemental payments to providers.

Stakeholder Impact

These proposals do not require new practices or requirements of stakeholders. The proposal to extend postpartum coverage from 60 days to 12 months and the proposal to reinstate beneficiaries into their prior Medicaid MCO within 90 days of late redetermination paperwork will be implemented within the state's existing Medicaid managed care and care delivery system. Additionally, HPE has not yet been implemented in Illinois, so waiving it will not require new practices or requirements from stakeholders.

The proposal to extend postpartum coverage from 60 days to 12 months is expected to impact the delivery and quality of Medicaid and CHIP services. The state plans to use its Medicaid performance management infrastructure to drive improved health outcomes. Through this process, the state anticipates interventions to be implemented by the Medicaid MCOs to increase access to needed services for mothers, resulting in improved quality of care over the postpartum period. For example, targeted interventions could include strategies to improve outcomes for non-Hispanic black women in addition to improving overall health outcomes.

The proposal to reinstate beneficiaries into their prior Medicaid MCO within 90 days of late redetermination paperwork also is expected to impact stakeholders in the delivery and quality of Medicaid and CHIP services being provided. As discussed previously, this policy is expected to reduce burden on beneficiaries and providers by connecting beneficiaries back with their prior MCOs through a more efficient and streamlined process. Additionally, to the extent more complete HEDIS reports impacts quality results, new interventions may be implemented to improve health plan quality and performance.

As HPE has not yet been implemented in Illinois, waiving it will not directly impact the delivery and/or quality of Medicaid and CHIP services. However, waiving HPE will allow Illinois to prioritize changes to the eligibility system that improve the performance of the system rather than ones that introduce new and complex functionality like HPE that could increase the risks of new defects or performance issues. By waiving HPE and thus allowing more time for priority system improvements, the state will be able to continue its progress to reduce system defects and eligibility backlogs which will allow Medicaid applicants to have better and faster access to health coverage.

The expected impact on stakeholders will support the state in meeting its stated goals and objectives for the Section 1115 waiver demonstration by resulting in improved quality outcomes for Medicaid and CHIP beneficiaries, as discussed above. There are not any expected impacts on stakeholders that would not support the state in meeting its stated goals under the proposed demonstration.

Overall Impact on Eligibility, Delivery, and Quality

The overall impact of the demonstration includes extended eligibility for postpartum mothers through the 12 month postpartum period, with continuous eligibility, a drive to improve health care delivery and improve health outcomes through the postpartum extension proposal and the proposal to retroactively enroll beneficiaries into their previous MCO due to late redetermination paperwork. These proposals are being implemented within the state's existing Medicaid managed care infrastructure; this allows the state to continue to sustain and build on successes from these proposals over time without the need for new processes or procedures. Additionally, the overall impact of waiving HPE is improved eligibility system performance and reduced eligibility processing times as a result of waiving HPE.

Enrollment Projections

Extending Postpartum Coverage

For the extension of postpartum coverage from 60 days to 12 months, Milliman summarized data into two eligibility groups: 1) U.S. Citizens and Lawfully Present Residents (LPRs) meeting the five year waiting period and 2) LPRs in the five year waiting period. Based on April 2018 through March 2019 enrollment experience, Milliman estimates approximately 5,000 women will have Medicaid coverage extended from 60 days to 12 months postpartum on an annual basis, as a result of this proposal.

Projected member months assume the average length of postpartum eligibility will increase to 12 months under the waiver. Milliman estimates Medicaid member months to increase by approximately 19,000 in the first demonstration year and 38,000 in the second demonstration year as additional women retain Medicaid eligibility under the waiver. A ramp-up period is assumed during the first demonstration year as HFS does not intend to automatically reinstate postpartum women who previously lost Medicaid eligibility at the end of 60 days postpartum.

PROJECTION PERIOD					
Moms and Babies 138% to 213% FPL, Citizens and LPR Meeting 5 Year Requirement	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
UNIQUE BENEFICIARIES	2,458	2,446	2,434	2,422	2,410
Moms and Babies 138% to 213% FPL, LPR Under 5 Year Requirement	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
UNIQUE BENEFICIARIES	1,476	1,505	1,535	1,566	1,597

Managed care reinstatement when a Medicaid beneficiary submits late redetermination paperwork within 90 days & Waiving HPE

Milliman does not project managed care reinstatements within 90 days and waiving HPE to impact Medicaid enrollment. A result, a separate table is provided below for these two components of the waiver.

PROJECTION PERIOD					
Affordable Care Act Adults	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
ELIGIBLE MEMBER MONTHS	699,598	696,100	692,620	689,157	685,711
Disabled Adults	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
ELIGIBLE MEMBER MONTHS	184,101	185,942	187,801	189,679	191,576
Non-disabled Children and Adults	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
ELIGIBLE MEMBER MONTHS	1,998,192	1,988,201	1,978,260	1,968,369	1,958,527
Managed Long Term Services and Supports	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
ELIGIBLE MEMBER MONTHS	83,492	85,162	86,865	88,602	90,374
Medicare-Medicaid Alignment Initiative	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
ELIGIBLE MEMBER MONTHS	207,189	211,333	215,560	219,871	224,268
Department of Children and Family Services	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
ELIGIBLE MEMBER MONTHS	47,620	47,620	47,620	47,620	47,620
Special Needs Children	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
ELIGIBLE MEMBER MONTHS	43,979	43,979	43,979	43,979	43,979

Demonstration Conditions of Eligibility

The Illinois 1115 waiver proposal does not seek to implement additional beneficiary requirements as conditions of eligibility.

Impact Analysis

Extending Postpartum Coverage

For the postpartum eligibility extension, postpartum eligibility in the historical experience period were summarized for women giving birth that met the following criteria: 1) For both the beginning and end of the postpartum Medicaid eligibility period, the beneficiary had a MANG-P code of “A1” (Pregnant women either non-citizen, inmate, or in a state operated facility with income less than 213% FPL) or “B” (Moms and Babies – Pregnant Women – income between 138-213% FPL), and 2) At least one month of the postpartum eligibility period was contained in the 12 month experience period (eligibility month and associated expenditures outside of the 12 month experience period were excluded). For purposes of identifying LPRs in the eligibility data, HFP provided a separate list of beneficiaries by “Alien Status Code.” For the managed care reinstatement and HPE components of the waiver, historical data was classified consistent with expected CY 2020 managed care populations. Due to HFS eligibility system changes, Milliman uses the distributions in the fifth year of the historical period between U.S. Citizens and LPRs who meet the five year waiting period and LPRs who do not meet the five year waiting period to allocate enrollment in the first through fourth years of the historical period.

Milliman assumed a 0.5% member month trend assumption for citizens and qualifying LPR member months because Medicaid enrollment for women impacted by the waiver has decreased for the past several years and DPH projections for 2020 through 2025 estimates a declining number of women between ages 15 to 29 from 2020 through 2025.⁵⁴ A 2% member month trend assumption was used for LPRs in the five year waiting period to reflect recent eligibility growth for this population.

5 YEARS OF HISTORIC DATA						
SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:				April 1, 2014 through March 31, 2019		
Moms and Babies 138% to 213% FPL, Citizens and LPR Meeting 5 Year Requirement	2014	2015	2016	2017	2018	5-YEARS
UNIQUE BENEFICIARIES	2,293	2,476	2,416	2,134	2,480	11,800
Moms and Babies 138% to 213% FPL, LPR Under 5 Year Requirement	2014	2015	2016	2017	2018	5-YEARS
UNIQUE BENEFICIARIES	1,318	1,423	1,389	1,226	1,425	6,782
Note: Historical time periods reflect 12 month period beginning April 1st of each year.						

Managed care reinstatement when a Medicaid beneficiary submits late redetermination paperwork within 90 days & Waiving HPE

For the proposals on managed care reinstatements within 90 days of late redetermination paperwork and waiving HPE, the state and Milliman do not project any changes in enrollment based on the proposals. Historical data was classified consistent with expected CY 2020 managed care populations. Milliman uses the following enrollment trend assumptions by population: Affordable Care Act Adults, -

⁵⁴ Illinois Department of Public Health (2015, February). Population Projections Illinois, Chicago and Illinois Counties by Age and Sex: July 1, 2010 to July 1, 2025. Retrieved from https://www2.illinois.gov/sites/hfsrb/InventoriesData/Documents/Population_Projections_Report_Final_2014.pdf

0.5%; Disabled Adults, 1.0%; Non-Disabled Children and Adults, -0.5%; Managed Long-Term Services and Supports, 2.0%; Medicare-Medicaid Alignment Initiative, 2.0%; Department of Children and Family Services beneficiaries 0%; and Special Needs Children 0%.

5 YEARS OF HISTORIC DATA						
SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:				April 1, 2014 through March 31, 2019		
Affordable Care Act Adults	2014	2015	2016	2017	2018	5-YEARS
ELIGIBLE MEMBER MONTHS	677,261	790,800	775,720	732,005	705,762	3,681,548
Disabled Adults	2014	2015	2016	2017	2018	5-YEARS
ELIGIBLE MEMBER MONTHS	161,216	161,121	158,840	180,498	180,923	842,598
Non-disabled Children and Adults	2014	2015	2016	2017	2018	5-YEARS
ELIGIBLE MEMBER MONTHS	2,301,644	2,216,129	2,159,344	2,079,431	2,015,797	10,772,345
Managed Long Term Services and Supports	2014	2015	2016	2017	2018	5-YEARS
ELIGIBLE MEMBER MONTHS	74,188	76,833	77,628	82,417	80,648	391,714
Medicare-Medicaid Alignment Initiative	2014	2015	2016	2017	2018	5-YEARS
ELIGIBLE MEMBER MONTHS	173,770	170,616	171,655	198,558	200,132	914,731
Department of Children and Family Services	2014	2015	2016	2017	2018	5-YEARS
ELIGIBLE MEMBER MONTHS	51,542	48,860	46,547	46,373	47,620	240,942
Special Needs Children	2014	2015	2016	2017	2018	5-YEARS
ELIGIBLE MEMBER MONTHS	37,666	32,709	31,866	43,430	43,979	189,650

Note: Historical time periods reflect 12 month period beginning April 1st of each year.

Costs, Fiscal Impact, and Funding Sources:

Information about each proposal in the Demonstration is provided below:

Extending postpartum coverage from 60 days to 12 months

For the extension of postpartum coverage from 60 days to 12 months, Milliman summarized expenditure data into two eligibility groups: 1) U.S. Citizens and Lawfully Present Residents (LPRs) meeting the five year waiting period and 2) LPRs in the five year waiting period. Capitation rates do not differ between these two groups due to immigration status. Due to HFS eligibility system changes, Milliman uses the distributions in the fifth year of the historical period between U.S. Citizens and LPRs who meet the five year waiting period and LPRs who do not meet the five year waiting period to allocate enrollment and cost experience in the first through fourth years of the historical period.

Expenditures under the 1115 waiver are primarily based on managed care capitation payments. Capitation expenditures in the first year of the demonstration are based on CY 2020 HealthChoice Illinois capitation rates. Capitation rates in the remaining four years of the demonstration have been assumed to increase by 3% annually.

Hypothetical estimates of expenditures were used in accordance with the August 22, 2018 State Medicaid Director Letter (SMD #18-009). As a result, Milliman’s estimates assume no variation in projected per capita costs between the without-waiver and with-waiver scenarios. However, Milliman notes that per capita savings are likely to occur from the postpartum eligibility extension as the waiver will result in lower capitation rates for adult females attributed to a lower proportion of covered members incurring maternity delivery services.

Additionally, because U.S. Citizens and qualified immigrants who lose Medicaid coverage after 60 days postpartum are currently eligible for Premium Tax Credits (PTCs) on the Marketplace, a Medicaid postpartum extension will result in savings to the federal government in addition to increasing continuity of care and providing continued access to care coordination support. For example, 2019, the average Marketplace PTC in Illinois was \$525 per month. In contrast, the weighted 2019 MCO rate for women ages 14 through 44 was \$279 per month. If Medicaid coverage is extended through 12 months postpartum, mothers eligible for the extended Medicaid coverage would no longer be eligible for Marketplace PTCs due to an offer of alternative minimum essential coverage (Medicaid); this results in aggregate savings to the federal government.

5 YEARS OF HISTORIC DATA						
SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:			April 1, 2018 through March 31, 2019			
Moms and Babies, Citizens and LPR Meeting 5 Year Requirement	2014	2015	2016	2017	2018	5-YEARS
TOTAL EXPENDITURES	\$ 1,522,956	\$ 1,595,146	\$ 1,477,261	\$ 1,492,431	\$ 2,104,066	\$ 8,191,860
ELIGIBLE MEMBER MONTHS	\$ 6,190	\$ 7,279	\$ 7,015	\$ 6,475	8,054	35,012
PMPM COST	\$ 246.02	\$ 219.15	\$ 210.60	\$ 230.50	\$ 261.25	\$ 233.97
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		4.74%	-7.39%	1.03%	40.98%	8.42%
ELIGIBLE MEMBER MONTHS		17.58%	-3.63%	-7.70%	24.39%	6.80%
PMPM COST		-10.92%	-3.90%	9.45%	13.34%	1.51%
Moms and Babies, LPR Under 5 Year Requirement	2014	2015	2016	2017	2018	5-YEARS
TOTAL EXPENDITURES	\$ 789,703	\$ 871,004	\$ 832,754	\$ 839,867	\$ 1,197,290	\$ 4,530,618
ELIGIBLE MEMBER MONTHS	\$ 3,558	\$ 4,184	\$ 4,032	\$ 3,721	4,629	20,124
PMPM COST	\$ 221.96	\$ 208.20	\$ 206.55	\$ 225.69	\$ 258.64	\$ 225.14
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		10.30%	-4.39%	0.85%	42.56%	10.96%
ELIGIBLE MEMBER MONTHS		17.58%	-3.63%	-7.70%	24.39%	6.80%
PMPM COST		-6.20%	-0.79%	9.26%	14.60%	3.90%

Note: Historical time periods reflect 12 month period beginning April 1st of each year.

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS										
ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
					CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	
Moms and Babies, Citizens and LPR Meeting 5 Year Requirement										
Pop Type: Medicaid										
Eligible Member Months	-0.5%	9	NA	-0.5%	11,754	23,831	23,712	23,593	23,475	
PMPM Cost	21.2%	9	NA	3.0%	\$ 365.98	\$ 376.96	\$ 388.27	\$ 399.92	\$ 411.92	
Total Expenditure				0	\$ 4,301,638	\$ 8,983,346	\$ 9,206,611	\$ 9,435,440	\$ 9,669,967	\$ 41,597,001
Moms and Babies, LPR Under 5 Year Requirement										
Pop Type: Medicaid										
Eligible Member Months	2.0%	9	NA	2.0%	7,055	14,665	14,958	15,257	15,562	
PMPM Cost	22.4%	9	NA	3.0%	\$ 368.37	\$ 379.42	\$ 390.80	\$ 402.52	\$ 414.60	
Total Expenditure				0	\$ 2,599,010	\$ 5,564,019	\$ 5,845,520	\$ 6,141,242	\$ 6,452,057	\$ 26,601,848

Note: There are 21 months between the midpoint of the last year of the historic period (October 1, 2018) and first demonstration year (July 1, 2020).

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS										
ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW		
			CY 2020	CY 2021	CY 2022	CY 2023	CY 2024			
Moms and Babies, Citizens and LPR Meeting 5 Year Requirement										
Pop Type: Medicaid										
Eligible Member Months	NA	-0.5%	11,754	23,831	23,712	23,593	23,475			
PMPM Cost	NA	3.0%	\$ 365.98	\$ 376.96	\$ 388.27	\$ 399.92	\$ 411.92			
Total Expenditure			\$ 4,301,638	\$ 8,983,346	\$ 9,206,611	\$ 9,435,440	\$ 9,669,967	\$ 41,597,001		
Moms and Babies, LPR Under 5 Year Requirement										
Pop Type: Medicaid										
Eligible Member Months	NA	2.0%	7,055	14,665	14,958	15,257	15,562			
PMPM Cost	NA	3.0%	\$ 368.37	\$ 379.42	\$ 390.80	\$ 402.52	\$ 414.60			
Total Expenditure			\$ 2,599,010	\$ 5,564,019	\$ 5,845,520	\$ 6,141,242	\$ 6,452,057	\$ 26,601,848		

Budget Neutrality Summary						
<u>Without-Waiver Total Expenditures</u>						
	DEMONSTRATION YEARS (DY)					TOTAL
	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	
Medicaid Populations						
Moms and Babies, Citizens and LPR Meeting 5 Year Requirement	\$ 4,301,638	\$ 8,983,346	\$ 9,206,611	\$ 9,435,440	\$ 9,669,967	\$ 41,597,001
Moms and Babies, LPR Under 5 Year Requirement	\$ 2,599,010	\$ 5,564,019	\$ 5,845,520	\$ 6,141,242	\$ 6,452,057	\$ 26,601,848
TOTAL	\$ 6,900,648	\$ 14,547,365	\$ 15,052,130	\$ 15,576,682	\$ 16,122,024	\$ 68,198,849
<u>With-Waiver Total Expenditures</u>						
	DEMONSTRATION YEARS (DY)					TOTAL
	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	
Medicaid Populations						
Moms and Babies, Citizens and LPR Meeting 5 Year Requirement	\$ 4,301,638	\$ 8,983,346	\$ 9,206,611	\$ 9,435,440	\$ 9,669,967	\$ 41,597,001
Moms and Babies, LPR Under 5 Year Requirement	\$ 2,599,010	\$ 5,564,019	\$ 5,845,520	\$ 6,141,242	\$ 6,452,057	\$ 26,601,848
TOTAL	\$ 6,900,648	\$ 14,547,365	\$ 15,052,130	\$ 15,576,682	\$ 16,122,024	\$ 68,198,849
VARIANCE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Managed care reinstatement when a Medicaid beneficiary submits late redetermination paperwork within 90 days & Waiving HPE

The policies to reinstate beneficiaries into their prior MCO due to late redetermination paperwork within 90 days and waiving HPE will not have an impact on the number of individuals enrolled in Medicaid coverage. The first only impacts the number of months Medicaid beneficiaries are enrolled in Medicaid MCOs instead of Medicaid FFS and costs are considered hypothetical per SMD #18-009. Removing HPE requirements also would not change Medicaid eligibility for anyone; it merely promotes the use of traditional application methods. Additionally, because Illinois has yet to implement HPE, waiving the implementation and administration of a new HPE program prevents new Medicaid costs for Illinois; costs are considered hypothetical per SMD #18-009.

In the tables below expenditures and member months reflect beneficiaries served in FFS and MCOs. For beneficiaries enrolled in MCOs, capitation payments exclude pass-through and supplemental payment amounts, as well as any directed payments made outside of the capitation rates for services incurred by managed care beneficiaries. FFS expenditures reflect direct claim experience. FFS expenditures reflect direct claim experience.

5 YEARS OF HISTORIC DATA						
SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:						
	April 1, 2014 through March 31, 2019					
Affordable Care Act Adults	2014	2015	2016	2017	2018	5-YEARS
TOTAL EXPENDITURES	\$ 1,976,517,186	\$ 2,780,801,999	\$ 2,800,538,918	\$ 2,764,858,064	\$ 2,734,248,872	\$ 13,056,965,038
ELIGIBLE MEMBER MONTHS	\$ 5,808,151	\$ 7,306,771	\$ 7,354,532	\$ 7,151,246	6,623,161	34,243,861
PMPM COST	\$ 340.30	\$ 380.58	\$ 380.79	\$ 386.63	\$ 412.83	\$ 381.29
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		40.69%	0.71%	-1.27%	-1.11%	8.45%
ELIGIBLE MEMBER MONTHS		25.80%	0.65%	-2.76%	-7.38%	3.34%
PMPM COST		11.84%	0.06%	1.53%	6.78%	4.95%
Disabled Adults	2014	2015	2016	2017	2018	5-YEARS
TOTAL EXPENDITURES	\$ 2,548,590,235	\$ 2,529,366,973	\$ 2,601,553,803	\$ 2,760,711,850	\$ 2,982,478,609	\$ 13,422,701,470
ELIGIBLE MEMBER MONTHS	\$ 1,751,164	\$ 1,738,010	\$ 1,751,380	\$ 1,803,617	1,961,563	9,005,734
PMPM COST	\$ 1,455.37	\$ 1,455.32	\$ 1,485.43	\$ 1,530.65	\$ 1,520.46	\$ 1,490.46
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		-0.75%	2.85%	6.12%	8.03%	4.01%
ELIGIBLE MEMBER MONTHS		-0.75%	0.77%	2.98%	8.76%	2.88%
PMPM COST		0.00%	2.07%	3.04%	-0.67%	1.10%
Non-disabled Children and Adults	2014	2015	2016	2017	2018	5-YEARS
TOTAL EXPENDITURES	\$ 4,222,883,783	\$ 4,319,144,735	\$ 4,356,104,624	\$ 4,314,378,847	\$ 4,141,940,027	\$ 21,354,452,016
ELIGIBLE MEMBER MONTHS	\$ 23,915,776	\$ 23,042,704	\$ 22,517,029	\$ 21,938,166	20,942,543	112,356,218
PMPM COST	\$ 176.57	\$ 187.44	\$ 193.46	\$ 196.66	\$ 197.78	\$ 190.06
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		2.28%	0.86%	-0.96%	-4.00%	-0.48%
ELIGIBLE MEMBER MONTHS		-3.65%	-2.28%	-2.57%	-4.54%	-3.26%
PMPM COST		6.15%	3.21%	1.66%	0.57%	2.88%
Managed Long Term Services and Supports	2014	2015	2016	2017	2018	5-YEARS
TOTAL EXPENDITURES	\$ 1,724,009,204	\$ 1,503,103,535	\$ 1,628,875,629	\$ 1,673,773,089	\$ 1,707,219,322	\$ 8,236,980,779
ELIGIBLE MEMBER MONTHS	\$ 845,425	\$ 748,866	\$ 775,605	\$ 789,538	795,077	3,954,511
PMPM COST	\$ 2,039.22	\$ 2,007.17	\$ 2,100.14	\$ 2,119.94	\$ 2,147.24	\$ 2,082.93
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		-12.81%	8.37%	2.76%	2.00%	-0.24%
ELIGIBLE MEMBER MONTHS		-11.42%	3.57%	1.80%	0.70%	-1.52%
PMPM COST		-1.57%	4.63%	0.94%	1.29%	1.30%
Medicare-Medicaid Alignment Initiative	2014	2015	2016	2017	2018	5-YEARS
TOTAL EXPENDITURES	\$ 363,252,206	\$ 566,706,764	\$ 539,806,906	\$ 533,461,552	\$ 544,411,876	\$ 2,547,639,304
ELIGIBLE MEMBER MONTHS	\$ 1,639,359	\$ 1,731,969	\$ 1,749,597	\$ 1,896,103	1,983,249	9,000,277
PMPM COST	\$ 221.58	\$ 327.20	\$ 308.53	\$ 281.35	\$ 274.51	\$ 283.06
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		56.01%	-4.75%	-1.18%	2.05%	10.64%
ELIGIBLE MEMBER MONTHS		5.65%	1.02%	8.37%	4.60%	4.88%
PMPM COST		47.67%	-5.71%	-8.81%	-2.43%	5.50%
Department of Children and Family Services	2014	2015	2016	2017	2018	5-YEARS
TOTAL EXPENDITURES	\$ 205,764,013	\$ 189,428,866	\$ 183,966,072	\$ 180,660,499	\$ 184,810,332	\$ 944,629,783
ELIGIBLE MEMBER MONTHS	\$ 506,685	\$ 485,368	\$ 464,867	\$ 454,970	458,803	2,370,693
PMPM COST	\$ 406.10	\$ 390.28	\$ 395.74	\$ 397.08	\$ 402.81	\$ 398.46
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		-7.94%	-2.88%	-1.80%	2.30%	-2.65%
ELIGIBLE MEMBER MONTHS		-4.21%	-4.22%	-2.13%	0.84%	-2.45%
PMPM COST		-3.90%	1.40%	0.34%	1.44%	-0.20%
Special Needs Children	2014	2015	2016	2017	2018	5-YEARS
TOTAL EXPENDITURES	\$ 303,726,219	\$ 238,432,852	\$ 258,196,929	\$ 289,153,464	\$ 312,751,459	\$ 1,402,260,924
ELIGIBLE MEMBER MONTHS	\$ 424,585	\$ 361,007	\$ 358,167	\$ 397,548	479,081	2,020,388
PMPM COST	\$ 715.35	\$ 660.47	\$ 720.88	\$ 727.34	\$ 652.82	\$ 694.06
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		-21.50%	8.29%	11.99%	8.16%	0.73%
ELIGIBLE MEMBER MONTHS		-14.97%	-0.79%	11.00%	20.51%	3.06%
PMPM COST		-7.67%	9.15%	0.90%	-10.25%	-2.26%

Note: Historical time periods reflect 12 month period beginning April 1st of each year.

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS										
ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
					CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	
Affordable Care Act Adults										
Pop Type: Medicaid										
Eligible Member Months	-0.5%	9	NA	-0.5%	6,557,095	6,524,309	6,491,688	6,459,230	6,426,933	
PMPM Cost	12.4%	9	NA	3.0%	\$ 506.70	\$ 521.90	\$ 537.56	\$ 553.69	\$ 570.30	
Total Expenditure					\$ 3,322,491,738	\$ 3,405,037,123	\$ 3,489,671,769	\$ 3,576,410,782	\$ 3,665,280,090	\$ 17,458,891,501
Disabled Adults										
Pop Type: Medicaid										
Eligible Member Months	1.0%	9	NA	1.0%	2,000,990	2,021,000	2,041,210	2,061,622	2,082,239	
PMPM Cost	5.4%	9	NA	3.0%	\$ 1,668.18	\$ 1,718.22	\$ 1,769.77	\$ 1,822.86	\$ 1,877.55	
Total Expenditure					\$ 3,338,004,247	\$ 3,472,523,170	\$ 3,612,472,788	\$ 3,758,049,045	\$ 3,909,507,159	\$ 18,090,556,408
Non-disabled Children and Adults										
Pop Type: Medicaid										
Eligible Member Months	-0.5%	9	NA	-0.5%	20,733,641	20,629,973	20,526,823	20,424,189	20,322,068	
PMPM Cost	4.5%	9	NA	3.0%	\$ 213.44	\$ 219.84	\$ 226.44	\$ 233.23	\$ 240.23	
Total Expenditure					\$ 4,425,417,391	\$ 4,535,293,249	\$ 4,648,093,816	\$ 4,763,533,589	\$ 4,881,970,398	\$ 23,254,308,443
Managed Long Term Services and Supports										
Pop Type: Medicaid										
Eligible Member Months	2.0%	9	NA	2.0%	827,198	843,742	860,617	877,829	895,386	
PMPM Cost	12.4%	9	NA	3.0%	\$ 2,633.41	\$ 2,712.41	\$ 2,793.78	\$ 2,877.59	\$ 2,963.92	
Total Expenditure					\$ 2,178,350,853	\$ 2,288,574,428	\$ 2,404,374,311	\$ 2,526,032,672	\$ 2,653,851,999	\$ 12,051,184,262
Medicare-Medicaid Alignment Initiative										
Pop Type: Medicaid										
Eligible Member Months	2.0%	9	NA	2.0%	2,063,372	2,104,640	2,146,732	2,189,667	2,233,460	
PMPM Cost	10.4%	9	NA	3.0%	\$ 326.48	\$ 336.28	\$ 346.37	\$ 356.76	\$ 367.46	
Total Expenditure					\$ 673,654,759	\$ 707,748,238	\$ 743,563,733	\$ 781,185,649	\$ 820,707,388	\$ 3,726,859,767
Department of Children and Family Services										
Pop Type: Medicaid										
Eligible Member Months	0.0%	9	NA	0.0%	458,803	458,803	458,803	458,803	458,803	
PMPM Cost	6.3%	9	NA	3.0%	\$ 445.97	\$ 459.35	\$ 473.13	\$ 487.32	\$ 501.94	
Total Expenditure					\$ 204,614,416	\$ 210,751,158	\$ 217,073,463	\$ 223,583,878	\$ 230,291,578	\$ 1,086,314,493
Special Needs Children										
Pop Type: Medicaid										
Eligible Member Months	0.0%	9	NA	0.0%	479,081	479,081	479,081	479,081	479,081	
PMPM Cost	10.4%	9	NA	3.0%	\$ 770.21	\$ 793.32	\$ 817.12	\$ 841.63	\$ 866.88	
Total Expenditure					\$ 368,993,727	\$ 380,064,539	\$ 391,466,667	\$ 403,208,942	\$ 415,305,737	\$ 1,959,039,612

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS								
ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	
Affordable Care Act Adults								
Pop Type: Medicaid								
Eligible Member Months	NA	-0.5%	6,557,095	6,524,309	6,491,688	6,459,230	6,426,933	
PMPM Cost	NA	3.0%	\$ 506.70	\$ 521.90	\$ 537.56	\$ 553.69	\$ 570.30	
Total Expenditure			\$ 3,322,491,738	\$ 3,405,037,123	\$ 3,489,671,769	\$ 3,576,410,782	\$ 3,665,280,090	\$ 17,458,891,501
Disabled Adults								
Pop Type: Medicaid								
Eligible Member Months	NA	1.0%	2,000,990	2,021,000	2,041,210	2,061,622	2,082,239	
PMPM Cost	NA	3.0%	\$ 1,668.18	\$ 1,718.22	\$ 1,769.77	\$ 1,822.86	\$ 1,877.55	
Total Expenditure			\$ 3,338,004,247	\$ 3,472,523,170	\$ 3,612,472,788	\$ 3,758,049,045	\$ 3,909,507,159	\$ 18,090,556,408
Non-disabled Children and Adults								
Pop Type: Medicaid								
Eligible Member Months	NA	-0.5%	20,733,641	20,629,973	20,526,823	20,424,189	20,322,068	
PMPM Cost	NA	3.0%	\$ 213.44	\$ 219.84	\$ 226.44	\$ 233.23	\$ 240.23	
Total Expenditure			\$ 4,425,417,391	\$ 4,535,293,249	\$ 4,648,093,816	\$ 4,763,533,589	\$ 4,881,970,398	\$ 23,254,308,443
Managed Long Term Services and Supports								
Pop Type: Medicaid								
Eligible Member Months	NA	2.0%	827,198	843,742	860,617	877,829	895,386	
PMPM Cost	NA	3.0%	\$ 2,633.41	\$ 2,712.41	\$ 2,793.78	\$ 2,877.59	\$ 2,963.92	
Total Expenditure			\$ 2,178,350,853	\$ 2,288,574,428	\$ 2,404,374,311	\$ 2,526,032,672	\$ 2,653,851,999	\$ 12,051,184,262
Medicare-Medicaid Alignment Initiative								
Pop Type: Medicaid								
Eligible Member Months	NA	2.0%	2,063,372	2,104,640	2,146,732	2,189,667	2,233,460	
PMPM Cost	NA	3.0%	\$ 326.48	\$ 336.28	\$ 346.37	\$ 356.76	\$ 367.46	
Total Expenditure			\$ 673,654,759	\$ 707,748,238	\$ 743,563,733	\$ 781,185,649	\$ 820,707,388	\$ 3,726,859,767
Department of Children and Family Services								
Pop Type: Medicaid								
Eligible Member Months	NA	0.0%	458,803	458,803	458,803	458,803	458,803	
PMPM Cost	NA	3.0%	\$ 445.97	\$ 459.35	\$ 473.13	\$ 487.32	\$ 501.94	
Total Expenditure			\$ 204,614,416	\$ 210,751,158	\$ 217,073,463	\$ 223,583,878	\$ 230,291,578	\$ 1,086,314,493
Special Needs Children								
Pop Type: Medicaid								
Eligible Member Months	NA	0.0%	479,081	479,081	479,081	479,081	479,081	
PMPM Cost	NA	3.0%	\$ 770.21	\$ 793.32	\$ 817.12	\$ 841.63	\$ 866.88	
Total Expenditure			\$ 368,993,727	\$ 380,064,539	\$ 391,466,667	\$ 403,208,942	\$ 415,305,737	\$ 1,959,039,612

Budget Neutrality Summary						
Without-Waiver Total Expenditures						
	DEMONSTRATION YEARS (DY)					TOTAL
	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	
Medicaid Populations						
Affordable Care Act Adults	\$ 3,322,491,738	\$ 3,405,037,123	\$ 3,489,671,769	\$ 3,576,410,782	\$ 3,665,280,090	\$ 17,458,891,501
Disabled Adults	3,338,004,247	3,472,523,170	3,612,472,788	3,758,049,045	3,909,507,159	18,090,556,408
Non-disabled Children and Adults	4,425,417,391	4,535,293,249	4,648,093,816	4,763,533,589	4,881,970,398	23,254,308,443
Managed Long Term Services and Supports	2,178,350,853	2,288,574,428	2,404,374,311	2,526,032,672	2,653,851,999	12,051,184,262
Medicare-Medicaid Alignment Initiative	673,654,759	707,748,238	743,563,733	781,185,649	820,707,388	3,726,859,767
Department of Children and Family Services	204,614,416	210,751,158	217,073,463	223,583,878	230,291,578	1,086,314,493
Special Needs Children	368,993,727	380,064,539	391,466,667	403,208,942	415,305,737	1,959,039,612
TOTAL	\$ 14,511,527,131	\$ 14,999,991,905	\$ 15,506,716,547	\$ 16,032,004,556	\$ 16,576,914,348	\$ 77,627,154,486
With-Waiver Total Expenditures						
	DEMONSTRATION YEARS (DY)					TOTAL
	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	
Medicaid Populations						
Affordable Care Act Adults	\$ 3,322,491,738	\$ 3,405,037,123	\$ 3,489,671,769	\$ 3,576,410,782	\$ 3,665,280,090	\$ 17,458,891,501
Disabled Adults	3,338,004,247	3,472,523,170	3,612,472,788	3,758,049,045	3,909,507,159	18,090,556,408
Non-disabled Children and Adults	4,425,417,391	4,535,293,249	4,648,093,816	4,763,533,589	4,881,970,398	23,254,308,443
Managed Long Term Services and Supports	2,178,350,853	2,288,574,428	2,404,374,311	2,526,032,672	2,653,851,999	12,051,184,262
Medicare-Medicaid Alignment Initiative	673,654,759	707,748,238	743,563,733	781,185,649	820,707,388	3,726,859,767
Department of Children and Family Services	204,614,416	210,751,158	217,073,463	223,583,878	230,291,578	1,086,314,493
Special Needs Children	368,993,727	380,064,539	391,466,667	403,208,942	415,305,737	1,959,039,612
TOTAL	\$ 14,511,527,131	\$ 14,999,991,905	\$ 15,506,716,547	\$ 16,032,004,556	\$ 16,576,914,348	\$ 77,627,154,486
VARIANCE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Financing Sources

Illinois will use General Revenue Funds to fund the state share of the postpartum extension. Illinois is seeking a federal match through this 1115 waiver proposal. Funding for the state share of this coverage extension was provided through Public Act 101-0010, which is the state’s budget implementation act.

Additionally, Illinois seeks to use HSI funding to extend coverage for qualified immigrants in their five-year waiting period from 60 days to 12 months postpartum. This funding source is currently used to fund postpartum coverage for this population through 60 days postpartum.

The proposals to allow managed care reinstatements when Medicaid beneficiaries submit late redetermination paperwork within 90 days and waiving HPE do generate new costs, as discussed in previous sections of this application.

Program Implementation:

Concurrent Federal Authorities

The state does not require other concurrent federal authorities (e.g., state plan amendments, section 1915 waivers) to achieve its section 1115 demonstration goals.

Initial Implementation Plans

HFS plans to implement the demonstration without a phase-in approach shortly after receiving federal CMS approval. The proposal to extend coverage from 60 days to 12 months postpartum requires

system reprogramming of the eligibility system, and the proposal to reinstate Medicaid beneficiaries into their prior Medicaid MCO after submitting late redetermination paperwork within 90 days requires system reprogramming in the Medicaid Management Information System (MMIS) and the HFS Client Enrollment Broker. Currently, HFS is not implementing HPE, so no system changes are needed if it is waived. However, implementation of HPE if the waiver is not granted will require substantial modifications to the eligibility system which would impede the state’s ability to implement other state eligibility priorities, including efforts to improve the performance of state systems.

Additionally, the proposal to extend coverage from 60 days to 12 months postpartum continues current coverage for enrollees, so their coverage will continue without a special notification. Medicaid beneficiaries who are reinstated into their prior MCO after submitting late redetermination paperwork within 90 days will receive a Welcome Packet from their Medicaid MCO when they are reinstated into it; this is the same process that occurs when late redetermination paperwork is processed within 60 days today. HFS currently is not implementing HPE, so no new notifications/enrollments are needed if it is waived.

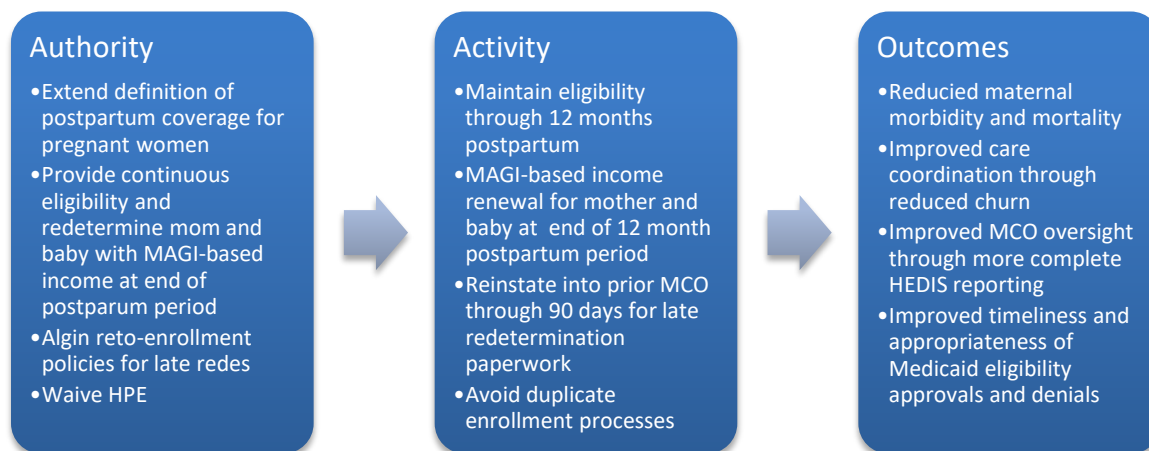
The Demonstration does not require new MCO procurement action. Under the Demonstration, coverage under MCOs will occur within HFS’s current MCO infrastructure.

Evaluation:

The demonstration evaluation will utilize a pre/post comparison for all three initiatives. The table below presents an overview of the hypotheses and goals associated with each waiver policy. In regards to the logic model, most metrics below will begin being measured immediately, however, the maternal morbidity and mortality results from DPH Committee analysis will be a long-term metric due to the data lag.

A basic logic model and chart describing the goals, hypothesis, and metrics for the waiver proposals are included below.

High-Level Logic Model



Goals, Hypothesis, and Metrics

Goal	Hypothesis	Metrics
Reduce maternal morbidity and mortality in Illinois.	Extending eligibility for pregnant women from 60 days to 12 months postpartum will reduce maternal morbidity and mortality in Illinois by providing continued MCO care coordination and continuity in provider networks at a medically vulnerable time.	Number of women between 139-213% FPL who retained coverage. Maternal morbidity and mortality results from DPH Committee analysis (long-term metric due to data lag).
	Extending eligibility for pregnant women from 60 days to 12 months postpartum will reduce maternal morbidity and mortality in Illinois by allowing HFS to leverage its MCO performance management infrastructure to improve health outcomes for postpartum women.	MCO performance reporting metrics. <i>Example: Women receiving a second postpartum depression screening.</i>
Increase continuity of coverage and improve MCO quality oversight by minimizing churn between Medicaid FFS and Medicaid managed care.	Allowing a 90 day reinstatement period into the prior MCO will increase continuity of care by preventing gaps in MCO coverage and care coordination support.	Number of reinstatements into MCOs.
	Allowing a 90 day reinstatement period into the prior MCO will allow for more complete MCO quality measurement through HEDIS reporting.	MCO enrollees meeting HEDIS 12 month continuous enrollment standard.
Promote continuity of care through full benefit Medicaid applications and improved application processing times.	Waiving HPE will continue to promote hospitals assisting with full benefit Medicaid applications.	Medicaid approval and denial rates.
	Waiving HPE will allow HFS to continue to improve application processing times by promoting the submission of full Medicaid applications and preventing the need for duplicative HPE applications.	Application processing backlog and turnaround time.

The MCO performance reporting metrics within the postpartum proposal will include targets set by the state after baselines have been established. The state will collaborate with DPH and Medicaid MCOs to determine if reporting results by race/ethnicity is possible to better address and evaluate health outcomes and disparities.

Illinois will continue to work with stakeholders to develop a full list of MCO performance reporting metrics for the postpartum extension. An example of a metric Illinois anticipates using is the number of women with a second depression screening during the postpartum period. This metric has established data definitions through HEDIS and, if done with a pre-approved postpartum depression screening tool,

can be completed by the mother's primary care provider, the mother's OBGYN, the infant's pediatrician, or an appropriately certified home health provider as long as the mother has Medicaid coverage at the time of the screen. This metric provides the Medicaid MCO with a variety of tools to increase results and health outcomes.

Independent Demonstration Evaluation

The state has engaged the University of Illinois Office of Medicaid Innovation (OMI) to serve as the independent evaluator and complete a fair and conflict-free objective evaluation of whether the demonstration was implemented as planned, whether the intended performance outcomes were reached, and the major challenges and successful strategies associated with program implementation. OMI currently provides HFS with clinical and technical support through an intergovernmental agreement, and has previously supported the state with an independent evaluation for an 1115 waiver. OMI has access to the Illinois Department of Healthcare and Family Services' (HFS') data warehouse, as well as the expertise to access and evaluate all relevant data. As a public research university, OMI will conduct the evaluation with full academic independence.

The state also is planning to submit a proposal for the National Governors Association Center for Best Practices Health Division (NGA Health) "Building State Capacity to Evaluate Innovative Medicaid Policies" project, which will announce selections the week of January 20, 2020. If selected, Illinois would receive additional technical assistance from NGA Health and the State Health Access Data Assistance Center (SHADAC) to further develop its logic model, data collection approach, and monitoring and evaluation plans to assess the cost and health impacts of the demonstration with the goal of informing future decision-making at the state and federal levels.

Evaluation Design

The draft evaluation design below provides additional detail about further hypotheses and research questions the state is considering based on initial conversations with OMI. A more detailed description of the independent evaluation will be developed by OMI pursuant to the requirements Special Terms and Conditions provided by federal CMS.

Hypothesis 1A – Extending eligibility from 60 days to 12 months postpartum should reduce maternal morbidity and mortality.

Evaluating, Data Sources and Isolating Dependent Variables: Evaluators will identify mothers who lost eligibility during the postpartum period prior to the policy change and use available data to assess their health outcomes compared to women who maintained eligibility through the postpartum period. Evaluators will use paid claims, MCO encounter records and vital statistics from the Illinois Department of Public Health to assess the differences between the two groups.

Hypothesis 1B – Twelve months postpartum eligibility should reduce costs through improved health outcomes and a reduction in repeat pregnancies.

Evaluating, Data Sources and Isolating Dependent Variables: Using paid claims and encounter records from the groups described above, evaluators will quantify differences in costs between the two groups and measure the effect on savings as a result of improved health outcomes and savings through the spacing of future pregnancies and birth outcomes.

Hypothesis 2A – Allowing a 90 day reinstatement period into the prior MCO should improve the quality of care provided by MCOs.

Evaluating, Data Sources and Isolating Dependent Variables: The hypothesis will be assessed using paid claims, MCO encounter records and contractual reporting requirements to compare MCO performance before and after the policy change. The pre-change group will include clients who are dis-enrolled and re-enrolled into MCOs prior to the change, taking into account those that switched to a different MCO after their Medicaid FFS reinstatement. Continuity of care and care coordination will be compared to those who re-applied after the 60th day and retained enrollment in the same MCO. The quality impact will also be evaluated using HEDIS reporting and benchmarks.

Hypothesis 2B – Allowing a 90 day reinstatement period into the prior MCO should result in a savings through improved continuity of care.

Evaluating, Data Sources and Isolating Dependent Variables: Using the same comparison groups from 2A, the value of encounter records and paid claims will be used to identify any cost savings as a result of the policy change. Comparisons will include the identification and costs associated with unnecessary, duplicative, or avoidable services resulting from a change in MCOs.

Hypothesis 3 – The elimination of Hospital Presumptive Eligibility (HPE) should result in more efficient determinations of Medicaid Eligibility.

Evaluating, Data Sources and Isolating Dependent Variables: Medicaid eligibility is determined through the Illinois Department of Human Services and the Department of Healthcare and Family Services. While HPE has not been implemented, eliminating the mandate will allow Illinois to promote continuity of care by continuing to promote the use of full benefit Medicaid applications and by avoiding the need for duplicative applications and the other administrative complexities associated with HPE. Evaluative measures should include progress in improving application processing timeframes and maintaining or improving approval rates for full Medicaid applications.

State Public Notice and Input Process prior to submission to CMS:

As part of the stakeholder engagement process required within the development of this Section 1115 Demonstration Waiver, Illinois sought consultation with stakeholders including state, county, and local officials and health care providers, health care payers, patients, and their families. The state gathered input during the required public comment period from November 27, 2019 through December 27, 2019 at 5pm Central Time. Comments received within the public comment period were reviewed and revisions to the waiver application were considered.

The state published public notices in newspapers and distributed them through the HFS listserve on November 27, 2019. During the public comment period, the state held two public hearings and host a dedicated website. The dedicated website has hyperlinks to the public notices, the Section 1115 waiver application narrative, as well as the public hearing presentation.

The public hearings on the waiver were held on:

- Monday, December 9, 2019, 10am to 12pm, Illinois Department of Healthcare and Family Services, 1st Floor Video Conference Room, 401 S. Clinton Street, Chicago, IL 60607
 - There was also be a conference line option for this meeting: Dial-In Number: 877-226-8163; Access Code: 904010
- Tuesday, December 10, 2019, 10am to 12pm, Memorial Center for Learning and Innovation, 2A Curtis Theatre Classroom, 228 W. Miller Street, Springfield, IL 62702

During the public hearings, the state solicited input on the proposed waiver and accepted verbal and/or written comments and questions. The state continued to solicit input through comments submitted to hfs.bpra@illinois.gov. Stakeholders also had the option of submitting comments via mail at Illinois Department of Healthcare and Family Services, Division of Medical Programs, Bureau of Program and Policy Coordination, 201 South Grand Avenue East, Springfield, IL 62794. The state did not receive any comments by mail, but it did receive multiple comments from stakeholders after the public hearings through the dedicated email address.

During the approval process and upon approval from CMS, the State will continue to seek stakeholder input through stakeholder engagement and spreading awareness about the proposed system improvements.

Copy of the State’s Full Public Notice

**Notice of Public Information
Illinois Department of Healthcare and Family Services
Section 1115 Research and Demonstration Waiver**

The Illinois Department of Healthcare and Family Services (HFS) is providing public notice of its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a written application to request approval of a Section 1115 Research and Demonstration Waiver and to hold public hearings to receive comments on this proposal pursuant to Title 42, Section 431.408, Code of Federal Regulations.

Program Description, Goals, and Objectives

This demonstration application seeks to improve health outcomes through the promotion of continuity of care while also promoting administrative simplifications for the Illinois Medicaid program. The following initiatives will help the Department achieve these goals:

1) Extending postpartum coverage from 60 days to 12 months

Illinois proposes to extend Medicaid coverage for women in the pregnant women category of eligibility from 60 days postpartum to 12 months postpartum. The extended postpartum coverage is for full Medicaid benefits for women up to 200% of the federal poverty level (FPL), which is the income threshold for the Medicaid pregnant women category of eligibility in Illinois.

Illinois also proposes to align continuous eligibility for the mom and baby so that both are eligible through 12 months after delivery. Additionally, if a woman applies during the 12 month postpartum period, Illinois proposes enrolling her in the pregnant women category of eligibility for the remainder of her 12 month postpartum period.

The goal of this proposal is to reduce maternal morbidity and mortality in Illinois by providing additional health care access and care coordination support to new mothers during the entire medically-vulnerable postpartum period.

2) Managed care reinstatement within 90 days

The state proposes to allow Medicaid beneficiaries to be retro-enrolled into their prior Medicaid MCO within 90 days of losing Medicaid coverage due to late submission of a renewal form. Federal requirements limit reinstatement to 60 days.

The goal of this proposal is to minimize churn between Medicaid Fee-for-Service (FFS) and managed care to increase continuity of coverage and improve MCO quality oversight. This policy will not have an impact on the number of individuals eligible for Medicaid; it only impacts the number of months Medicaid beneficiaries are enrolled in Medicaid MCOs versus Medicaid FFS.

3) Waiving Hospital Presumptive Eligibility

Illinois proposes to waive the requirement to permit hospitals to make presumptive eligibility determinations. The waiver request will include the removal of all six required Hospital Presumptive Eligibility (HPE) groups: children, pregnant women, former foster care, parent or caretaker relatives, breast and cervical cancer, and single adults made eligible under the Affordable Care Act. Removal of HPE requirements would not impact Medicaid eligibility requirements for these six groups; they all would remain eligible with the same requirements that exist today.

The goal of this proposal is to promote continuity of care with full benefit Medicaid applications and reduced processing times by avoiding the administrative complexities involved with HPE.

Healthcare Delivery System

1) Extending postpartum coverage

In Illinois, women who are eligible for Medicaid benefits under the pregnant women category generally are enrolled in Medicaid Managed Care Organizations (MCOs). Extending coverage from 60 days to 12 months postpartum gives Medicaid MCOs the ability to provide care coordination and support for both the mother and baby during the pregnancy, labor and delivery, and the entire postpartum period.

Care coordination is provided through Medicaid MCOs, but it is not a covered benefit under the Health Insurance Marketplace Qualified Health Plans. Additionally, an extension of Medicaid coverage through 12 months postpartum maximizes continuity of care by allowing women to keep seeing the doctors they saw throughout their pregnancy and the first 60 days postpartum period without a gap or transition of care during a medically vulnerable time.

2) Managed care reinstatement within 90 days

Late submissions that are not processed within 60 days currently result in Medicaid beneficiaries being reinstated in Medicaid FFS despite most of these beneficiaries being enrolled in a Medicaid MCO at the time their Medicaid eligibility terminated. This proposal prevents disruptions in care, otherwise known as “churning,” at a systemic level, which can be challenging for beneficiaries and MCOs managing individual care needs. Churning disrupts communication with care coordinators, creates potential confusion at the beneficiary and provider level over standing prior authorizations and transportation arrangements, and can create gaps in claims history for MCOs monitoring members’ care.

3) Waiving Hospital Presumptive Eligibility

HPE coverage is, at its essence, temporary coverage and does not align with Illinois' promotion of continuity of care. The state instead wishes to encourage applications for full Medicaid coverage, allowing a client to have coverage as long as they remain eligible. While HPE applications may be followed by a full Medicaid application, the process does not incentivize the hospital or client to submit a follow-up application once the hospital stay is covered through HPE.

Eligibility Requirements

1) Extending postpartum coverage

Illinois proposes to extend Medicaid coverage for women up to 200% FPL in the pregnant women category of eligibility from 60 days postpartum to 12 months postpartum. Additionally, Illinois seeks to align continuous eligibility for the mom and baby to be 12 months after delivery. Extending continuous eligibility for the full postpartum period allows the mother's healthcare needs to continue uninterrupted and allows Illinois to redetermine the mom and baby at the same time, creating efficiencies for caseworkers.

2) Managed care reinstatement within 90 days

This policy will not have an impact on the number of individuals eligible for Medicaid; it only impacts the number of months Medicaid beneficiaries are enrolled in Medicaid managed care in place of Medicaid FFS.

3) Waiving Hospital Presumptive Eligibility

Removing HPE requirements would not change Medicaid eligibility for anyone; it merely promotes the use of traditional application methods.

Benefits and Cost-Sharing Requirements

This 1115 waiver does not change the Medicaid benefit package design; there is no new cost-sharing, copayments, or coinsurance for any benefit provided under the waiver. State Plan benefits will continue to be applied in accordance with the State Plan and all eligibility groups will continue to receive all State Plan benefits.

Enrollment and Expenditures

1) Extending postpartum coverage

HFS estimates that extending coverage through the full 12 month postpartum period with continuous eligibility will result in coverage of an additional 55,788 postpartum member months per year for U.S. Citizens, an additional 1,211 postpartum member months qualified immigrants who meet the five year waiting period, and an additional 5,933 postpartum member months for qualified immigrants in their five year waiting period.

Costs for U.S. Citizens and qualified immigrants who meet the five year waiting period are considered hypothetical per the August 22, 2018 State Medicaid Director Letter (SMD #18-009). Qualified immigrants in their five-year waiting period are currently covered in the pregnant women category of eligibility 60 days postpartum using Health Services Initiative (HSI) funding. Illinois seeks to use HSI

funding to extend coverage for qualified immigrants in their five-year waiting period from 60 days to 12 months postpartum; the total estimated new liability is about \$2.1 million.

Additionally, because U.S. Citizens and qualified immigrants who lose Medicaid coverage after 60 days postpartum are currently eligible for Premium Tax Credits (PTCs) on the Marketplace, a Medicaid postpartum extension will result in savings to the federal government in addition to increasing continuity of care and providing continued access to care coordination support. In 2019, the average Marketplace PTC in Illinois was \$525 per month. In contrast, the weighted 2019 MCO rate for women ages 14 through 44 was \$279 per month. If Medicaid coverage is extended through 12 months postpartum, mothers eligible for the extended coverage would no longer be eligible for Marketplace PTCs due to an offer of alternative minimum essential coverage (Medicaid), resulting in aggregate savings to the federal government.

2) Managed care reinstatement within 90 days

This policy will not have an impact on the number of individuals enrolled in Medicaid coverage; it only impacts the number of months Medicaid beneficiaries are enrolled in Medicaid MCOs instead of Medicaid FFS. Costs are considered hypothetical per SMD #18-009.

3) Waiving Hospital Presumptive Eligibility

Removing HPE requirements would not change Medicaid eligibility for anyone; it merely promotes the use of traditional application methods. Additionally, because Illinois has yet to implement HPE, waiving the implementation and administration of a new HPE program prevents new Medicaid costs for Illinois. Costs are considered hypothetical per SMD #18-009.

Hypothesis and Evaluation

Overview of the hypotheses and goals associated with each waiver policy.

Goal 1: Reduce maternal morbidity and mortality in Illinois.

Hypothesis: Extending eligibility for pregnant women from 60 days to 12 months postpartum will reduce maternal morbidity and mortality by 1) providing continued MCO care coordination and continuity in provider networks at a medically vulnerable time, and 2) allowing HFS to leverage its MCO performance management infrastructure to improve health outcomes for postpartum women.

Goal 2: Minimize churn between Medicaid MCOs and FFS to increase continuity of coverage and improve MCO quality oversight.

Hypothesis: Allowing a 90 day reinstatement period will 1) increase continuity of care by preventing gaps in MCO coverage with care coordination support, and 2) allow for more complete MCO quality measurement through HEDIS reporting.

Goal 3: Promote continuity of care through full benefit Medicaid applications and improved application processing times.

Hypothesis: Waiving HPE will promote full Medicaid benefit coverage by 1) continuing to promote hospitals assisting with full benefit Medicaid applications, and 2) allowing HFS to continue to improve application processing times by preventing the need for duplicative HPE applications.

Waiver and Expenditure Authorities

The State requests the following waivers:

1. Waiver of § 1902(a)(10)(A) and 1902(e)(5) and (6), to the extent necessary, to extend eligibility for pregnant women from 60 days postpartum to 12 months postpartum and to implement continuous eligibility for the entire postpartum period.
2. Waiver of § 1902(e)(2), to the extent necessary, to reinstate Medicaid beneficiaries into their prior Medicaid MCO within 90 days of losing Medicaid coverage due to late submission of Medicaid redetermination paperwork.
3. Waiver of § 1902(a)(47), to the extent necessary, to waive hospital presumptive eligibility and apply streamlined eligibility redetermination rules.

The State requests expenditure authority for women up to 200% FPL in the pregnant women category of eligibility through the full 12 month postpartum period.

Public Notice and Input

The draft waiver application is available for public review at the Public Notices link located on the HFS web site: <http://www.illinois.gov/hfs/>. Copies of the draft waiver application will also be available at the location provided below.

Written comments concerning these proposed changes will be accepted on or before December 27, 2019. Comments may be sent to:

Illinois Department of Healthcare and Family Services
Division of Medical Programs
Bureau of Program and Policy Coordination
201 South Grand Avenue East
Springfield, IL 62794
Email address: hfs.bpra@illinois.gov

The State will host two public hearings and will provide interested stakeholders the opportunity to learn about and provide input into HFS's proposed Section 1115 Demonstration.

Monday, December 9, 2019

10:00 AM to 12:00 PM

Illinois Department of Healthcare and Family Services
1st Floor Video Conference Room
401 S. Clinton Street
Chicago, IL 60607

There will be a conference line option for this meeting. Call-in information will be posted with the waiver information at the web site and link provided above

Tuesday, December 10, 2019

10:00 AM to 12:00 PM
Memorial Center for Learning and Innovation
2A Curtis Theatre Classroom
228 W. Miller Street
Springfield, IL 62702

Written comments will be accepted at the public hearings. The outcome of this process and the input provided will be summarized for CMS upon submission of the demonstration application. A summary of comments will be posted for public viewing at <http://www.illinois.gov/hfs/> along with the waiver application when it is submitted to CMS.

Copy of the State's Abbreviated Public Notice Statement

**NOTICE OF PUBLIC HEARING
ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**

Summary of Hearing: The hearing will provide the opportunity to learn about and provide input into Illinois Department of Healthcare and Family Services' (DHFS') proposed Section 1115 Demonstration. The Illinois Department of Healthcare and Family Services is proposing an 1115 waiver that promotes continuity of care and administrative simplification. Illinois is committed to providing quality health care with care coordination to Medicaid beneficiaries while reducing unnecessary administrative burdens. The following initiatives will help the Department achieve these goals:

- 1) Extending postpartum coverage from 60 days to 12 months;
- 2) Managed care reinstatement when a Medicaid beneficiary submits late redetermination paperwork within 90 days; and
- 3) Waiving Hospital Presumptive Eligibility.

These proposals are included in the 1115 waiver to improve health outcomes through the promotion of continuity of care while also promoting administrative simplifications for the Illinois Medicaid program.

The draft waiver application will be posted on November 27, 2019 at the Public Notices link located on the HFS web site: <http://www.illinois.gov/hfs/>

Date, Time and Location of Public Hearing:

Monday, December 9, 2019

10:00 AM to 12:00 PM
Illinois Department of Healthcare and Family Services
1st Floor Video Conference Room
401 South Clinton Street
Chicago, IL 60607

(There will be a conference line option for this meeting. Call-in information will be posted with the waiver information at the web site and link provided above.)

Tuesday, December 10, 2019

10:00 AM to 12:00 PM
Memorial Center for Learning and Innovation

MCLI 2A Curtis Theatre Classroom
228 West Miller Street
Springfield, IL 62702

Other Pertinent Information:

- Persons must sign in at the registration desk located outside of the public hearing location. Persons wishing to provide oral testimony will indicate such during registration and must submit a written copy of the testimony at that time.
- Written testimony from those choosing not to speak will also be accepted during the registration period.
- Speakers will be heard on a first come, first served basis.
- Individuals giving oral testimony are asked to limit their comments to three minutes.
- Organizations are asked to select one spokesperson to present oral testimony on behalf of the organization and will be asked to limit their comments to five minutes.
- To assist the orderly conduct of the hearing and to ensure that the opinions of all interested individuals and/or groups are considered, the Department may impose other rules of procedure as necessary, including, but not limited to, adjusting the time limit or the order of presentation.

Name and address of Agency Contact Person: Any interested party may direct comments, data, views or arguments concerning these proposed changes. All comments not provided at the hearing must be in writing and received by December 27, 2019, and addressed to:

Illinois Department of Healthcare and Family Services
Division of Medical Programs
Bureau of Program and Policy Coordination
201 South Grand Avenue East
Springfield, IL 62794
Email address: hfs.bpra@illinois.gov

This notice is being provided in accordance with federal requirements provided at 42 CFR 431.408.

Application includes a copy of the state's Tribal notice with documentation of how such notice was disseminated to Federally-recognized Tribes, Indian health programs, and Urban Indian organizations (e.g., email, mail certification), if applicable.

From: Eckert, Jane
Sent: Monday, December 02, 2019 10:12 AM
To: krscott@aol.com; bellinger4@aol.com; cassiejcleary@gmail.com; oneidagirl@sbcglobal.net
Cc: Doran, Mary <Mary.Doran@Illinois.gov>; Eckert, Jane <Jane.Eckert@Illinois.gov>; Barger, Sara <Sara.Barger@illinois.gov>
Subject: 1115 Demonstration Waiver - Tribal Notification

Mr. Scott,

The Illinois Medicaid Program is applying to the Centers for Medicare and Medicaid Services (CMS) for a comprehensive waiver granted under authority of Section 1115 of the Social Security Act. This demonstration application seeks to improve health outcomes through the promotion

of continuity of care while also promoting administrative simplifications for the Illinois Medicaid program. The following initiatives will help the Department achieve these goals:

1) Extending postpartum coverage from 60 days to 12 months

Illinois proposes to extend Medicaid coverage for women in the pregnant women category of eligibility from 60 days postpartum to 12 months postpartum. The extended postpartum coverage is for full Medicaid benefits for women up to 200% of the federal poverty level (FPL), which is the income threshold for the Medicaid pregnant women category of eligibility in Illinois. Illinois also proposes to align continuous eligibility for the mom and baby so that both are eligible through 12 months after delivery. Additionally, if a woman applies during the 12 month postpartum period, Illinois proposes enrolling her in the pregnant women category of eligibility for the remainder of her 12 month postpartum period.

The goal of this proposal is to reduce maternal morbidity and mortality in Illinois by providing additional health care access and care coordination support to new mothers during the entire medically-vulnerable postpartum period.

2) Managed care reinstatement within 90 days

The state proposes to allow Medicaid beneficiaries to be retro-enrolled into their prior Medicaid MCO within 90 days of losing Medicaid coverage due to late submission of a renewal form. Federal requirements limit reinstatement to 60 days. The goal of this proposal is to minimize churn between Medicaid Fee-for-Service (FFS) and managed care to increase continuity of coverage and improve MCO quality oversight.

3) Waiving Hospital Presumptive Eligibility

Illinois proposes to waive the requirement to permit hospitals to make presumptive eligibility determinations. The waiver request will include the removal of all six required Hospital Presumptive Eligibility (HPE) groups: children, pregnant women, former foster care, parent or caretaker relatives, breast and cervical cancer, and single adults made eligible under the Affordable Care Act. Removal of HPE requirements would not impact Medicaid eligibility requirements for these six groups; they all would remain eligible with the same requirements that exist today.

A [Notice of Public Hearing](#) will publish in newspapers statewide on November 27, 2019 and provides information on two hearings that will be held in Chicago on Monday, December 9, 2019, and in Springfield on December 10, 2019. We encourage you and your staff to attend. Please note that the hearing notice provides a link to a [webpage](#) dedicated to the 1115 waiver. The waiver [application](#) can be accessed from this webpage, as well.

We want to provide you an opportunity to review the 1115 waiver application and welcome comments or suggestions. Please let me know if you would like to set up a meeting to discuss the waiver application in more detail. We will be happy to accommodate. If you have trouble with the links provided in this email, let me know and I will forward the information to you in document form. It's always a pleasure working with you and your organization.

Sincerely,

Mary

Mary T. Doran
Bureau Chief
Bureau of Program and Policy Coordination
217/782-3953

Active Links to the State's 1115 Waiver Website

The state posted the public notice documents, waiver application for the state comment period, and public hearing presentation on the HFS 1115 Waiver Demonstration Home Webpage:

- Section 1115 Waiver Demonstration Home Webpage:
<https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/1115DemonstrationWaiverHome.aspx>
- Abbreviated public notice statement:
<https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/1115DemonstrationWaiverHome.aspx>
- Full public notice statement:
<https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/1115DemonstrationWaiverHome.aspx>
- Notice of Public Hearing Reminder:
<https://www.illinois.gov/hfs/SiteCollectionDocuments/NOTICEOFPUBLICHEARINGSTATEOFILLINOISDEPARTMENTOFHEALTHCAREANDFAMILYSERVICES.pdf>
- Illinois Continuity of Care & Administrative Simplification Section 1115 Waiver Application Narrative:
<https://www.illinois.gov/hfs/SiteCollectionDocuments/11272019Section1115DemonstrationContinuityofCareandAdministrativeSimplificationupdated.pdf>
- Section 1115 Demonstration Waiver Public Hearing Presentation:
<https://www.illinois.gov/hfs/SiteCollectionDocuments/120920191115WaiverPublicHearingSlideDeckFinal.pps>

Summary of Comments & State Responses to Comments

The Department held two public hearings on the 1115 waiver, one on December 9, 2019 in Chicago and the other on December 10, 2019 in Springfield. Attendees represented advocacy groups, healthcare providers, provider associations, and managed care organizations. Questions and a couple of comments raised during these hearings included the following:

- Whether undocumented women will lose coverage from what they get today.
- The General Assembly's involvement in the waiver request process.
- The benefits to hospitals of HPE.
- Whether MCO performance measures and metrics will be made public through the MCO scorecard.

- Budget projection assumptions.
- Availability of state funds to cover 12-month post-partum coverage for undocumented women.
- Whether metrics will be reported by race and ethnicity.
- Whether the Department investigate system changes to implement HPE.
- Whether the HPE waiver could be eventually reversed to implement HPE at a later date.
- When post-partum 12-month period begins.
- One commenter spoke in support of the post-partum expansion and 90 day managed care reinstatement; observed that Illinois has a poor record of maternal deaths; recommended that the impact of the waiver on this be tracked; and recommended that since hospital discharge planning improves health outcomes, the state should focus on speeding up processing of applications from individuals being discharged from the hospital.
- One commenter noted that some providers do not take patients with Medicaid pending. If the HPE delay reduces the applications backlog and shortens the amount of time a person is pending Medicaid, enrollees can be connected to care more quickly.

In addition to questions received at these hearings, the following organizations submitted written comments:

- Lake County Health Department and Community Health Center
- EverThrive Illinois
- Nurse-Family Partnership
- Shriver Center on Poverty Law
- Two OB/GYN physicians
- March of Dimes
- Blue Cross Blue Shield of Illinois
- Thresholds
- The Ounce of Prevention Fund
- Healthcare Council of Illinois
- American College of Obstetricians and Gynecologists, Illinois Section

Comments specific to the three proposals within the 1115 waiver request are summarized below:

Extending postpartum coverage from 60 days to 12 months

We received comments on the provision to extend postpartum coverage and to provide continuous eligibility during the post-partum period.

All written comments, except one that did not address this provision, expressed support for the post-partum proposal. Commenters spoke of this proposal as ensuring, “continuous care coordination and support for new mothers, ultimately reducing maternal morbidity and mortality in the state” and as supporting, “the health of women and infants...across the state.” Many of these comments included data with citations indicating the public health need for this provision and the recommendations of national medical groups and state public health organizations to extend coverage in this way. One organization advocated for statewide solutions to decrease maternal death rates. One organization spoke of how imperative this provision is “even in an expansion state” and asked that metrics be collected by race and ethnicity. Many commenters spoke of the importance of extended prenatal care to reducing maternal mortality and morbidity disparities that disadvantage non-Hispanic black women.

Two organizations raised concern about the exclusion of undocumented women from the 12-month post-partum provision citing the importance of a mother's health status to the wellbeing of children.

Managed care reinstatement when a Medicaid beneficiary submits late redetermination paperwork within 90 days

Commenters also expressed support for 90-day retroactive managed care reinstatement. One commenter said this provision will "mitigate some of the challenges people face when they don't know about or receive paperwork related to their redeterminations." Several commenters expressed support for the waiver goal to minimize churn between managed care and fee for service coverage.

Waiving Hospital Presumptive Eligibility

Several commenters found the proposal to waive hospital presumptive eligibility to not be ideal, stated their recognition of the state's inability to implement HPE, and expressed their hope that the state will eventually make plans to fully implement HPE. One commenter strongly disagreed with the request to waive HPE since HPE can be a crucial avenue into treatment for people experiencing a mental health crisis. Another commenter expressed concerns with waiving HPE, stating that "immediate eligibility for Medicaid in a hospital setting, especially for women who are pregnant, would protect the health of our communities." A third commenter urged HFS to reconsider this proposal or, if the proposal moved forward, to consider a carve out for behavioral health hospitalizations or a plan to implement HPE as soon as possible.

State Response to Comments:

The state did not revise any proposals within its 1115 demonstration waiver request based on any of the submitted public comments. The state also did not receive any comments on the impact of the demonstration on Medicaid or CHIP enrollment.

The state appreciates the comments and feedback it received at the public hearings and in writing through the state public comment process. In response to time Illinois stakeholders spent conducting their own research in support of the postpartum coverage extension, the state also has chosen to share a sample of the research conducted by state stakeholders with federal CMS for its review.

Additional responses to comments on the specific waiver proposals are included below:

Extending postpartum coverage from 60 days to 12 months

The state did add additional research and citations to the postpartum section to incorporate additional research provided by state stakeholders demonstrating the need for this waiver proposal. Based on comments from stakeholders, the state also noted within the waiver application that it is evaluating the ability to break out performance metrics by race/ethnicity for the postpartum proposal; this information was also shared during a public hearing.

The state also understands and appreciates the feedback from stakeholders regarding the health care needs of undocumented women during the postpartum period. The state will continue to evaluate the feasibility of providing coverage for this group of women during the postpartum period in the future. Outside of the requests to add undocumented women to the waiver proposal, the state only received supportive public comments for the postpartum extension proposal.

Managed care reinstatement when a Medicaid beneficiary submits late redetermination paperwork within 90 days

The state did not make any changes to the proposal to allow reinstatements into the beneficiary's prior Medicaid MCO due to late redetermination paperwork. The state only received supportive comments for this proposal.

Waiving Hospital Presumptive Eligibility

The state agrees with the public commenters who expressed their understanding that the state needs to delay HPE implementation to make urgently needed system performance improvements. The state also does not necessarily disagree with the commenters who urged for eventual implementation of HPE at a later, more practical date. Waiving HPE requirements will allow the state to make those necessary improvements in the system. Waiving HPE also will allow the state to test its hypothesis that it can promote the continuity of care by promoting full Medicaid applications in lieu of creating a new and duplicative presumptive eligibility application for hospitals. The state's goals in promoting the use of full applications are to create efficiencies that will allow the state to reduce its application backlogs and to facilitate long-term Medicaid coverage that allows clients to enroll in an MCO and receive care coordination, as opposed to the temporary FFS coverage that comes with HPE.

While the state recognizes the potential benefit of HPE to people experiencing mental a health crisis, the law does not provide a mechanism to offer HPE coverage to such a limited population. The state has determined that the burdens associated with HPE administration outweigh the advantages to implementing the program. HPE implementation would increase delays in processing applications and redeterminations as well as delay urgent upgrades and improvements to the system that could help HFS better serve all at-risk Medicaid populations.

The state also does not believe that HPE is critical for pregnant women as one commenter argued. Illinois participates in Medicaid Presumptive Eligibility (MPE) today, so pregnant women already have an opportunity to be presumptively enrolled. HPE benefits for pregnant women also do not include inpatient hospital stays, so there are no additional services a pregnant woman would receive if Illinois implemented HPE compared to its current practice of allowing MPE as well as full Medicaid applications.