

Illinois Continuity of Care & Administrative Simplification 1115 Waiver

Section I - Program Description

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 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 Medicaid coverage for women in the pregnant women category of eligibility from 60 days postpartum to 12 months postpartum. In line with recommendations of maternal mortality review committees in Illinois and around the country, as well as the American College of Obstetricians and Gynecologists (ACOG) and the American Medical Association (AMA), the Governor of Illinois signed Public Act 101-0010 into law on June 5, 2019, which amended 305 ILCS 5/5-2 to extend Medicaid coverage for pregnant women from 60 days to 12 months postpartum, effective January 1, 2020. The extended postpartum coverage is for 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).

Additionally, In Illinois, women eligible for Medicaid benefits under the pregnant women category generally are enrolled in Medicaid Managed Care Organizations (MCOs), and their newborns are auto-assigned to the mother's MCO with a 90-day switch period. Extending coverage from 60 days to 12 months postpartum prevents the mother from having to switch providers during a medically vulnerable time due to different health plan networks, and provides continued care coordination and support through a Medicaid MCO 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).¹

To further promote continuity of coverage and administrative simplification, Illinois also seeks to align continuous eligibility for the mom and baby so that both are eligible through 12 months after

¹ 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>

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, even when the delivery occurred more than three months prior to the Medicaid application date.

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. In Illinois, this extended postpartum coverage generally will be within Medicaid managed care, with the mom and baby enrolled in the same Medicaid MCO. 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 quality and operational metrics, in addition to continuing to monitor the findings of the Illinois Department of Public Health (DPH) Maternal Mortality Review Committee and Maternal Mortality Review of Violent Deaths Committee (the “Committees”).

For this proposal, Illinois requests to waive:

- 42 CFR 435.4 to define pregnant women through 12 months postpartum instead of 60 days postpartum;
- 42 CFR 435.170 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) to extend the renewal of MAGI-based income to the end of the 12 month postpartum period.

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

The state proposes to waive 42 CFR 438.56(g) 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 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. This creates a gap where individuals are reinstated into Medicaid Fee-for-Service (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. 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 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.

Hypotheses and Evaluation

The table below presents an overview of the hypotheses and goals associated with each waiver policy.

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.
	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.
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	Waiving hospital PE will continue to promote hospitals assisting with full benefit Medicaid applications.	Medicaid approval and denial rates.

benefit Medicaid applications and improved application processing times.	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.
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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.

Section II – Demonstration Eligibility

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.

Based on an analysis of claims data and enrolled days for women in the pregnant women and parent, caretaker, relative categories of eligibility in 2017, HFS estimated that extending coverage through the full 12 month postpartum period with continuous eligibility would have resulted in coverage of an additional 55,788 postpartum member months per year for U.S. Citizens, an additional 1,211 postpartum member months per year for qualified immigrants meeting the five year waiting period, and an additional 5,933 postpartum member months for immigrants in their five year waiting period. To create projections for five years under this Demonstration, HFS used an actuarial analysis to trend more

recent historical data for the impacted population into future years; data tables with this additional information is provided in the Section IV Demonstration Financing and Budget Neutrality.

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.

Section III – Demonstration Benefits and Cost Sharing Requirements

This Demonstration 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.

Section IV – Delivery System and Payment Rates for Services

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.

Section V – Implementation of Demonstration

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. HFS currently is not implementing HPE, so no system changes are needed if it is waived. However, implementation of HPE if the waiver is not granted, it will require substantial modifications to the eligibility system which would trade off with other state 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.

Section VI – Demonstration Financing and Budget Neutrality

Information about each proposal in the Demonstration is provided below.

Extending postpartum coverage from 60 days to 12 months

The budget neutrality calculation was created by actuaries using historical data for the impacted population trended into future years. While five years of historical data will be included in the formal budget neutrality form, to develop projections, historical data was limited to April 1, 2018 through March 31, 2019. This time period coincides with the first 12 months of statewide risk-based managed care for the population covered under the Demonstration as well as automation of the state’s Medicaid eligibility redetermination system. Medicaid eligibility and costs for postpartum women prior to April 1, 2018 is likely to materially differ as a result of these changes, making historical data from prior periods inconsistent with recent time periods.

The historical data for postpartum women meeting the Waiver eligibility criteria has been summarized into the following Medicaid Eligibility Groups:

- Medicaid beneficiaries who are citizens or qualified immigrants meeting the five year waiting period; and
- Qualified immigrants in the five year waiting period.

Hypothetical estimates of expenditures were used in accordance with the August 22, 2018 State Medicaid Director Letter (SMD #18-009).

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 138% to 213% FPL, Citizens and LPR Meeting 5 Year Requirement, 0% to 213% FPL										
Pop Type: Medicaid										
Eligible Member	NA	9	NA	-0.5%	14,365	31,019	30,864	30,710	30,556	
Months										
PMPM Cost	4.0%	9	NA	3.0%	\$ 362.00	\$ 372.86	\$ 384.05	\$ 395.57	\$ 407.44	
Total Expenditure					\$ 5,200,118	\$ 11,565,913	\$ 11,853,455	\$ 12,147,968	\$ 12,449,933	\$ 53,217,387
Moms and Babies 0% to 213% FPL, LPR Under 5 Year Requirement										
Pop Type: Medicaid										
Eligible Member	NA	9	NA	2.0%	5,234	11,586	11,818	12,054	12,296	
Months										
PMPM Cost	4.1%	9	NA	3.0%	\$ 366.88	\$ 377.89	\$ 389.23	\$ 400.91	\$ 412.94	
Total Expenditure					\$ 1,920,315	\$ 4,378,375	\$ 4,599,960	\$ 4,832,755	\$ 5,077,326	\$ 20,808,731

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 138% to 213% FPL, Citizens and LPR Meeting 5 Year Requirement, 0% to 213% FPL								
Pop Type:	Medicaid							
Eligible Member								
Months	NA	NA	14,365	31,019	30,864	30,710	30,556	
PMPM Cost	NA	3.0%	\$ 362.00	\$ 372.86	\$ 384.05	\$ 395.57	\$ 407.44	
Total Expenditure			\$ 5,200,118	\$ 11,565,913	\$ 11,853,455	\$ 12,147,968	\$ 12,449,933	\$ 53,217,387

Moms and Babies 0% to 213% FPL, LPR Under 5 Year Requirement								
Pop Type:	Medicaid							
Eligible Member								
Months	NA	NA	5,234	11,586	11,818	12,054	12,296	
PMPM Cost	NA	3.0%	\$ 366.88	\$ 377.89	\$ 389.23	\$ 400.91	\$ 412.94	
Total Expenditure			\$ 1,920,315	\$ 4,378,375	\$ 4,599,960	\$ 4,832,755	\$ 5,077,326	\$ 20,808,731

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	
Medicaid Populations						
Moms and Babies 138% to 213% FPL, Citizens and LPR Meeting 5 Year Requirement, 0% to 213% FPL	\$ 5,200,118	\$ 11,565,913	\$ 11,853,455	\$ 12,147,968	\$ 12,449,933	\$ 53,217,387
Moms and Babies 0% to 213% FPL, LPR Under 5 Year Requirement	\$ 1,920,315	\$ 4,378,375	\$ 4,599,960	\$ 4,832,755	\$ 5,077,326	\$ 20,808,731
TOTAL	\$ 7,120,432	\$ 15,944,288	\$ 16,453,415	\$ 16,980,723	\$ 17,527,259	\$ 74,026,119

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	
Medicaid Populations						
Moms and Babies 138% to 213% FPL, Citizens and LPR Meeting 5 Year Requirement, 0% to 213% FPL	\$ 5,200,118	\$ 11,565,913	\$ 11,853,455	\$ 12,147,968	\$ 12,449,933	\$ 53,217,387
Moms and Babies 0% to 213% FPL, LPR Under 5 Year Requirement	\$ 1,920,315	\$ 4,378,375	\$ 4,599,960	\$ 4,832,755	\$ 5,077,326	\$ 20,808,731
TOTAL	\$ 7,120,432	\$ 15,944,288	\$ 16,453,415	\$ 16,980,723	\$ 17,527,259	\$ 74,026,119

VARIANCE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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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.

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 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.

Managed care reinstatement when a Medicaid beneficiary submits late redetermination paperwork 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.

Waiving HPE

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.

Section VII – List of Proposed Waivers and Expenditure Authorities

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 is proposing to use 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.

Extending postpartum coverage from 60 days to 12 months

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.

Continuity of Care

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. 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).²

Support for Medicaid Postpartum Extension

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.³ According to the CDC, pregnancy-related deaths occur up to one year after delivery and 60% are preventable.⁴ The proposal to extend Medicaid benefits for 12 months postpartum has become a consensus position to address the maternal mortality crisis within the United States based on data and expert analysis. Experts are looking to Medicaid because it currently covers nearly half of all births in the United States, but coverage under the pregnant women category of eligibility ends at 60 days postpartum, causing some mothers to lose coverage during a medically vulnerable time.

To further understand the cause of pregnancy-related deaths, state maternal mortality review committees are researching pregnancy-related deaths within their states, determining if the deaths were preventable, and recommending actions to prevent maternal mortality based on their findings. The Illinois Department of Public Health (DPH) released an Illinois Maternal Morbidity and Mortality Report in October 2018 with the recommendation to extend Medicaid coverage from 60 days to 12 months postpartum.⁵ The report notes that because the majority of the reviewed deaths occurred late in the postpartum period, the DPH Committees felt strongly that Illinois should follow ACOG's recommendation to extend Medicaid benefits from 60 days to 12 months postpartum.⁶ This recommendation is also listed as a systemic recommendation in the CDC Vital Signs report⁷ and has been endorsed by the AMA.⁸

² 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>

³ 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/>

⁴ 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>

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 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>

⁷ 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>

⁸ 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>

The findings of state maternal mortality review committees across the country highlight the importance of coverage for women in the postpartum period that includes comprehensive medical and behavioral health services. 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).⁹ Additionally, the Illinois Maternal Morbidity and Mortality Report noted 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.¹⁰ The Illinois proposal provides full Medicaid benefits during the 12 month postpartum period.

Implementation through Care Coordination and MCO Performance Management

The Illinois Maternal Morbidity and Mortality Report recommends that the state require coverage of case management and outreach for postpartum high-risk women for up to one year after delivery¹¹; this is built into Illinois' Medicaid managed care system. Working through the Medicaid managed care system will be a key component to providing continuity of coverage and care coordination support during the medically vulnerable postpartum period in addition to providing the state with additional oversight and performance management opportunities to reduce preventable pregnancy-related deaths.

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. The report also notes that "social determinants" of health, such as poverty, quality of education, health literacy, employment, housing, availability of childcare, and neighborhood safety all affect a woman's ability to seek and receive health care, in addition to affecting her underlying health status.¹² In Illinois, Medicaid MCOs are expanding their partnerships with providers and increasingly incorporating social determinants of health 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 Fee-for-Service (FFS).

⁹ 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

¹⁰ 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>

¹¹ Ibid.

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>

Administrative Simplification

To create administrative simplification, Illinois seeks to align continuous eligibility for the mom 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 will allow Illinois to redetermine the mother and newborn at the same time, creating efficiencies for caseworkers. This policy also allows the mother's healthcare needs to continue uninterrupted to prevent pregnancy-related deaths within the Medicaid managed care system, as late redetermination paperwork often creates gaps in coverage that are then filled retroactively through a mix of Medicaid FFS and managed care.

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 also creates administrative simplicity for the state and simplifies understanding 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.

Additionally, 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.¹³ The administrative simplification requests within this proposal will not only create efficiencies for the state, but also lead to better care and improved health outcomes for mothers.

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

The state is requesting 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.

Continuity of Care

The timely submission of redetermination paperwork continues to be a challenge in Illinois. 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. In Illinois, about 80% of Medicaid enrollees are enrolled in managed care, so the current processes create 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.

¹³ 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, this proposal allows the state to better manage the performance and quality of health plans through more complete HEDIS 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.”¹⁴ 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.”¹⁵ This proposal not only improves continuity of coverage for Medicaid MCO members, but also allows the state to better manage the performance of its Medicaid MCOs and measure quality of care.

Administrative Simplification

Waiving 42 CFR 438.56(g) allows reinstatement in a Medicaid MCO within 90 days, rather than 60 days, of late renewal paperwork. This creates alignment with the reinstatement policy in 42 CFR 435.916(a)(3)(iii). Additionally, it creates efficiencies for HFS Bureau of Managed Care enrollment staff as well as the state’s Client Enrollment Broker contractor, which currently sends 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

The state is requesting waiver authority to promote continuity of care with full benefit Medicaid applications and reduced processing times by avoiding the administrative complexities involved with HPE.

Continuity of Care

In regards to the waiver of HPE requirements, the state seeks to encourage the use of full applications that allow for longer term Medicaid coverage as well as to promote administrative simplicity. HPE coverage is, at its essence, temporary coverage and does not align with Illinois’ promotion of the continuity of care. The state instead wishes to encourage applications for full Medicaid which would allow a client to have coverage as long as they remain eligible. While HPE applications may be followed by a full Medicaid application, the state is concerned that both the hospital and the client will lack to submit that follow-up application once the initial hospital stay has been covered through HPE.

Payments for services during an HPE segment also 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.

¹⁴ 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>

¹⁵ Ibid.

Administrative Simplification

Illinois has also determined the implementation of HPE to be overly administratively burdensome for three primary reasons:

- 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 will 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 that would be required to implement HPE in Illinois would trade off with high priority efforts to improve the performance of the eligibility system. Those system performance improvements are another important mechanism by which the state is working to reduce backlogs.
- 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.
- 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. Continuing traditional Medicaid application processes would avoid these additional bureaucratic steps and instead would promote administrative simplicity.

Section VIII – Public Notice

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

During this public comment period, the state will hold two public hearings and host a dedicated website. The public hearings on the waiver are intended to solicit input on the proposed waiver and the State will accept verbal and/or written comments. The details for the public hearings are:

- 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 will also be a conference line option for this meeting, with a call-in number posted on the HFS website (<http://www.illinois.gov/hfs/>).
- Tuesday, December 10, 2019, 10am to 12pm, Memorial Center for Learning and Innovation, 2A Curtis Theatre Classroom, 228 W. Miller Street, Springfield, IL 62702

The HFS webpage (<http://www.illinois.gov/hfs/>) will include a copy of the waiver draft, materials from stakeholder meetings, logistics on public hearings, and instructions on how to submit comments on the waiver application draft. Written comments also 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.

During the approval process and upon approval from CMS, the State will continue to seek stakeholder input and will conduct a robust engagement process to spread awareness about these system improvements.

Section IX – Demonstration Administration

Please visit the HFS website at <http://www.illinois.gov/hfs/>

Please attend the public hearings:

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 <http://www.illinois.gov/hfs/>.

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

Please email hfs.bpra@illinois.gov to submit questions and comments regarding the Illinois Continuity of Care & Administrative Simplification Section 1115 Demonstration Waiver.