DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

October 16, 2013

Ms. Theresa Eagleson
Administrator
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield, IL 62763

Dear Ms. Eagleson:

Thank you for the state's communication regarding the extension of Illinois' Medicaid section 1115 family planning demonstration, entitled "Illinois Healthy Women." The state requested that the current program, which is due to expire on December 31, 2013, be extended to December 31, 2014.

With this letter, the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of your program until December 31, 2014. The demonstration is currently operating under the authority of section 1115(a) of the Social Security Act. Additionally, the current lists of waiver and expenditure authorities and special terms and conditions will continue to apply to Illinois Healthy Women until December 31, 2014.

As you know, starting January 1, 2014, eligibility for Medicaid for most individuals will be determined using methodologies that are based on modified adjusted gross income (MAGI). This requirement applies to eligibility for family planning section 1115 demonstrations. In addition, starting October 1, 2013, states were also required to make available a single, streamlined application for MAGI-based eligibility.

We understand that there are special attributes of this demonstration to consider when deciding how to integrate family planning eligibility into the state's MAGI eligibility rules and the single, streamlined application process. Should you need additional time to integrate these features into your family planning section 1115 demonstration, CMS requests that you use the standard process of requesting acceptable mitigations. Your project officer, Shanna Wiley, with the Division of State Demonstrations and Waivers, is available to work with you to determine the appropriate approach for your state if you are not able to integrate these features into your family planning 1115 demonstration by January 1, 2014. Please do not hesitate to contact Ms. Wiley at (410) 786-1370, or at shanna.wiley@cms.hhs.gov.

Sincerely,

/s/

Jennifer Ryan
Deputy Director for Policy

cc: Eliot Fishman, Director, Children and Adults Health Programs Group
Verlon Johnson, Associate Regional Administrator, Region V
Catherine Song, CMS Chicago Regional Office

Approved: December 30, 2009

Mr. Barry S. Maram
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763

Dear Mr. Maram:

We are pleased to inform you that Illinois' request for an extension of its section 1115 family planning demonstration, entitled Illinois Healthy Women, as modified by the Special Terms and Conditions (STCs) accompanying this award letter, has been approved as project number 11-W-00165/5. Under this Demonstration, the State will cover family planning services for uninsured women of childbearing age who are not eligible for Medicaid or the Children's Health Insurance Program (CHIP) and who have family income at or below 200 percent of the Federal poverty level (FPL). Approval of the extension of this Demonstration is under the authority of section 1115(a) of the Social Security Act (the Act) and is effective as of January 1, 2010, through March 31, 2012.

We are also granting approval of the State's service code amendment request submitted in July 2008. Specifically, the State requested adding the service codes listed below to the list of services provided through the Demonstration. Attachment A to the enclosed STCs has been updated to reflect these additional approved services and the corresponding Federal Medical Assistance Percentage (FMAP) rate at which these services will be reimbursed.

Procedure	**Procedure Code**	**Procedure Code Description**
Sexually Transmitted Infection Treatment	56501	Destruction of lesion(s), vulva; simple
Essure (sterilization procedure)	58340	Hysterosalpinography (HSG) implant post-procedure confirmatory test
	58565	Hysteroscopy with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
	74740	Implant post-procedure confirmatory test, radiological supervision and interpretation
	99070	Supply code to be used for female sterilization micro insert device provided at the physician's office

Procedure	Procedure Code	Procedure Code Description
Cervical Cancer Screening	88174	Cytopathology slides, cervical or vaginal collected in preservative fluid, screened by automated system under physician supervision
	88175	Cytopathology slides, same as 88174, except screened by automated system and manual rescreening under physician supervision

Enclosed are the STCs that the State must meet as a condition for approval of this Demonstration extension. These STCs define the nature, character, and extent of Federal involvement in this project. This award letter is subject to our receipt of your written acceptance of the award, including the STCs, within 30 days of the date of this letter.

All requirements of the Medicaid program as expressed in law, regulation, and policy statement not expressly identified as not applicable in this letter, shall apply to the Illinois Healthy Women Demonstration.

Your project officer for this Demonstration is Ms. Julie Sharp. Ms. Sharp is available to answer any questions concerning the scope and implementation of the project in your application. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard
Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-2292
Facsimile: (410) 786-5882
Email: Juliana.Sharp@cms.hhs.gov

Official communications regarding program matters should be submitted simultaneously to Ms. Sharp and to Ms. Verlon Johnson, Associate Regional Administrator, in the Chicago Regional Office. Ms. Johnson's address is:

Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601-5519

If you have additional concerns regarding the Centers for Medicare & Medicaid Services oversight of this demonstration or questions, please contact Ms. Victoria Wachino, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

Sincerely,

//s//

Charlene Frizzera
Acting Administrator

Enclosures

cc:
Ms. Verlon Johnson, Associate Regional Administrator, CMS Chicago Regional Office
Ms. Maria Chickering, State Representative

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00165/5**

TITLE: **Illinois Healthy Women**

AWARDEE: **Illinois Department of Healthcare and Family Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Illinois for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this Demonstration, be regarded as expenditures under the State's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.

The following expenditure authority and the provisions specified as "not applicable" enable Illinois to operate its section 1115 Medicaid "Illinois Healthy Women" demonstration through March 31, 2012, unless otherwise stated.

Expenditures for extending Medicaid eligibility for family planning services to

1. Women, ages 19 through 44, losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum;
2. Women, ages 19 through 44, losing Medicaid coverage with gross income up to and including 200 percent of the FPL;
3. Women, ages 19, aging out of Children's Health Insurance Program (CHIP) coverage with gross income up to and including 200 percent of the Federal poverty level (FPL); and,
4. Women ages, 19 through 44, with gross income up to and including 200 percent of the FPL.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. Amount, Duration, and Scope of Services (Comparability) Section 1902(a)(10)(B)

To the extent necessary to allow the State to offer the demonstration population a benefit package consisting only of approved family planning services.

2. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) **Section 1902(a)(43)(A)**

The State will not furnish or arrange for EPSDT services to the demonstration population.

3. Retroactive Coverage **Section 1902(a)(34)**

Individuals enrolled in the family planning demonstration will not be retroactively eligible.

Centers for Medicare & Medicaid Services

SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00165/5**

TITLE: **Illinois Healthy Women**

AWARDEE: **Illinois Department of Healthcare and Family Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Illinois Healthy Women section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Illinois Department of Healthcare and Family Services and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective January 1, 2010, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration is approved through March 31, 2012.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Benefits and Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and the Service Code List which is captioned Attachment A.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Illinois Healthy Women section 1115(a) Medicaid Demonstration expands the provision of family planning services to uninsured women of child bearing age (19-44) with gross family income at or below 200 percent of the Federal poverty level (FPL) who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP). The objective of the program is to decrease the number of Medicaid paid deliveries which will result in a decrease in annual Medicaid expenditures for prenatal, delivery, newborn and infant care.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid programs expressed in law, regulation, court order, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in Federal law, regulation, court order, or policy affecting the Medicaid programs that occur during this Demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

   a) To the extent that a change in Federal law, regulation, final court order, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.

   b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day, such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, covered under this Demonstration, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements in these STCs must be submitted to CMS as amendments to the Demonstration. Changes to the Service Code List, Attachment A, outside of STC 27 (Annual Submission of Service Code Listing) also require an amendment. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 6 below. The State will notify CMS of proposed Demonstration changes at the quarterly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.

6. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

a) An explanation of the public process used by the State consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;

b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit. Such analysis must include current "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;

c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

7. **Extension of the Demonstration**. States that intend to request demonstration extensions must submit to CMS a complete application at least **6 months prior** to the expiration of the current section 1115(a) extension period. The chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 8.

   As part of the Demonstration extension request, the State must provide documentation of compliance with the public notice requirements outlined in paragraph 14, as well as include the following supporting documentation:

   a) Demonstration Summary and Objectives: The State must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

   b) Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

   c) Draft report with Evaluation Status and Findings: The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

8. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 9 a phase-out plan shall not be shorter than six months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

9. **Enrollment Limitation During Demonstration Phase-Out**. If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 8, during the last 6 months of the Demonstration, individuals must not be enrolled into the Demonstration unless the Demonstration is extended by CMS. Enrollment may be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and must afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** While funding is subject to appropriation from the State General Assembly, the State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements to the extent they apply; and reporting on financial and other Demonstration components. If the State determines that its appropriated funding is insufficient to ensure adequate resources, the State must notify CMS within 90 days of its plans to amend the Demonstration as described in paragraphs 5 and 6 or terminate the demonstration as described in paragraph 8. If the State notifies CMS of its plans to terminate the demonstration, this Demonstration will terminate

after the 90th day referenced in the termination notice, unless the States withdraws its notice based on new appropriations or circumstances. The termination process does not preclude the State from requesting at any time a new Demonstration that would be adequately funded by available appropriated funding.

14. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the Demonstration, including, but not limited to, those referenced in paragraph 6 are proposed by the State.

15. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

16. **Citizenship Documentation Requirements.** For individuals who have declared that they are United States citizens or nationals, the State must only enroll individuals into the Illinois Healthy Women Program who document citizenship or nationality in accordance with sections 1902(a)(46) and 1903 of the Act**.** After January 1, 2010, the State may establish citizenship or nationality using the process set out in section 1902(ee) in lieu of the documentation requirements set forth in sections 1902(a)(46) and 1903 of the Act.

17. **Implementation Plan**. If the renewal expands or restricts eligibility or services, the State must submit an implementation plan within 30 days from the date of approval. To the extent the renewal affects the evaluation design the State must also submit a revised evaluation plan.

IV. ELIGIBILITY

18. **Eligibility Requirements.** The State must enroll only individuals meeting the following eligibility criteria into the Demonstration. The State must comply with third party liability (TPL) requirements as specified in 42 CFR 433.138 for any woman who has health insurance coverage for family planning services.

    1. Women, ages 19 through 44, losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum;
    2. Women, ages 19 through 44, losing Medicaid coverage with gross income up to and including 200 percent of the FPL;
    3. Women, ages 19, aging out of CHIP coverage with gross income up to and including 200 percent of the FPL; and,
    4. Women ages, 19 through 44, with gross income up to and including 200 percent of the FPL.

19. **Redeterminations.** The State must ensure that redeterminations of eligibility for the demonstration are conducted at least every 12 months. The process for eligibility redetermination may be administrative in nature for the first 24 months. The process for eligibility redeterminations must require that an action be taken by the recipient at least every 24 months. Illinois may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the

State.

20. **Integrity.** Within 60 days of approval of the demonstration's renewal, the State provided to CMS for approval, an appropriate methodology for ensuring the integrity of initial eligibility determinations and redeterminations of individuals covered under the family planning program.

    - The State will use this methodology to conduct reviews of the eligibility determination process on at least an annual basis.
    - As part of the submission, the State will also develop an eligibility determination error rate methodology.
    - The State's error rate will be included in the annual report as specified in paragraph 30.
    - If the error rate is beyond the State established threshold, the State will develop a corrective action plan for CMS approval.

21. **Demonstration Disenrollment.** If a woman becomes pregnant while enrolled in the Demonstration, she may be determined eligible for Medicaid under the State plan. If a woman becomes sterilized and completes all follow-up procedures/visits related to the sterilization, she will no longer require any family planning services, and system edits will prohibit reimbursement for other services. The State must have systems in place to prohibit a woman who becomes sterilized and completes all necessary follow-up procedures/visits from reenrolling into the Demonstration. The State has one year from the date of the approval of the renewal to modify its policies, procedures, and forms to comply with this requirement. A woman who is enrolled in a Medicaid State plan eligibility category will not be eligible for services under the Demonstration. The State must not submit claims under the Demonstration for any woman who is found to be eligible under the Medicaid State plan.

22. **Primary Care Referral.** The State assures CMS that providers of family planning services will make appropriate referrals to primary care providers as medically indicated. The State also assures that individuals enrolled in this Demonstration receive information about how to access to primary care services.

V. BENEFITS AND DELIVERY SYSTEMS

23. **Benefits.** Family planning services are medically necessary services and supplies related to contraception, pregnancy prevention and preventive services listed in Attachment A, including:

    - Approved methods of contraception;
    - Sexually transmitted infection testing and treatment, including pap tests and pelvic exams;
    - Drugs, supplies, or devices related to women's health services described above that are prescribed by a physician or advanced practice nurse (subject to the national drug rebate program requirements);
    - Contraceptive management; patient education; and counseling; and

- Primary care referrals to other social service and health care providers as medically indicated; however, the costs of those primary care services are not covered for enrollees of this Demonstration.

24. **Services.** Services provided through this Demonstration are paid fee for service (FFS).

VI. GENERAL REPORTING REQUIREMENTS

25. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in section VII.

26. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality as set forth in section VIII.

27. **Annual Submission of Service Code Listing.** Illinois will provide to CMS an updated list of Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding Systems (HCPCS) codes covered under the Demonstration on January 31 of each Demonstration year. The revised code list should reflect only changes due to updates in service codes for those services for which the State has already received approval and submitted on a template provided by CMS.

28. **Monitoring Calls.** CMS and the State will participate in quarterly conference calls following the receipt of the quarterly reports unless CMS determines that more frequent calls are necessary to adequately monitor the Demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments the State is considering submitting. The State and CMS will discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS will update the State on any amendments under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS will jointly develop the agenda for the calls.

29. **Quarterly Operational Reports.** The State must submit progress reports no later than 60 days following the end of each quarter.

    The intent of these reports is to present the State's data along with an analysis of the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

    a) Expenditures including administrative costs;
    b) The number of unduplicated demonstration enrollees who became pregnant or sterilized during the quarter in which the State learned of the pregnancy or sterilization. (Participants include all individuals who obtain one or more covered family planning services through the demonstration.)

c) Number of demonstration enrollees who have health insurance coverage for family planning services;
d) TPL collections for demonstration participants who have health insurance coverage for family planning services;
e) Events occurring during the quarter, or anticipated to occur in the near future that affect health care delivery, benefits, enrollment, grievances, quality of care, access, pertinent legislative activity, eligibility verification activities, and other operational issues;
f) Action plans for addressing any policy and administrative issues identified; and
g) Evaluation activities and interim findings.

30. **Annual Report.** The annual report is due 90 days following the end of the fourth quarter of each demonstration year and must include:

a) The average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)
b) The number of actual births that occur to family planning demonstration participants. (Participants include all individuals who obtain one or more covered medical family planning services through the family planning program each year.)
c) The eligibility error rate data referenced in paragraph 20.
d) An updated cumulative budget neutrality spreadsheet that includes the "Annual Budget Limit (ABL)."

1. The ABL will be the estimated cost savings of the births averted (BA) calculated as follows:

ABL = BA (births averted) X MCB (Medicaid cost of birth)

a) Births Averted will be estimated by the following equation:

- <u>Births Averted:</u> BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of female demonstration participants during DY). The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the demonstration. At its option, the State may also adjust the fertility rates for ethnicity.

- <u>The Base-Year Fertility Rate</u> must reflect fertility rates during 2001 for individuals in families with income at or below 200 percent of the FPL and ineligible for Medicaid except for pregnancy. The fertility rates *are* limited to births paid for by Medicaid. The State will submit to CMS base-year fertility

rates and a methodology for calculating the fertility rates. Preliminary base-year fertility rates must be submitted for approval within the first operational year of the demonstration and conform to the following requirements:

a) They must reflect fertility rates during the Base Year, for women in families with income at or below 200 percent of the FPL, and ineligible for Medicaid except for pregnancy.
b) They must be adjusted for the age of all potential demonstration participants.
c) The fertility rates will include births paid by Medicaid.
d) The State will be allowed up to 6 months after the end of the first demonstration year to finalize these preliminary rates. Following the conclusion of each year of the demonstration, a demonstration year fertility rate will be determined by computing an age-weighted average fertility rate during the DY, unless the State demonstrates that the age distribution is consistent with the prior demonstration year(s). The annual age distribution categories will correspond with the base-year age-specific fertility rates. At its option, the State may also adjust the fertility rates for ethnicity.

b) Medicaid Cost of Birth: (MCB) equals the cost of prenatal services + delivery and pregnancy related costs + costs for infants up to one year of life)/number of deliveries, where the costs and number of deliveries pertain to the Illinois' Medicaid program.

31. **Final Report.** No later than 90 days prior to the end of the demonstration award period, Illinois must submit a draft final report to CMS for comments. The final report will incorporate all CMS comments and evaluation findings. The final report must also contain a disclaimer that the opinions expressed are those of the State and do not necessarily reflect the opinions of CMS. The final report is due 90 days after the end of the demonstration award period.

VII. GENERAL FINANCIAL REQUIREMENTS

32. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS must provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section VIII.

33. **Reporting Expenditures Under the Demonstration.** In order to track expenditures under this Demonstration, Illinois must report Demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in sections 2115 and 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act must be

reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in paragraph 34. The State must report Demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:

a) Allowable family planning expenditures and other expenditures subject to the budget neutrality limit (see paragraph 34) that are eligible for reimbursement at the State's Federal medical assistance percentage (FMAP) rate should be entered in Column (B) on the appropriate waiver sheets (see paragraph 38). Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets (see paragraph 38).

b) Premiums and other applicable cost sharing contributions from enrollees that are collected by the State under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr by Demonstration year.

c) For each Demonstration year, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for Demonstration populations and Demonstration services.

34. **Expenditures Subject to the Budget Agreement.** For purposes of this section, the term "expenditures subject to the budget neutrality agreement" must include all title XIX expenditures provided to individuals who participate in this Demonstration. All expenditures that are subject to the budget neutrality agreement must be reported on Forms CMS 64.9 Waiver and/or 64.9P Waiver. A participant is any person that enrolls into this Demonstration and receives one or more covered family planning services through the Demonstration. Participation in the Demonstration and expenditures are further described as follows:

a) A participant is any person that enrolls into this demonstration and receives one or more covered family planning services through the demonstration. Persons that enroll in the demonstration and who subsequently have a Medicaid covered delivery are still considered a participant in the demonstration.

b) Expenditures incurred by the State on behalf of participants for either family planning expenditures as defined in paragraph 38 and subsequent expenditures for Medicaid covered delivery and postpartum cost, as well as first year of cost of their infant are also demonstration expenditures and are expenditures subject to the budget neutrality limit.

35. **Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10.

36. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

37. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

38. **Extent of FFP for the Demonstration.** CMS shall provide FFP for CMS-approved services (including prescriptions) provided to women at the following rates and as described in Attachment A.

    a) For procedures or services clearly provided or performed for the primary purpose of family planning (i.e., contraceptive initiation, periodic or inter-periodic contraceptive management and sterilizations) and which are provided in a family planning setting, FFP will be available at the 90 percent Federal matching rate. Reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service. Note: The laboratory tests done during an initial family planning visit for contraception include a PAP smear, screening tests for STIs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.

b) In order for family planning-related services to be reimbursed at the FMAP rate they must be defined as those services generally performed as part of, or as follow-up to, a family planning service for contraception. Such services are provided because a "family planning-related" problem was identified/diagnosed during a routine/periodic family planning visit. Three kinds of family planning related services are recognized:

   i. A colposcopy (and procedures done with/during a colposcopy) performed as a follow-up to an abnormal PAP smear which is done as part of a routine/periodic family planning visit. Only those colposcopies which can generally be performed in the office or clinic setting are coverable as a family planning-related service under this Demonstration. Colposcopies which are generally provided in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center or a hospital are not covered under these waivers as family planning-related services.

   ii. Treatment/drugs for sexually transmitted infections (STIs), except for HIV/AIDS and hepatitis, where the STDs/STIs are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/ encounter for the treatment/drugs may be covered at the applicable Federal matching rate for the State.

   iii. Treatment/drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders in women, and urinary tract infections, where these conditions are identified/diagnosed during a routing/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered at the applicable Federal matching rate for the State/.

   iv. Treatment for disorders/conditions such as hypertension, hypercholesterolemia, diabetes, upper genital tract disorders are not covered under these waivers because they are not considered "family planning-related," even though they may be identified/diagnosed as a result of family planning visit/encounter.

c) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. The match rate for the subsequent treatment would be paid at the applicable Federal matching rate for the State. For testing or treatment not associated with a family planning visit, (e.g., those provided at a public STI clinic), no FFP will be available.

d) CMS will provide FFP at the appropriate 50 percent administrative match rate for general administration costs, such as, but not limited to, claims processing, eligibility assistance and determinations, outreach, program development, and program monitoring and reporting.

39. **Sources of Non-Federal Share.** The State must certify that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds must not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

    b) Any amendments that impact the financial status of the program must require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

40. **State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

    a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

    b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

    c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

    d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX

payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

41. **Monitoring the Demonstration.** The State must provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

VIII. MONITORING BUDGET NEUTRALITY

42. The following is the method by which budget neutrality will be monitored for the Illinois section 1115 Family Planning Demonstration.

a) Illinois will be subject to a limit on the amount of Federal title XIX funding it will receive for extending Medicaid eligibility for family planning services during the demonstration renewal period. This limit will be determined using a pre/post comparison of fertility rates for demonstration participants. Thus, Illinois will be at risk for the cost of family planning services (including traditional family planning services at the enhanced match rate and ancillary services at the Federal Medical Assistance Percentage (FMAP) rate described in the Special Terms and Conditions) that are not offset by the demonstration intervention.

b) The demonstration will provide family planning services to uninsured women of child bearing age who have a gross family income at or below 200 percent of the FPL, who are not otherwise eligible for Medicaid or CHIP. The demonstration will not change the current division of Federal and State responsibility for costs of the current Medicaid program. CMS will confirm that the demonstration expenditures do not exceed the levels that would have been in the absence of the demonstration.

c) Budget Limit: To calculate the overall expenditure limit for the demonstration, separate budget limits will be calculated for each year, and will be on a demonstration year (DY) basis. These annual estimates will then be added to obtain an expenditure estimate over the entire demonstration period. The Federal share of the estimate will represent the maximum amount of FFP that the State can receive during the expanded family planning services demonstration. For each DY, the Federal share will be calculated using the FMAP rate(s) for that 12-month period.

d) Annual Budget Limit (ABL) The annual budget limit will be the estimated cost-savings of the births averted (BA) calculated as follows:

- ABL = BA (births averted) X MCB (Medicaid cost of a birth)

e) Births averted (BA) will be estimated by the following equation:

- BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of female demonstration participants during DY). The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the demonstration. At its option, the State may also adjust the fertility rates for ethnicity.

f) Medicaid Cost of Birth (MCB) is calculated as follows:

- MCB = cost of prenatal services + delivery and pregnancy related costs + costs for infants up to one year of life)/number of deliveries, where the costs and number of deliveries pertain to the Illinois' Medicaid program.

g) Base-Year Fertility Rate The State will submit to CMS base-year fertility rates and a methodology for calculating the fertility rates. The base-year fertility rate must reflect fertility rates during 2001 for individuals in families with income at or below 200 percent of the FPL and ineligible for Medicaid except for pregnancy. The fertility rates *are* limited to births paid for by Medicaid. Preliminary base-year fertility rates must be submitted for approval within the first operational year of the demonstration and conform to the following requirements:

- They must reflect fertility rates during the Base Year, for women in families with income at or below 200 percent of the FPL, and ineligible for Medicaid except for pregnancy.

- They must be adjusted for the age of all potential demonstration participants.

- The fertility rates will include births paid by Medicaid.

- The State will be allowed up to 6 months after the end of the first demonstration year to finalize these preliminary rates. Following the conclusion of each year of the demonstration, a demonstration year fertility rate will be determined by computing an age-weighted average fertility rate during the DY, unless the State demonstrates that the age distribution is consistent with the prior demonstration year(s). The annual age distribution categories will correspond with the base-year age-specific fertility rates. At its option, the State may also adjust the fertility rates for ethnicity.

h) Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures, as reported by the State on the CMS-64 forms. If at the end of the Demonstration period, the costs of the Demonstration services exceed the budget limit, the excess Federal funds will be returned to CMS.

i) Expenditure Review. CMS will enforce budget neutrality over the life of the demonstration, rather than annually. However, no later than 6 months after the end of each DY or as soon thereafter as the data are available, the State will calculate annual expenditure targets for the completed year. This amount will be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the State exceeds these targets, it will submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative Target Expenditures	Percentage
2009	DY 6 budget limit amount	+4 percent
2010	DY 6 and 7 combined budget limit amount	+2 percent
2011	DYs 6 through 8 combined budget limit amount	+0 percent

j) Failure to meet budget Neutrality Goals. The State, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, must immediately collaborate with CMS on corrective actions, which must include submitting a corrective action plan to CMS within 21 days of the date the State is informed of the problem. While CMS will pursue corrective actions with the State, CMS will work with the State to set reasonable goals that will ensure that the State is in compliance.

k) Definition of With and Without Waiver Demonstration Costs. The "with" and "without" demonstration costs (Federal share) follow. The "without" demonstration costs are estimates of the costs of births that would occur in the absence of the demonstration. The "with" demonstration costs are estimates of family planning services provided with the demonstration in effect.

State Plan Costs			
YEAR	WOW	WW	Estimated Annual Budget Limit
April 2009 - March 2010	$582,034,634	$567,323,396	$14,711,238
April 2010 - March 2011	$633,550,085	$617,336,379	$16,213,706
April 2011 - March 2012	$689,788,373	$671,906,612	$17,881,761
Demo Costs			
	WOW	WW	Estimated Annual Budget Limit - WW

April 2009 - March 2010		$9,376,944	$5,334,294
April 2010 - March 2011		$10,334,617	$5,879,089
April 2011 – March 2012		$11,397,836	$6,483,925
Total			
	WOW	WW	Projected Margin
April 2009 - March 2010	$582,034,634	$576,700,340	$5,334,294
April 2010 - March 2011	$633,550,085	$627,670,996	$5,879,089
April 2011 - March 2012	$689,788,373	$683,304,448	$6,483,925
3 Year Total	$1,905,373,092	$1,887,675,784	$17,697,308

IX. PRIMARY CARE REFERRAL AND EVALUATION

43. **Access to Primary Care Services.** The State must facilitate access to primary care services for enrollees in the Demonstration. The State must assure CMS that written materials concerning access to primary care services are distributed to the Demonstration participants. The written materials must explain to the participants how they can access primary care services.

44. **Final Evaluation Design.** A draft evaluation design report must be submitted to CMS for approval within 30 days from the award of the demonstration extension. At a minimum, the evaluation design should include a detailed analysis plan that describes how the effects of the demonstration will be isolated from those of other initiatives occurring in the State. The report should also include an integrated presentation and discussion of the specific hypotheses (including those that focus specifically on the target population for the demonstration) that are being tested. The report will also discuss the outcome measures that will be used in evaluating the impact of the demonstration, particularly among the target population. It will also discuss the data sources and sampling methodology for assessing these outcomes. The State must implement the evaluation design and report its progress in each of the demonstration's quarterly reports.

45. **Final Evaluation Plan and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 44, within 60 days of receipt of CMS comments.

    a) The State must implement the evaluation designs and report its progress on each in the quarterly reports.

    b) The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60

days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

46. **Federally Contracted Evaluation**. In addition, a federally-contracted evaluation has examined the appropriateness of the budget neutrality methodology of these demonstrations by assessing the births that have been averted as a result of the demonstrations, the data sources currently used to assess averted births and budget neutrality, and expenditures overall. Based on the evaluation findings and other information, CMS reserves the right to negotiate a new budget neutrality methodology, if CMS deems appropriate. Such a methodology change could range from a change in data sources used to determine budget neutrality, to a total change in methodology, such as incorporating a per capita cap. Any and all changes to the budget will be made in full consultation with the State, including expenditure data used in the methodology.

47. **Independent Evaluation**. Should CMS conduct further independent evaluations of section 1115 family planning demonstrations the State must cooperate fully with CMS or the independent evaluator selected by CMS, to assess the impact of the Medicaid demonstrations and/or to further examine the appropriateness of the averted birth budget neutrality methodology. The State must submit the required data to CMS or its contractor.

48. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.