ILLINOIS DEPARTMENT OF
HFS Healthcare and
Family Services

**Bruce Rauner, Governor**
Felicia F. Norwood, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

**Telephone:** (217) 782-1200
**TTY:** (800) 526-5812

March 31, 2015

Ms. Shanna Wiley
Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard
Mailstop: S2-01-16
Baltimore, MD 21244-1850

Re: Project Number 11-W-00165/5

Dear Ms. Wiley:

In accordance with the Special Terms and Conditions of the Illinois 1115 family planning waiver, *Illinois Healthy Women*, please find attached the Final Program Report for Years 1 – 11, April 2004 through December 2014. As required, the Final Evaluation Report, Budget Neutrality, Annual Budget Limits, and the IHW Phase-Out/Transition Plan are included as appendices to the report.

HFS is very pleased to have had the opportunity to administer this demonstration waiver since 2004. The evaluation findings reveal that having a family planning waiver reduces unplanned pregnancies and provides financial benefits to the State by reducing the amount of dollars spent on costly prenatal care, delivery, postpartum care and care provided during the first-year of the infant's life. However, additional benefits that are not easily measured include enabling women to obtain essential preventive reproductive healthcare services, the opportunity to make better-educated decisions regarding the timing of pregnancies which leads to enhanced self-sufficiency, and ultimately improved birth and health outcomes.

If you have any questions about these reports, please do not hesitate to contact me at 217-557-5438.

Sincerely,

Linda Wheal

Linda Wheal
Maternal Health Program Manager
Bureau of Quality Management

Enclosure

CC: Julie Sharp


# Illinois' Family Planning Expansion Initiative Under Medicaid

## Project Number 11-W-00165/5

# Final Program Report

Waiver Years 1- 11
April 2004 – December 2014

Demonstration Waiver under Authority of
Section 1115 of the Social Security Act
to the
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

## Submitted: March 31, 2015

*Illinois Department of Healthcare and Family Services*
*201 South Grand Avenue East*
*Springfield, Illinois 62763-0001*
*Felicia Norwood, Director*

*Division of Medical Programs*
*James Parker, Acting Medicaid Director*

# Illinois Healthy Women
# Final Program Report
### April 2004 – December 2014

## EXECUTIVE SUMMARY

*Illinois Healthy Women* (IHW) was a research and demonstration project that was approved by the Centers for Medicare & Medicaid Services (CMS) on June 23, 2003, for a five-year period, pursuant to Section 1115 (research and demonstration waivers) of the Social Security Act. The program was implemented by the Illinois Department of Healthcare and Family Services (HFS) on April 19, 2004, with coverage beginning May 1, 2004. The demonstration project was designed to improve women's health and birth outcomes by expanding access to, and coverage of, publicly funded family planning services. IHW was originally administered by the Bureau of Maternal and Child Health Promotion, but due to reorganization, was administered by the Bureau of Quality Management (BQM). (An acronyms list can be found at the end of the report)

### Goal of Program

The primary goal of the demonstration waiver was to increase the number of low-income women who received voluntary, confidential family planning services with the following expected outcomes:

- Increase the number of women obtaining publicly funded family planning services
- Decrease the proportion of low-income women experiencing an unplanned pregnancy
- Increase pregnancy intendedness among women experiencing a first-time birth
- Increase the proportion of women who wait at least 24 months before having another child
- Reduce Medicaid expenditures for pregnancy related and infant health care services

### Brief Description

The Illinois Healthy Women program was initially accessible only to women losing comprehensive medical coverage under other HFS medical programs (Population 1). In April 2006, HFS requested and was approved by CMS to expand the program to allow women with income levels at or below 200 percent of the Federal Poverty Level (FPL) to apply for family planning benefits under IHW (Population 2). Since May 2007, women were able to enroll in the IHW program two ways: 1) through an automatic enrollment process—Population 1, and 2) through an application process—Population 2.

In October 2008, HFS submitted an application to CMS requesting a three-year renewal of the waiver for the period April 2009 through March 2012, or for the maximum renewable period allowed. After several extensions to the original waiver, on December 30, 2009, HFS was awarded a three-year renewal of the waiver through March 2012. Effective January 1, 2010, Special Terms and Conditions (STC) allowed HFS to enroll women with other health insurance coverage and to cover additional services, such as, abnormal Pap follow-up; HPV vaccine; follow-up testing and treatment for sexually transmitted infections (STI); and testing, treatment, required follow-up for

vaginal infections and disorders, other lower genital tract and genital skin infections and urinary tract infections. In August 2011, HFS submitted a service code amendment to CMS to support the approved scope of service. CMS approved the IHW service code amendment December 8, 2011. These service codes were implemented effective January 1, 2012.

In March 2010, through the Affordable Care Act (ACA), CMS offered family planning waiver states the option to apply for a State Plan Amendment (SPA), which would allow States to include family planning services in their State's health care plan instead of via a family planning waiver. Due to Illinois Medicaid Reform legislation implemented in January 2011, which included a moratorium for any new populations or eligibility expansions, Illinois was prohibited from applying for a SPA. Therefore, Illinois submitted a waiver renewal application on September 30, 2011 for the period of April 2012 through March 2015, instead of submitting a SPA.

Since the submission of the renewal application, CMS granted several temporary extensions. During this time the Department decided to phase out the waiver program effective December 31, 2013 due to the roll-out of ACA, and notified CMS June 27, 2013 of this intention. Shortly thereafter, in July 2013, CMS announced an extension of family planning waivers through December 31, 2014. HFS submitted notification on September 3, 2013 to rescind its June 27th notice to CMS to phase out the IHW waiver. A formal request was submitted to CMS on October 3, 2013 to extend IHW through December 31, 2014, and also included a phase out/transition plan. This extension allowed a period for IHW clients to obtain other healthcare coverage and have continued access to their birth control method.

On October 16, 2013, CMS approved HFS' request to extend the waiver another year. On December 6, 2013, HFS received official notification from CMS approving the IHW phase out/transition plan, and HFS proceeded to implement the phase out/transition activities.

In recognition of the positive outcomes directly attributable to the family planning waiver, and to maintain a focus on quality family planning services, as part of the phase out/transition process, HFS developed a first-ever family planning policy to reinforce this service provision. A provider notice was released on June 26, 2014 to inform enrolled providers of HFS' new policy – *Quality Family Planning and Reproductive Health Care Services* – Appendix A.

This effort was part of a larger initiative HFS undertook to enhance family planning care for Medicaid beneficiaries. On August 20, 2014, HFS' Director announced the Department's new Illinois Family Planning Action Plan (IFPAP) at the Illinois Contraceptive Equity Summit held in Chicago. A new page was added to the Department's Website and made available for providers, clients and the public to obtain additional information about family planning – visit http://www2.illinois.gov/hfs/FamilyPlanning/Pages/default.aspx. Additionally, a provider notice was distributed November 10, 2014, providing an update on the status of the IFPAP implementation – Refer to Appendix B for IFPAP action plan and provider notice.

**Program Highlights**

IHW enabled low-income women who meet the eligibility requirements to have access to essential preventive, reproductive health care services and contraceptives. Access to these services allowed women to avoid an unintended pregnancy, choose the number and spacing of their pregnancies, and when desired, to plan a healthy birth. The following criteria apply to Illinois' family planning waiver:

- women only
- ages 19 through 44
- income at or below 200 percent of the FPL
- losing Medicaid or CHIP coverage or submit an application
- other health insurance coverage allowed

In the 2010 Special Terms and Conditions, HFS was allowed to expand the scope of benefits to cover additional family planning-related services, which was implemented January 2012. During the remainder of the waiver, IHW covered the following family planning (birth control) services and family planning-related services:

- Medical history and reproductive health exam
- Patient education and counseling about women's health and family planning
- Birth control – all FDA-approved methods, including emergency contraceptives and long-acting reversible contraceptives (LARC)
- Sterilization services for women 21 years of age or older, based on stringent informed consent
- Lab tests necessary for birth control method or related reproductive health
- Pap test and abnormal Pap follow-up (i.e., repeat Pap tests, colposcopy/biopsy, cryosurgery, LEEP, and CONE)
- HPV vaccine
- Screening mammograms, when ordered by the physician during a family planning visit (provided with 100% State funds)
- Testing, treatment, and required follow-up for sexually transmitted infections
- Testing, treatment, and required follow-up for urinary tract, vaginal, other lower genital tract and genital skin infections
- HIV testing (refer for treatment)
- Folic acid supplements and prenatal vitamins (by prescription only - provided with 100% State funds)

Additionally, family planning providers were encouraged to refer women to low-cost providers for services not covered by the waiver.

**Significant Program Changes**

On October 1, 2013 and November 15, 2014, open enrollment began for Illinois' Affordable Care Act (ACA) health insurance coverage through *Get Covered Illinois* with coverage beginning January 1, 2014, and January 1, 2015 respectively. Through the *Get Covered Illinois website*, individuals could evaluate their coverage options, including their eligibility for coverage and the cost of such coverage. Depending on one's income level, an individual could get health insurance coverage in Illinois through one of two programs -- expanded Medicaid (≤138% of FPL) or the Marketplace (139%

to 400% of FPL). Information about *Get Covered Illinois*, including an online application for coverage and contact information, can be found at http://getcoveredillinois.gov.

During 2014, regularly scheduled notices were sent to existing IHW enrollees informing them that IHW was ending, with coverage continuing through December 31, 2014. The notices discussed the importance of enrolling in expanded health care coverage options made possible through ACA (Medicaid Expansion or the Marketplace), and encouraged women to apply for full benefits. The final notice was sent November 10, 2014.

As outlined in the Phase-Out/Transition Plan, HFS ceased accepting and processing IHW applications effective October 1, 2014. For applications received after this date, the applicants were sent a letter informing them that the IHW program was ending. HFS used the information the women provided on the application to start the process of applying them for full medical coverage through ACA. If additional information was needed to complete the application, a request was sent to them.

As of March 24, 2015, 39 percent of IHW women had enrolled in expanded full benefits under Medicaid. Unfortunately, HFS is unable to track the remaining women who may have enrolled in a Marketplace Plan, rely on Federal Title X Family Planning providers, or may be uninsured. HFS has been working with family planning advocates and providers to monitor service utilization of former IHW clients to determine potential follow-up.

This report covers the lifespan of the waiver; therefore, the following is a point of reference for understanding time periods:

WY 1: April 2004 – March 2005
WY 2: April 2005 – March 2006
WY 3: April 2006 – March 2007
WY 4: April 2007 – March 2008
WY 5: April 2008 – March 2009
WY 6: April 2009 – March 2010
WY 7: April 2010 – March 2011
WY 8: April 2011 – March 2012
WY 9: April 2012 – March 2013
WY 10: April 2013 – March 2014
WY 11: April 2014 – December 2014

## Enrollment Numbers and Participation:

**Total Unduplicated Participation for Population 1 & 2, Years 1–11 = 193,715**

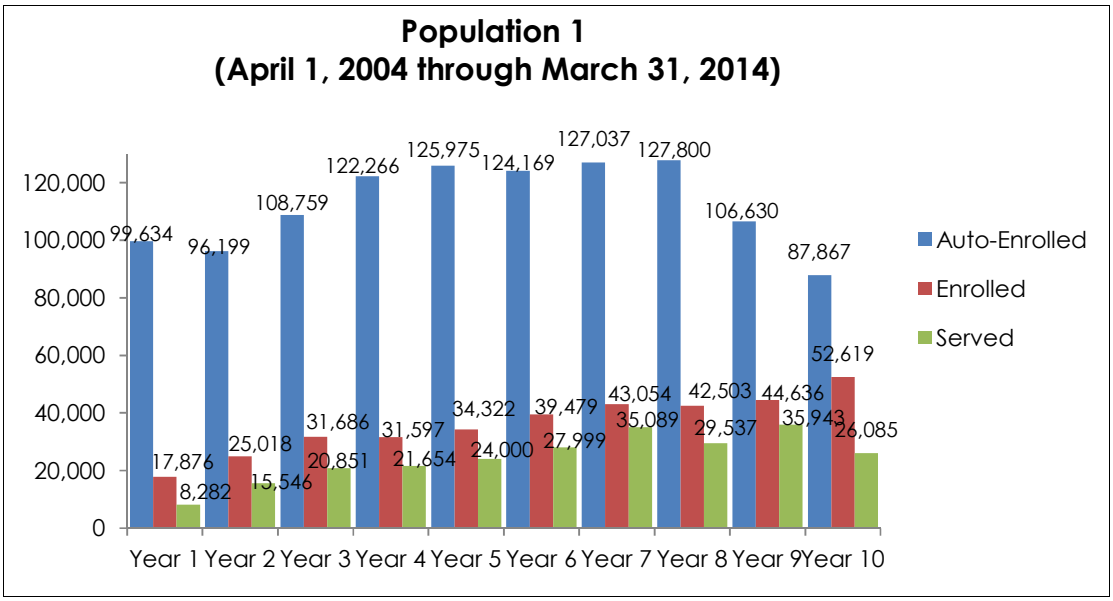
HFS is very pleased to report the success of providing family planning services to nearly 194,000 unduplicated women over the life of the waiver.

With the expansion of Population 2 in Year 4, CMS required separate data reporting for Population 1 and 2. Through ongoing quality data checks, it was identified that some women who had been counted in Population 1, dropped out of the program, applied at a later date, and were then counted in Population 2. In order to obtain an accurate total count of unduplicated IHW participants, a separate data report was developed.

Therefore, the following data for Population 1 and Population 2, in addition to the combined Population 1 and 2 data, stands on its own and is separate from the overall unduplicated number of women reported above.

**Population 1 – Automatic Enrollment**

Annual enrollment and participation numbers are presented in the graph below for Population 1 during Years 1 through 10:




Source: HFS claims data

During the last year of the evaluation period, of the 52,619 women enrolled, the retention rates are as follows:

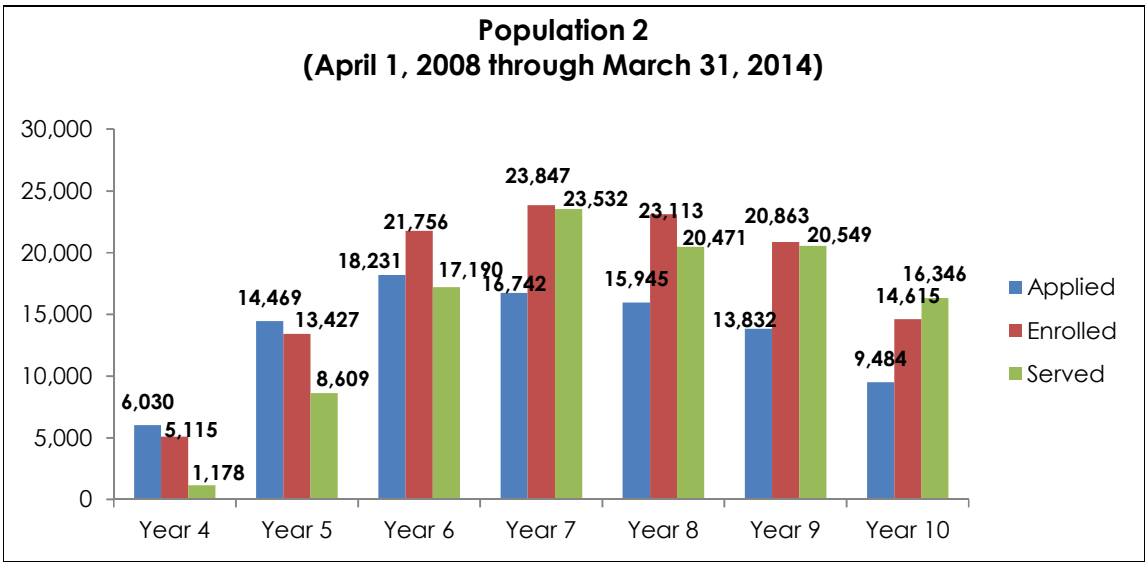
- 33,482 (64 percent) enrolled for their first year,
- 8,697 (17 percent) enrolled for their second year,
- 3,937 (7 percent) enrolled for their third year,
- 2,462 (5 percent) enrolled for their fourth year,
- 1,473 (3 percent) enrolled for their fifth year,
- 992 (2 percent) enrolled for their sixth year,
- 779 (1 percent) enrolled for their seventh year,
- 373 (1 percent) enrolled for their eighth year,
- 239 (.5 percent) enrolled for their ninth year
- 185 (.5 percent) enrolled for their tenth year

Of note, eight percent of women enrolled in Year 10 had been enrolled for five years or more.

The increase in enrollment in Year 10 was related to HFS' budgetary reform efforts, also known as "Save Medicaid Access and Resources Together" (SMART) Act, in which HFS' FamilyCare Share, Premium and Rebate programs ended for adults, effective July 1, 2012. Adults in these programs with an income over 138% FPL were dropped from coverage. This change had a significant impact on IHW Population 1 enrollment, as eligible women losing coverage from these programs were automatically enrolled in IHW. Otherwise, we have assessed that the decreasing trend over the last couple of years was most likely due to the uncertainty around continuation of the waiver program in the era of ACA.

**Population 2 – Application Enrollment**

Annual enrollment and participation numbers are presented in the graph below for Population 2 (implemented in Year 4):




Source: HFS claims data

During the last year of the evaluation period, of the 14,615 women enrolled, the retention rates are as follows:

- 5,219 (36 percent) enrolled for their first year
- 2,964 (20 percent) enrolled for their second year
- 2,090 (14 percent) enrolled for their third year
- 1,618 (11 percent) enrolled for their fourth year
- 1,488 (10 percent) enrolled for their fifth year
- 981 (7 percent) enrolled for their sixth year
- 255 (2 percent) enrolled for their seventh year

Nineteen percent of women enrolled in Year 10 had been enrolled for five years or more, however, the same decreasing trend over the last couple of years applied to Population 2 as well regarding the uncertainty around continuation of the waiver program.

Upon implementation of Population 2, application denials were tracked to determine if additional training of providers was needed when assisting women in applying, as well as identifying possible eligibility barriers. The following indicates the average rate over the five year period of the primary reasons for denial at the initial processing stage of the application:

- 65 percent did not have all the required documents
- 19 percent did not meet income guidelines
- 6 percent were under 19 years old
- 6 percent did not meet immigration requirements
- 2 percent were sterilized
- 2 percent were eligible for comprehensive coverage
- 1 percent were pregnant

- 1 percent were not Illinois residents
- 1 percent did not meet Social Security requirements

Prior to denial of an application, two attempts (form letter and phone call) were made to obtain the missing required documentation.

Analysis comparing Population 1 & 2:

- Compared to Population 1, on average, a higher rate of Population 2 women accessed services, which suggests that women *applying* for IHW (Population 2) had a higher rate of service utilization than those who automatically received an IHW card, and
- Population 2 had a higher retention rate than Population 1 – it is assumed the difference is attributable to intent – women who apply for a service are intentionally seeking that service, whereas women who are automatically enrolled may not necessarily need or want the service.

## Waiver Projections and Participation (Population 1 & 2)

The difficulty of projecting numbers for a new "start up" program, coinciding with the influx of a changing service delivery environment, proved to be a challenge with IHW. After Population 2 stabilized in Year 6, and HFS was able to revise projections based on history, the trend of actual served exceeding the estimated totals continued until Year 9. The decline, most likely, was attributable to provider/client awareness regarding the phase out/transition of the program, as well as the termination of automatic enrollment (Population I) and re-enrollment (Population 1 & 2) processing in late December 2013.

| Waiver Projections and Participation | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Estimated & Actual Participation*** | **Year 1 (04/04-03/05)** | **Year 2 (04/05-03/06)** | **Year 3 (04/06-03/07)** | **Year 4 (04/07-03/08)** | **Year 5 (04/08-03/09)** | **Year 6 (04/09-03/10)** | **Year 7 (04/10-03/11)** | **Year 8 (04/11-03/12)** | **Year 9 (04/12-03/13)** | **Year 10 (04/13-03/14)** |
| **Population 1 Automated Process** | | | | | | | | | | |
| Estimated Women | 15,942 | 16,579 | 17,242 | 17,932 | 18,649 | 25,326 | 26,339 | 27,392 | 38,975 | 43,973 |
| Actual Women | 10,199 | 13,261 | 18,544 | 23,415 | 24,044 | 28,050 | 33,038 | 27,809 | 35,943 | 26,085 |
| **Population 2 Application Process** | | | | | | | | | | |
| Estimated Women | | | | 44,403 | 46,179 | 11,491 | 12,640 | 13,904 | 28,119 | 30,931 |
| Actual Women | | | | 1,779 | 8,614 | 17,195 | 23,239 | 20,241 | 20,549 | 16,346 |
| **Population 1 & 2** Estimated Total | 15,942 | 16,579 | 17,242 | 62,335 | 64,828 | 36,817 | 38,979 | 41,296 | 68,094 | 74,904 |
| Actual Total | 10,199 | 13,261 | 18,544 | 25,194 | 32,658 | 45,245 | 56,277 | 48,050 | 56,492 | 42,431 |

* Participation is defined as receiving family planning services under the waiver. Year totals represent unduplicated count for that year. Data based on paid claims.

## Participant Characteristics:

**Age** – the following chart depicts the percentage of IHW participants by age group during the ten years of the waiver program. An analysis of Population 2, Year 10 data (April 1, 2013 through March 31, 2014) indicates that 75.8 percent of the women enrolled in IHW through the application process were 19 to 29 years old. During Year 10 for Population 1, the percentage of women 19 to 29 years of age who were automatically enrolled in IHW was 70.7 percent. This continues to be evidence that the IHW expansion is reaching the intended population of women who are most likely to experience an unintended pregnancy.[1]

The highest participation rates for Population 1 were represented by those aging out of the CHIP program – these women were automatically enrolled and remained actively enrolled for the remaining nine months of coverage.

| Population 1 by Age | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Percentage of Participants | | | | | | | | | |
| Age | Y1 | Y 2 | Y 3 | Y 4 | Y 5 | Y 6 | Y7 | Y8 | Y9 | Y10 |
| 19 | 18.9 | 13.5 | 13.0 | 9.5 | 10.1 | 11.6 | 14.2 | 14.4 | 13.6 | 12.6 |
| 20 – 24 | 35.0 | 40.1 | 37.3 | 40.0 | 40.6 | 41.3 | 40.6 | 42.4 | 38.9 | 42.6 |
| 25 – 29 | 23.7 | 23.9 | 23.9 | 23.8 | 21.7 | 19.9 | 18.2 | 16.9 | 16.2 | 15.5 |
| 30 – 34 | 12.4 | 11.6 | 12.7 | 13.3 | 13.2 | 13.0 | 12.8 | 11.9 | 13.3 | 12.5 |
| 35 – 39 | 6.3 | 6.8 | 7.2 | 7.9 | 8.3 | 8.2 | 7.9 | 7.8 | 9.3 | 8.4 |
| 40 – 44 | 3.6 | 4.1 | 5.9 | 5.4 | 6.1 | 6.1 | 6.2 | 6.5 | 8.6 | 8.4 |

Source: HFS claims data

| Population 2 by Age | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Percentage of Participants | | | | | | | | | |
| Age | Y1 | Y2 | Y3 | Y 4 | Y5 | Y6 | Y7 | Y8 | Y9 | Y10 |
| 19 | | | | 6.7 | 2.6 | 1.9 | 1.3 | 1.1 | 0.8 | 0.6 |
| 20 – 24 | | | | 56.7 | 56.0 | 52.5 | 49.2 | 46.2 | 42.4 | 38.8 |
| 25 – 29 | | | | 23.4 | 27.7 | 30.6 | 33.2 | 34.6 | 35.8 | 36.4 |
| 30 – 34 | | | | 7.2 | 8.2 | 9.0 | 10.1 | 11.5 | 13.1 | 15.3 |
| 35 – 39 | | | | 3.5 | 3.5 | 3.7 | 3.7 | 4.0 | 4.7 | 5.3 |
| 40 – 44 | | | | 2.4 | 2.0 | 2.3 | 2.5 | 2.6 | 3.2 | 3.7 |

Source: HFS claims data

**Race/Ethnicity** -- During Year 4, HFS upgraded the race/ethnicity data collection methodology to meet new requirements. The system modifications took much longer than anticipated, and the data collected continued to report high rates of "unknown". Therefore, the decision was made to forgo reporting race/ethnicity data for IHW for the duration of the waiver.

## Additional STC data reporting requirements:

Starting in Year 7, HFS' STCs required additional data submission to ensure compliance with eligibility in the following areas:

[1] Institute of Medicine, *The Best Intentions*, 1995.

**Third-Party Liability**
Of the women who applied and were newly enrolled an average annual rate of 4.3 percent of IHW women were identified as having third-party insurance coverage. Since the Department already had systems in place to comply with federal third-party reporting requirements, data was readily available.

**Sterilizations**
HFS was also required to report the number of women who became sterilized as a result of receiving IHW services. During Years 7 - 10, less than one percent of IHW clients received a sterilization procedure, identified in the claims data with the sterilization diagnosis code V25.2. These women were no longer eligible for IHW.

**Eligibility Determination Error Rate Analysis**
As part of the Department's efforts to comply with having an appropriate methodology for ensuring the integrity of the initial eligibility determinations and redeterminations of individuals covered under the waiver, HFS' Office of Inspector General (OIG) received a CMS grant for FFY10 to conduct a Medical Eligibility Quality Control (MEQC) pilot project to review the IHW eligibility determinations for a sample period. Following the eligibility reviews, individual case corrective action was coordinated with the IHW unit and a payment review of each case was conducted. As a result, a case and payment error rate was calculated.

OIG completed a review of 1,321 active cases for the period of October 2009 through September 2010 for the following purposes:

- To examine the eligibility determination of women covered under IHW
- To monitor performance
- To facilitate program improvement related to case and payment error rates
- To establish an error rate threshold

Based on this review, the eligibility error rate threshold was established at 6.13 percent and the payment error rate threshold at 6.81 percent. OIG submitted the MEQC summary report of the findings from the IHW eligibility determination error rate review to CMS, and the IHW MEQC CAP was approved December 2011.

## Services and Providers:

**Service Codes**
The covered benefits package for family planning demonstration waivers are limited, with a focus on preventing unintended pregnancies; and, family planning-*related* services are more limited. CMS required approval for every service code added to the benefits package in order to monitor compliance. From the beginning, Illinois took opportunities to broaden the benefits package, as allowed, always ensuring the intent of the demonstration waiver. Many State waivers did not include STI testing and treatment or HIV testing, however, Illinois' waiver did include theses services, recognizing the important role STI and HIV screening has on reproductive health. Another area that Illinois felt passionate about, since low-income women are at a

higher risk and are less likely to obtain medical care outside of the waiver, was to cover screening mammograms and folic acid supplements under the IHW program. Since these services were not approved by CMS, HFS included them as part of the IHW benefits package using 100% State funds.

As more family planning waivers were being approved nationally, CMS gave further consideration to allowing additional family planning-*related* services. With the CMS approval of HFS' renewal application in Year 6, the updated STCs allowed HFS to broaden the scope of services and cover many new family planning-*related* services. The expanded benefit package was finally was approved by CMS in Year 8. Refer to the Executive Summary, Program Highlights for the detailed covered service package.

In Year 9, CMS approved HFS' request to support an additional service code for Illinois family planning providers. This effort was to recognize the importance of counseling clients on effective family planning methods, and to assure the delivery of quality family planning services. HFS established a supplemental rate for designated family planning clinics that met specific criteria outlined on the Family Planning Clinic Attestation form:

> *Provide primarily family planning services (V25 series diagnosis code – contraceptive management) – primarily family planning is defined as a provider with a minimum of 200 V25 visits and meeting at least 51% of V25 services compared to total services billed to the Department, or is a federal Title X family planning agency(excluding encounter rate agencies)*

CPT code 99401—d*efined as preventative medicine counseling and/or risk factor reduction interventions provided to an individual (separate procedure) approximately for 15 minutes* was approved and implemented January 2012. This payment reflected the Department's commitment to support facilities providing a high volume of family planning services to our clients. In order to receive this payment, both the facility and individual practitioner had to attest to meeting the criteria as outlined above.

Continuing HFS' efforts to assure the delivery of quality family planning services and recognizing the importance of utilization of highly effective contraceptive methods, in Year 10, HFS added a new dispensing fee for highly effective birth control methods purchased through the 340B federal Drug Pricing Program. Providers who met the 340B requirements, and whose claims were billed correctly, received a $35 dispensing fee for highly effective birth control methods such as, IUDs, implants, birth control pills, contraceptive patch and injections.

**Providers**

In Year 11, HFS released a provider notice regarding the Department's new policy on Quality Family Planning and Reproductive Health Care Services. Refer to the Executive Summary, Brief Description.

As the Department expanded its service delivery models to include Managed Care Organizations (MCO), the Bureau of Quality Management (BQM) worked closely with HFS' Bureau of Managed Care (BMC) to improve the scope of contraceptive care by providing specific family planning language to include in the FY2015 MCO contracts. This action provided a strong message that quality family planning was a priority of the

Department, with the goal to ensure coverage of, and access to, the recommended standards of care set by the Centers for Disease Control and Prevention (CDC) and/or American Congress of Obstetricians and Gynecologists (ACOG) for family planning and reproductive health services.

To better ascertain that each Plan had family planning protocols, including a drug formulary with a comprehensive list of FDA-approved contraceptive methods, HFS staff reviewed all MCO family planning policies. Additionally, a family planning Readiness Review Tool was developed by the Department's external quality review organization (EQRO) to monitor compliance. Also, the contract now includes language that all barriers to care must be removed, such as prior authorizations and step-therapy measures.

**Program Outreach, Awareness, and Notification:**

Throughout the waiver, outreach efforts were ongoing to ensure the public, clients and providers were aware of IHW and of the family planning services available. The following are examples of some of these outreach efforts:

- The IHW website was regularly maintained and received over 50,000 external visitors each year. BQM/IHW staff responded to e-mail inquiries through the IHW website regarding the IHW program – about 1,000 every year.

- Annually, through HFS' Hotline, over 20,000 calls regarding IHW were responded to by the Hotline staff.

- Throughout the waiver, HFS provided training opportunities for providers through webinars, notices and on-site meetings. Updates on current reproductive health practice, such as highly effective contraceptive methods and STI Testing and Treatment Guidelines were included. To assist HFS providers, and to ensure a high level of expertise, BQM/IHW staff attended and actively participated with national family planning organizations to learn new strategies to measure quality maternal/reproductive health care, reduce costs, and to maximize compliance.

- Monthly webinars were conducted by HFS' Primary Care Case Management (PCCM) administrator, Illinois Health Connect, to educate providers on topics such as billing, provider profiles, use of the MEDI system, coding and reimbursement, HFS medical programs, and specific services. These webinars gave providers an opportunity to get questions answered by experts on specific topics, including IHW.

- Participated in ongoing collaboration between HFS and the Departments of Public Health (DPH) and Human Services (DHS) to ensure statewide community partners and providers were updated on IHW, as well as other HFS initiatives.

- Involved in the CHIPRA Child Health Quality Demonstration Grant Project, Category E workgroup, which focuses on several strategies to improve birth outcomes, including inter-pregnancy spacing. One of the goals of HFS is to

demonstrate the impact family planning has on improving birth outcomes through better birth spacing.

- Provided workshop sessions on IHW and Medicaid Family Planning at several conferences/meetings held by Illinois organizations, such as the Illinois Public Health Association, DHS Title X Family Planning program, Illinois Maternal & Child Health Association, DPH Illinois Breast and Cervical Cancer program, and DHS' Family Case Management and WIC programs.

**Phase Out/Transition Plan:**

HFS' STCs required a transition and phase-out plan be submitted to CMS for approval prior to initiation of the waiver phase out process. Refer to the Executive Summary, Brief Description, for specific details. A copy of the updated and final version of the plan is attached as Appendix C.

HFS took a comprehensive approach to phasing out the waiver by involving several HFS Divisions/Bureaus – Administration, Quality Management, Medical Eligibility Policy, Information Systems, Communications/Webmaster, Provider Billing/Claiming, Finance, Technical Support and the IHW Application Case Worker Unit. The expertise from each specialty area ensured that all aspects of this complex waiver program complied with federal requirements, addressed client and provider understanding of changes, and to the extent possible, focused on continuity of care to reduce gaps in coverage for family planning services.

The additional year extension through December 2014 allowed participants to have continued access to their contraceptive method while obtaining affordable healthcare coverage through options available through ACA. HFS released an informational notice to update family planning providers on the phase out/transition of the IHW program, and several notices were distributed to IHW clients throughout the year to remind them that the program was ending, and the importance of enrolling in ACA.

Fortunately, Illinois was one of the States that implemented Expanded Medicaid under ACA, and as of March 25, 2014, approximately 40 percent of the IHW participants have enrolled in Medicaid Expansion. We are not able to track the number of women who have enrolled into the Marketplace; however, providers and advocates are monitoring potential gaps of coverage for their clients in order to assist them as needed.

**Program Evaluation:**

The comprehensive evaluation report is attached as Appendix D. However, a brief synopsis of the successes experienced during the ten years of IHW is recapped below:

- 193,715 unduplicated women received family planning services through IHW
- More low-income women received *publicly-funded* family planning services with IHW experiencing a five-fold increase
- IHW showed a lower rate of women with a birth spacing interval of <18 months compared to Medicaid women

- IHW showed a higher rate of women with a birth spacing interval of 24 months or greater compared to Medicaid women
- The Illinois unintended pregnancy rate decreased 9.1percent (2001-2011), while the HFS rate for the same period decreased 10.4 percent
- The IHW fertility rate is substantially lower than the total population and population of women ≤200 percent FPL. From 2005 to 2009, the fertility rate of IHW women on average (2.1%) was 9.5 percentage points less than Illinois women in poverty (11.6%) and nearly 5 percentage points less than the total Illinois population (7.0%)
- Reduction in births among low-income women under age 25
- Delays in pregnancies demonstrated by an increase in low-income women delivering between ages 30 through 39
- 48,369 averted births resulting in an estimated $559M in cost savings

**Budget Neutrality/Annual Budget Limit (BN/ABL)** – Refer to Appendices E and F
Per CMS' approval on February 27, 2015, the BN/ABL worksheets submitted with the Year 10 Program Progress Report are being re-submitted as the final documents for this final report. Updated birth data is not available; therefore, we are unable to update the worksheets beyond Year 9. However, it is clearly demonstrated that by having a family planning waiver, a significant savings to the State and Federal governments has been achieved, hence meeting the budget neutrality requirement.

The early submissions of the BN/ABL were calculated using the Guttmacher Institute's births averted methodology. In Year 6, CMS required HFS to calculate the BN/ABL with CMS' methodology. The average annual cost of IHW's family planning services was **$309***, while the average annual cost for prenatal care, delivery, postpartum and first year of infant's life was **$11,198***. The BN/ABL demonstrated that during Years 1-10, expanded access to contraceptive services through IHW has averted an estimated **48,369*** births, which resulted in a savings of approximately **$391.7M*** in pregnancy-related and infant health care expenditures. *Source: IHW Budget Neutrality-Appendix E

Another approach to looking at cost savings is reported in the Evaluation Report, Objective 6, attached as Appendix D. This analysis represents the cost difference of pregnancy-related and infant health care (includes prenatal care, delivery, 60 days postpartum and first year of infant's life), without the waiver and with the waiver, which resulted in an even greater overall savings of more than **$559M** over the ten year period.

**Annual Expenditures**
IHW expenditures are submitted to CMS in the CMS 64 report. The service expenditures for Years 1 - 10 (April 1, 2004 - March 31, 2014) totaled **$110,812,964** (federal share -- **$81,723,012**) as reported below:

**Service** Expenditures

| Waiver Year | Computable | Federal Share |
|---|---|---|
| **Year 1** | $1,811,139 | $1,384,683 |
| **Year 2** | $3,119,542 | $2,389,558 |
| **Year 3** | $4,731,520 | $3,510,852 |

| | | |
|---|---|---|
| **Year 4** | $6,931,116 | $5,168,769 |
| **Year 5** | $11,040,938 | $8,241,423 |
| **Year 6** | $15,229,925 | $11,628,943 |
| **Year 7** | $18,365,881 | $14,024,212 |
| **Year 8** | $19,499,791 | $14,128,474 |
| **Year 9** | $17,801,621 | $12,687,438 |
| **Year 10** | $12,281,491 | $8,558,660 |
| **Total** | **$110,812,964** | **$81,723,012** |

As reported on CMS 64 May 2014

Beginning in Year 5, CMS required States to report waiver expenditures for administrative oversight in the quarterly and annual reports – the chart below depicts those annual costs for Years 5 – 10 (April 1, 2008 – March 31, 2014) totaling **$6,027,430 (federal share -$3,013,725)**

**Administrative** Expenditures

| Waiver Year | Computable | Federal Share |
|---|---|---|
| **Year 5** | $422,613 | $211,307 |
| **Year 6** | $521,546 | $260,773 |
| **Year 7** | $1,688,625 | $844,314 |
| **Year 8** | $577,839 | $288,922 |
| **Year 9** | $729,640 | $364,823 |
| **Year 10** | $2,087,167 | $1,043,587 |
| **Total** | **$6,027,430** | **$3,013,725** |

As reported on CMS 64 May 2014

## Conclusion

HFS is very pleased to have had the opportunity to administer this demonstration waiver since 2004. The evaluation findings reveal that having a family planning waiver reduces unplanned pregnancies and provides financial benefits to the State by reducing the amount of dollars spent on costly prenatal care, delivery, postpartum care and care provided during the first-year of the infant's life, which is consistent with evaluation results of family planning waivers nationally. However, additional benefits that are not easily measured include enabling women to obtain essential preventive reproductive healthcare services, the opportunity to make better-educated decisions regarding the timing of pregnancies which leads to enhanced self-sufficiency, and ultimately improved birth and health outcomes.

These results validate HFS' recent efforts to improve and expand comprehensive, quality family planning services to all of HFS recipients of medical care, therefore, sustaining the work of the family planning waiver.

# Acronym List

| | |
|---|---|
| **ABL** | Annual Budget Limit |
| **ACA** | Affordable Care Act |
| **ACOG** | American Congress of Obstetricians and Gynecologists |
| **BMC** | Bureau of Managed Care |
| **BN** | Budget Neutrality |
| **BQM** | Bureau of Quality Management |
| **CDC** | Centers for Disease Control and Prevention |
| **CHIPRA** | Children's Health Insurance Program Reauthorization Act |
| **CMS** | Centers for Medicare & Medicaid Services |
| **DHS** | Illinois Department of Human Services |
| **DPH** | Illinois Departments of Public Health |
| **EDW** | Enterprise Data Warehouse |
| **EQRO** | External Quality Review Organization |
| **FPL** | Federal Poverty Level |
| **FQHCs** | Federally Qualified Health Centers |
| **HFS** | Illinois Department of Healthcare and Family Services |
| **IFPAP** | Illinois Family Planning Action Plan |
| **IHW** | Illinois Healthy Women |
| **LARC** | Long-Acting Reversible Contraceptives |
| **MCO** | Managed Care Organizations |
| **MEQC** | Medical Eligibility Quality Control |
| **MMIS** | Medicaid Management Information System |
| **OIG** | Office of Inspector General |
| **PCCM** | Primary Care Case Management |
| **PRAMS** | Pregnancy Risk Assessment and Monitoring System |
| **SMART ACT** | Save Medicaid Access and Resources Together Act |
| **SPA** | State Plan Amendment |
| **STC** | Special Terms and Conditions |
| **STI** | Sexually Transmitted Infections |
| **WIC** | Women, Infants, and Children |
| **WY** | Waiver Year |

# Appendix A

# Family Planning and Reproductive Health Services Provider Notice

ILLINOIS DEPARTMENT OF Healthcare and Family Services

**Pat Quinn, Governor**
**Julie Hamos, Director**

201 South Grand Avenue East
Springfield, Illinois 62763-0002

**Telephone:** 1-877-782-5565
**TTY:** (800) 526-5812

**Informational Notice**

**Date:** June 26, 2014

**To:** Participating Physicians, Advanced Practice Nurses, Physician Assistants, Local Health Departments, Enrolled Encounter Rate Clinics, Federally Qualified Health Centers, Rural Health Clinics, Enrolled Hospitals, and Managed Care Entities

**Re:** Family Planning and Reproductive Health Services

The purpose of this notice is to provide further guidance regarding family planning and reproductive health services. Consistent with requirements of the Affordable Care Act, all Healthcare and Family Services (HFS) enrolled providers shall ensure that the full spectrum of family planning options and reproductive health services are appropriately provided with no cost sharing. Family planning and reproductive health services are defined as those services offered, arranged or furnished for the purpose of preventing an unintended pregnancy, and to improve health and birth outcomes. Family planning and reproductive health services shall be provided by, or administered under the supervision/collaboration of a physician (MD or DO), advanced practice nurse or physician assistant, and must follow the most current nationally recognized evidence-based standards of care and guidelines for sexual and reproductive health, such as those established by the Centers for Disease Control and Prevention (CDC) (pdf) or the American Congress of Obstetricians and Gynecologists.

Medicaid's free choice of provider's statute (pdf) allows clients to see any Medicaid provider of their choice when seeking family planning and reproductive healthcare services. Thus, clients can access contraceptive services and supplies without managed care network restrictions. Additionally, provider policies/protocols shall not present barriers that delay or prevent access, such as prior authorizations or step-therapy failure requirements. Clients should receive education and counseling on all FDA-approved birth control methods (pdf) from most effective to least effective, and have the option to choose the preferred birth control method that is most appropriate for them – CDC Guidance (pdf).

The following services are covered under HFS' comprehensive medical programs* and, at a minimum, must be offered to patients through direct services or timely referral:

- A reproductive life plan (pdf) which may include a preconception care risk assessment (pdf) and preconception and interconception care discussions.
- Education and counseling on all contraceptive methods with emphasis on presenting the most effective methods first, specifically long acting reversible contraceptives (LARC) such as intrauterine devices (IUD) (pdf) and the implantable rod.
- Contraceptive methods must also include over-the-counter and prescription emergency contraception, including the provision of the copper IUD for emergency contraception.
- Permanent methods of birth control: tubal ligation, transcervical sterilization and vasectomy
- Basic infertility counseling, consisting of medical/sexual history review and fertility awareness education. Infertility medications and procedures are NOT covered.
- Reproductive health exam, with pelvic exam decoupled from the provision of contraception
- Age and risk appropriate Sexually Transmitted Infection (STI) screening and treatment (pdf)
- Universal HIV testing and counseling

- Testing and treatment for genital and related infections and other pathological conditions
- Lab test or screening necessary for family planning and reproductive health services
- Cervical cancer screening, management, and early treatment
- Vaccines for preventable reproductive health related conditions (i.e., HPV, Hepatitis B)
- Mammography referral and BRCA genetic counseling and testing

**Note, not all services are covered by Illinois Healthy Woman, please refer to http://www.illinoishealthywomen.com/covered.html*

Please refer to the Handbook for Practitioners Rendering Medical Services (pdf) for policy and procedures for medical services.

Theresa A. Eagleson, Administrator, Division of Medical Programs

# Appendix B

# Illinois Family Planning Action Plan
# November 2014 Provider Notice

# Illinois Family Planning Action Plan

8/20/2014

**GOAL: Increase access to family planning services for women and men in the Medicaid Program by providing comprehensive and continuous coverage to ensure that every pregnancy is a planned pregnancy.**

**ACTION #1: Payments and operational policies reflect the value HFS places on providing the most effective form of contraception.**

1) Double the provider reimbursement rate for intrauterine device insertion from $44 to $88.
2) Double the provider reimbursement rate for vasectomy service from $204 to $408.
3) Increase 340B medical providers' dispensing fee for all long acting reversible contraceptives (LARC) from $20 to $35. Increase 340B medical providers' dispensing fee for all hormonal contraceptives from $20 to $35 (three-month month supply required, except in extenuating circumstances).
4) Allow medical provider reimbursement (with modifier 25) for two services on the same day when one is a LARC procedure AND includes an initial or established annual exam or problem visit. Continue current practice allowing FQHCs to bill for one encounter rate.
5) Allow FQHCs to bill fee-for-service for permanent, non-surgical sterilization kits (*Essure*), consistent with LARC policy.
6) Investigate allowing hospitals to bill for LARC device insertion immediately postpartum.

**ACTION #2: Health plans and providers in the Medicaid Program make all forms of family planning available to Medicaid clients in a convenient and seamless manner.**

1) Communicate to all health plans and providers HFS' commitment that clients receive evidence-based counseling and education on all FDA-approved contraceptives, from most-effective method to least-effective method. [Informational Notice was sent to all Medical Assistance Providers on 6/26/14.]

2) Communicate to all health plans and providers that cost sharing (co-pays/deductibles/co-insurance), step therapy failure requirements and prior authorization are not acceptable in the provision of family planning services. [This was reflected in new and updated health plan contracts with most managed care entities].
3) Require annual submission of all health plans' family planning policies to HFS, including referral policies by those plans with Right of Conscience objections to providing contraception.
4) Continue working with the LARC pharmaceutical industry to help ensure Medicaid providers have LARC inventory on the shelf for same day-insertion, with ongoing training, quality assurance and notice of any policy improvements.
5) Institute more effective communication regarding timely physician and FQHC reimbursements for current fee-for-service payments as well as contractual requirements for health plan payments.

Please email your comments on this draft Illinois Family Planning Action Plan by September 15, 2014 to kai.tao@illinois.gov.

ILLINOIS DEPARTMENT OF Healthcare and Family Services

**Pat Quinn, Governor**
**Julie Hamos, Director**

201 South Grand Avenue East
Springfield, Illinois 62763-0002

**Telephone:** 1-877-782-5565
**TTY:** (800) 526-5812

# Informational Notice

**Date:** November 10, 2014

**To:** Participating Physicians, Advanced Practice Nurses, Local Health Departments, Encounter Rate Clinics, Federally Qualified Health Centers, and Rural Health Clinics

**Re:** Important Family Planning Policy Change and Payment Increases- **Updated from 10/10/14**

The purpose of this notice is to provide further information regarding patient centered family planning services as follow up to the Illinois Family Planning Action Plan.

High quality, effective and voluntary contraceptive education and services help families control the number, timing and spacing of birth. The Illinois Department of Healthcare and Family Services (HFS) encourages providers to ensure that participants receive education and counseling on all FDA-approved birth control methods (pdf) with emphasis on presenting the most effective methods first, specifically long acting reversible contraceptives (LARCs) such as intrauterine devices (IUD) and the implant (pdf). Systems that support primary prevention of unplanned pregnancy are critical to improve outcomes for both mother and baby. All changes are effective for dates of service on, and after October 1, 2014 unless otherwise noted.

1. **Increased Reimbursement Rate for Insertion/Removal Procedures of Long Acting Reversible Contraceptives (LARCs)**

   Chart below details the new rates:

| CPT Code | Description | Previous Rate | New Rate |
|---|---|---|---|
| 11981 | Insertion of implant | $72.30 | **$88.00** |
| 11982 | Removal of implant | $87.00 | **$99.00** |
| 11983 | Removal and reinsertion of implant | $108.00 | **$143.00** |
| 58300 | Insertion of IUD | $44.00 | **$88.00** |
| 58301 | Removal of IUD | $37.40 | **$37.40** |
| 58300 + 58301 | Removal and reinsertion of IUD | $44.00 | **$106.70** |

   Removal and reinsertion is calculated at 100% of the higher CPT code rate plus 50% of the lower CPT code rate. Note that no single CPT code currently exists for IUD removal with reinsertion; therefore, providers should submit CPT codes for **each** service.

2. **Evaluation/Management (E/M) visit on the Same Day as LARC Insertion or Removal**

   Providing same day family planning services is critical to support patient centered family planning services. LARCs do not require on-going patient maintenance, have an excellent safety profile, and have very few contraindications for girls and women of childbearing age. In the asymptomatic client, there are no clinical indications to delay insertion due to lack of sexually transmitted infection screening or cervical cancer screening results. This policy supports providing screenings and exams on the same day as insertion.

Payment for an annual preventive, problem focused E/M visit, or postpartum visit along with a LARC insertion or removal procedure is allowable when the medical record documents the significant, separately identifiable services and modifier 25 is appended to the E/M service. See below for examples:

- When the provider and patient discuss contraceptive options during an initial or annual preventive visit (99381-99397) or a postpartum visit (59430) and subsequently, the device is placed, a service code with modifier 25 in addition to the insertion procedure code is reimbursable. If the provider removed a device and reinserted a new device with the preventive visit, rates as noted in chart above plus the preventive visit is reimbursable.

- When the provider and patient discuss contraceptives during a problem focused E/M visit (99201-99215) that was initiated for a reason other than LARC insertion, and on the same date of service the provider places the device, a problem focused E/M service code with modifier 25 in addition to the insertion procedure is reimbursable. If the provider removed a device and reinserted a new device with the problem focused visit, rates as noted in chart above plus the problem focused visit is reimbursable.

- When the provider and the patient review a previously chosen LARC method and proceed with placement of the LARC, only the insertion procedure code may be submitted.

Providers must use the appropriate diagnosis code from the V25.xx (encounter for contraceptive management) series in the ICD-9-CM, or the appropriate ICD-10–CM (upon implementation) for the primary code attached to the insertion (and/or removal) procedure code.

**3. Vasectomy Reimbursement Rate Increase**

Vasectomy is the only long term method men can use to achieve their reproductive life plans. Post operative complications are lower than female sterilization, recovery time is minimal, and the procedure can be safely done in the office or out-patient setting. Providers who bill for this service with CPT code 55250 will be reimbursed at $408. Such claims must be submitted on a paper claim form with the consent form HFS 2189 (pdf) attached, which must be completed at least 30 days, but no more than 180 days, prior to the procedure. Accuracy and legibility of procedures, dates and providers on the sterilization consent form are critical to prevent delayed payment

**4. Federally Qualified Health Centers (FQHC) and Rural Health Center (RHC) Fee for Service Billing for Transcervical Sterilization Device**

Permanent female sterilization with placement of inserts in the fallopian tube via the cervix is an alternative to hospital based, surgical sterilization. The procedure does not require an incision, does not require general anesthesia, and has a very high efficacy rate. An FQHC or RHC may bill fee for service for the transcervical sterilization kit following the fee-for-service billing guidelines for LARC devices:

- Reimbursement shall be made at the FQHC or RHC's actual acquisition cost or the rate on the department's practitioner fee schedule, whichever is lowest;

- This service must be billed separately from, and reimbursement shall be made separately from, any encounter payment the FQHC or RHC may receive for the insertion procedure.

**As a reminder, IUDs, contraceptive implants, and transcervical sterilization devices are the only items separately reimbursable to FQHCs and RHCs from the encounter rate.**

**5. Increase in Medical Dispensing Fee Add-On for Certain 340B Birth Control Methods and Change in allowable coding for Emergency Contraceptive Pills**

Effective with dates of service July 1, 2014 and after, the following birth control methods purchased through the 340B program will receive an increase in the dispensing fee add-on. In order to receive the $35 medical dispensing fee add-on, providers must identify 340B purchased drugs by reporting modifier "UD" in conjunction with the appropriate procedure code. The provider charge should be the actual acquisition cost plus the $35 dispensing fee. Providers should monitor the department's Claims Processing System Issues page for information regarding adjustments.

Effective with dates of service July 1, 2014 and after, the department will no longer reimburse emergency contraceptive pills (ECPs) billed with procedure code J8499. All ECPs must be billed using S4993.

- Providers who billed and were paid for procedure code J8499 for ECPs dispensed on or after July 1, 2014 must complete replacement claims following these new guidelines.
- Providers who billed J8499 and received rejections for ECPs dispensed on or after July 1, 2014 may re-bill following these new guidelines.

| HCPCS | Birth Control Method | Medical Dispensing Fee Add- On |
|---|---|---|
| J7300 | Copper Intrauterine Device ( Paragard) | $35/device |
| J7301 | Levonorgestrel-releasing Intrauterine Device 13.5mg (Skyla) | $35/device |
| J7302 | Levonorgestrel-releasing Intrauterine Device, 52mg (Mirena) | $35/device |
| J7307 | Etonogestrel Implant (Nexplanon) | $35/device |
| J1050 | Medroxyprogesterone acetate 150 mg Injection | $35/ injection |
| J3490 | Depo-SubQ Provera 104 mg Injection (must include the name of the item in the note/description field) | $35/injection |
| J7303 | Vaginal ring* | $35/ 3 month supply |
| J7304 | Contraceptive Patch* | $35 / 3 month supply |
| S4993 | Oral Contraceptives* | $35/ 3 month supply |
| S4993 | Emergency Contraceptive Pills** | $35/ 1 to 3 doses |

**Providers must dispense the three (3) month supply allowable by the department whenever possible. In most cases, providing patients with sufficient supply increases adherence to the method. Exceptions may be made when medically contraindicated as documented in the chart or if patient and provider medical decision making does not require 3 packs to be dispensed. Please ensure medical records document reason for NOT dispensing the required 3 packs.*

***HFS has updated the dispensing policy for ECPs allowing for advance provision of up to 3 doses. Clinical guidelines encourage timely provision and patients should be counseled on a more effective form of birth control*

**Special Information Regarding Care Coordination Billing and Eligibility**

The specific billing instructions in this notice apply to patients enrolled in traditional fee-for-service, Accountable Care Entities (ACEs) and Care Coordination Entities (CCEs). Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs) will reimburse at these new rates though their implementation date is 1-2 months out depending on the plan.

It is imperative that providers check HFS electronic eligibility systems regularly to determine beneficiaries' enrollment in a plan. Electronic Data Interchange vendors (formerly the Recipient Eligibility Verification (REV) System), the Automated Voice Response System (AVRS) at 1-800-842-1461, and the Medical Electronic Data Interchange (MEDI) system will identify the enrollee's care coordination plan. Questions related to coverage and billing requirements as well as information regarding the way each plan is displayed in the department's electronic eligibility systems may be located in the June 24, 2014 informational notice titled, Revised - Care Coordination Enrollment for Children, Families and ACA Adults (pdf)

**Final Reminders**

- Providers interested in LARC training/refreshers should refer to the links for pharmaceutical contacts that can bring training to a practitioner's office. Further education for providers and staff will be offered later this fall with details to be posted on the department's Family Planning and Birth Control web page. Additionally, if practitioners and/or patients encounter issues related to contraceptive access, please communicate concerns in writing via the Feedback Forum.

- HFS is exploring innovative ways to provide devices at your office without incurring the high upfront costs. Coming soon, we will pilot a system where providers are provided sufficient devices at the office, employing a technological solution for streamlined auto replenishing. The department will notify providers when this system is operational.

- *Illinois Healthy Women* (IHW) ends 12/31/2014. Women enrolled in IHW will now have the opportunity to obtain comprehensive healthcare coverage through either Expanded Medicaid or the Health Insurance Marketplace. For more information, see the IHW informational notice update from 6/4/2014.

Thank you for your commitment to helping ensure every pregnancy is a planned pregnancy. HFS is committed to ensuring timely reimbursement for all medical assistance providers. Questions related to this notice should be directed to the Bureau of Professional and Ancillary Services at 1-877-782-5565.

Theresa A. Eagleson, Administrator
Division of Medical Programs

# Appendix C

# IHW Phase-Out and Transition Plan

# PHASE-OUT/TRANSITION PLAN - ILLINOIS HEALTHY WOMEN (IHW) ENDING 12/31/2014

| Area of Focus | Action Steps | Completion Status | Notes |
|---|---|---|---|
| **Transition Process** | • Meet with HFS staff (Policy/Eligibility, Systems, BCHS) to identify process—transitioning to full Medicaid & health exchanges, timely communication to clients/providers, or other areas identified | Completed | Initial meeting (Nov2012) with HFS' Bureau of Policy staff regarding transition plan.<br>Ongoing communications with the Bureau of Policy regarding eligibility system edits. |
| **Required Communication with CMS regarding Program Termination and Transition Plan** | • Send request to rescind phase-out letter (6/27/13) and draft transition plan based on CMS' notification (7/2013) to extend waivers through 12/31/2014 | Completed | Sent on 9/3/2013<br>CMS approved 12/6/13 |
| **Informational Materials** | • Change end date to 12/31/2014 on web site & web-based materials —brochures and fact sheets. No new printed materials will be developed | Completed | Updated 3/13/2014 |
| | • Re-direct IHW application link to the ABE application link and include a notice to applicants about ACA | Completed | Finalized 3/13/2014 |
| | • Remove from IHW Website and forms repository | Completed | Finalized 3/13/2014 |
| | • Allow Planned Parenthood, Title X agencies, LHDs, FQHCs, and RHC to submit IHW applications for clients with the expectation that they provide information about ACA. Individuals may request applications via web inquiry and hotline | Completed | Allowed submission until established date of 9/30/2014, the date application processing ceased |
| **Information Systems** | • Extend all current enrollees' enrollment period through 12/31/2014. (current enrollment forms state eligibility ends 12/31/2013) | Completed | Finalized 1/31/2014 |
| | • Stop system from sending 3815 (auto-enrollment) and 3815A (REDEs). DHS will need to send a cancellation notice | Completed | Last Re-enrollment form generated 11/16/2013<br>Last Enrollment form generated 12/14/2013 |
| | • Cease all IHW application enrollments | Completed | STCs (2009) state we must cease program enrollment 6 months prior to the expiration date of the program. Guidance from CMS was to include in transition plan how IL will handle continued enrollment. IL made decision to continue enrollment as late as possible to ensure contraceptive coverage is available to women. CMS verbally agreed with us when we discussed with them. Sent notice to individuals who submitted applications after the due date and assisted with completion of ACA application. |

## PHASE-OUT/TRANSITION PLAN - ILLINOIS HEALTHY WOMEN (IHW) ENDING 12/31/2014

| Area of Focus | Action Steps | Completion Status | Notes |
|---|---|---|---|
| | • Ensure no dual payments are made during transition of clients into other HFS programs | Completed | Programming already in place |
| **Client Notices** | • Send **bi-monthly client notices** to existing clients that IHW is ending 12/31/2014 and explain how to apply for full benefits through Medicaid Expansion or the Marketplace during open enrollment | Completed | 1st notice sent 12/26/2013<br>2nd notice sent 4/16/2014 |
| | • Insert a hardcopy of the ACA application with **final client notice**<br>• Send client letter to individuals who submitted applications after the due date | Completed<br><br>Completed | Started 10/1/2014<br><br>Notice sent to all who submitted applications after 9/30/2014, ACA application was initiated to enroll individuals |
| **Staff In-service** | • Notify/update hotline staff (HFS, IHC, IBCCP, DHS) of phase-out and on client transition process | Completed | 12/31/2013, ongoing updates during 2014 |
| | • Ensure IHW/All Kids/Family Care caseworkers have been updated on IHW client transition process to ensure uninterrupted coverage and status of IHW program enrollment | Completed | Ongoing communication throughout duration of phase-out to ensure adherence to plan |
| **Provider/Stakeholder Notification** | • Provide update of IHW program phase-out and client transition at advisory board meetings (MCH, FPAC, IMCHC, IPHA, etc) | Completed | Regular communication and announcements at scheduled meetings |
| | • Send notification/update to key stakeholders re IHW phase-out and client transition—community-based agencies, PPIL, DHS Title X, provider associations, advocacy groups and other state programs (including local offices) – Be sure to include groups that do not receive provider notices | Completed | 1st notification 12/6/2013<br>2nd notification 6/4/2014 |
| | • Discuss with DHS Title X and PPIL regarding client transition to address specific questions/issues (since these providers serve high number of IHW clients) | Completed | Notices sent to DPH Title X Grantee for distribution to delegate agencies, including PPIL |
| | • Notify/update tribal organization, per the 2010 STCs | Completed | Notice sent 5/27/2014 |
| **Quality Assurance Activities** | • Scheduled customer satisfaction survey and medical record review will be canceled due to phase-out | | IHW evaluation design includes a customer satisfaction survey & medical record review on WY8 participants to identify areas for improvement. Since IHW is phasing out, there is no need to spend fed/state funds or staff time to carry out these activities since we won't be working to "improve"— |

| Area of Focus | Action Steps | Completion Status | Notes |
|---|---|---|---|
| | | | previous results have been consistent over the waiver. |
| **Required Reporting to CMS for Waiver Phase-out** | • Submit Final Program and Evaluation Report to CMS for comments no later than 90 days after the end of the Demonstration, including Final Budget Neutrality and Annual Budget Limits | 3/31/2015 | On 2/27/2015, HFS submitted/discussed a proposed plan to CMS regarding final reporting requirements for the Evaluation and Program Reports—the same day, CMS provided written approval to our approach and plan. The IHW STCs (2009) required submission of *draft* final reports to CMS 90 days prior to the end of the waiver. **Therefore, the action steps listed in this phase-out plan will not apply as listed.** |
| **Administrative Procedures** | • Ensure all federal claiming for waiver services provided during the waiver period is claimed within 2 years of service date | 12/31/16 | Ongoing until claims deadline is met (6/30/2015), and HFS' federal claiming deadline is met |
| | • Include close-out costs associated with transitioning the program with Administrative claiming costs—to be included in CMS 64 | 12/31/16 | |

# Appendix D

# IHW Final Evaluation Report


# Illinois' Family Planning Expansion Initiative Under Medicaid

**Project Number: 11-W-00165/5**

## Final Evaluation

Waiver Years 1 - 10
April 2004 - March 2014
Waiver Evaluation Submitted Under Authority of
Section 1115 of the Social Security Act
to the
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Submitted: March 31, 2015

*Illinois Department of Healthcare and Family Services*
*201 South Grand Avenue East*
*Springfield, Illinois 62763-0001*
*Felicia Norwood, Director*

*Division of Medical Programs*
*James Parker, Acting Medicaid Director*

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**Illinois Family Planning Demonstration Waiver**
**Illinois Healthy Women**
**Draft Final Evaluation: Waiver Years 1 - 10**

## Introduction

The Illinois Healthy Women (IHW) Evaluation Design, approved by the Centers for Medicare & Medicaid Services (CMS), focuses on measuring the defined program objectives. Attainment of the objectives has been examined (with available data) through a series of comparisons to determine whether outcomes differ from those that would be expected without the waiver and as compared to those of a historical group. The IHW Evaluation Design document, revised and submitted by the Illinois Department of Healthcare and Family Services (HFS) on July 13, 2005, and approved by CMS on December 21, 2006 (evaluation design document at end of report).

Major external partners involved with the IHW Evaluation throughout this ten year evaluation period include:

- Illinois Department of Human Services (DHS)/Illinois Department of Public Health (IDPH) administers Title V and Title X and provides statistical data on fertility rates and inter-pregnancy spacing and Title X non-Medicaid service data (Title V and Title X were transferred to IDPH from DHS in 2012)
- IDPH provides the Pregnancy Risk Assessment and Monitoring System (PRAMS) Report and is the repository for Vital Records
- eQHealth Solutions is HFS' Quality Improvement Organization responsible for the IHW medical record review (focused clinical studies) process to assess quality of care
- University of Illinois at Chicago (UIC) contributed to select evaluation components

Other data were collected for the evaluation from HFS enrollment and claims data, Customer Satisfaction Surveys, medical record reviews and referral information reported to HFS. Data sources are referenced at the end of this report.

In 2002, during the development of the Illinois family planning waiver, it was established that 2001 would be the baseline year used for measuring and analyzing the objectives in future evaluations conducted on IHW, as well as for this evaluation.

During the baseline year (2001), the fertility rate of low-income women (at or below 200 percent of the federal poverty level [FPL]) in Illinois was 11.6 percent. At this same time, according to PRAMS, the unintended pregnancy rate was 46.2 percent of which 64.7 percent were paid for by HFS. Most of these unintended births occurred in women under age 25, according to both PRAMS and Vital Records data.

In April 2004, IHW was implemented in Illinois, allowing low-income women who were losing coverage from another more comprehensive HFS medical program to receive a limited package of family planning (birth control) services and related reproductive healthcare. IHW gave women the opportunity to access family planning services to help women control the number and timing of their children, plan for a healthy pregnancy and birth, and to have a baby when they were most able to care for them.

The program was expanded in May 2007 to allow women with income levels up to 200 percent of poverty to apply for family planning benefits under IHW. This expansion gave eligible women two ways to enter IHW: Population 1 - through automatic enrollment (initial 3-month period with a subsequent 9-month enrollment option) when losing eligibility for a more comprehensive HFS medical program (e.g., aging out of CHIP, after 60 days postpartum period), or Population 2 - through an application process.

Providing quality family planning services and related reproductive health care are critical in order to:

- Reduce the number of short interpregnancy intervals or unintended pregnancies in this population of women. *The proportion of women who wait at least 24 months before having another child is expected to increase compared to other low-income women who obtain Medicaid coverage for pregnancy/delivery*. This analysis was performed through an historical birth file match. Many experts believe that short interpregnancy intervals are potentially more harmful among poor women, who are often less well-nourished and under more physical, economic, emotional and social stress than their middle and high income women counterparts, who have the resources to minimize the impact of the short interval.[1]

- Provide detection, treatment and education regarding sexually transmitted infections. The diagnosis and treatment of sexually transmitted infections discovered during the family planning visit was a covered service under this waiver. This care is essential to help maintain the reproductive health of the waiver participant.

- Promote the early detection of breast cancer through the use of screening mammography. Uninsured women reported the lowest mammography usage with a rate of 38.3%.[1] Mammograms are proven to be the best way to detect breast cancer early when it is treatable.

- Breast cancer is the second leading cause of cancer deaths at 14 percent among women in the United States, and accounts for almost 30 percent of all cancer cases. A woman's lifetime risk of breast cancer, assuming no other cause for premature mortality, is about 1 in 8.[2] Suspicious mammographic lesions require referral to a physician outside of the waiver for follow up and final disposition. These women were referred to the Illinois Breast and Cervical Cancer Screening Program for diagnosis and treatment. Mammography was included in the IHW benefits package covered with State only funds.

- Encourage annual pelvic examination for the early detection of cancer. Ovarian cancer is the eighth most common cancer among American women and causes more deaths than any other cancer of the female reproductive system. The early detection of pre-malignant cervical lesions by Pap smear prevents at

[1] Sabatino, S.A., Coates, R.J., Uhler, R.J., Breen, N., Tangka, F., Shaw, K.M, "Disparities in mammography use among US women by race, ethnicity, income, and health insurance status, 1993-2005." *Medical Care*, July 2008, Vol. 46, No. 7.

[2] American Cancer Society. *Cancer Facts & Figures 2012*. Atlanta: American Cancer Society; 2012

least 70 percent of potential cancers.[3] Abnormal Pap test results or other suspect benign or malignant lesions were referred outside the waiver for definitive evaluation and management; many of these women were referred to the Illinois Breast and Cervical Cancer Screening Program for diagnosis and treatment.

- Promote continuity of care through referrals to primary care services as a result of the provision of family planning services. A referral process was established for services that were not covered under the waiver and required definitive treatment outside of the family planning environment to ensure continuum of care. The referral process was evaluated through medical record reviews, customer satisfaction surveys, and state hotline tracking system.

- Save costs – the Medicaid program has experienced a cost savings secondary to the utilization of the waiver services. This was realized as a decrease in the expenditures for prenatal, delivery, newborn and infant care compared to what would have been expected without the waiver. The women in the waiver were those who would be eligible for Medicaid coverage had they become pregnant.

This evaluation analyzes the data available pre-waiver and during the first ten years of the IHW family planning waiver period. The following is a point of reference for understanding waiver year (WY) time periods:

WY 1: April 2004 – March 2005
WY 2: April 2005 – March 2006
WY 3: April 2006 – March 2007
WY 4: April 2007 – March 2008
WY 5: April 2008 – March 2009
WY 6: April 2009 – March 2010
WY 7: April 2010 – March 2011
WY 8: April 2011 – March 2012
WY 9: April 2012 – March 2013
WY 10: April 2013 – March 2014
WY 11: April 2014 – December 2014

Waiver Year 11 began April 1, 2014 and ended December 31, 2014, an incomplete year. Therefore, it will not be included in this evaluation report. However, this nine-month period allowed HFS to capture birth data for those women who delivered toward the end of WY 10.

Based on available data, the following highlight the outcomes experienced during the first ten years of the waiver:

- More low-income women received publicly funded family planning services
- The number of unduplicated women receiving family planning services through the IHW program increased
- Lower Illinois unintended pregnancy rates were demonstrated
- Lower Illinois fertility rates were experienced
- Fewer unintended pregnancies paid for by HFS
- Birth interval spans among low-income women lengthened
- Fewer births occurred among women younger than age 25
- The number of women delaying pregnancy increased
- The number of averted births increased, resulting in an estimated $559M in cost savings

[3] Ibid.

Increased access to family planning services has had a positive impact on Illinois' birth rate, pregnancy intendedness, birth spacing, and the HFS expenditures for pregnancy related care and subsequent child health care costs.

## Evaluation Design

Primary Goal:
Increase the number of low-income women who receive voluntary, confidential family planning services.

Objectives/Measurements:

- Number of Enrolled Women Using Family Planning Services
- Interpregnancy Spacing of Enrolled Women Using Family Planning Services
- Cost Savings Due to Reduction In Unplanned Pregnancies
- Client Satisfaction with Referrals and Access to Primary Care
- Pregnancy Intendedness for Women Experiencing First-Time Births

**Enrollment and Participation:**

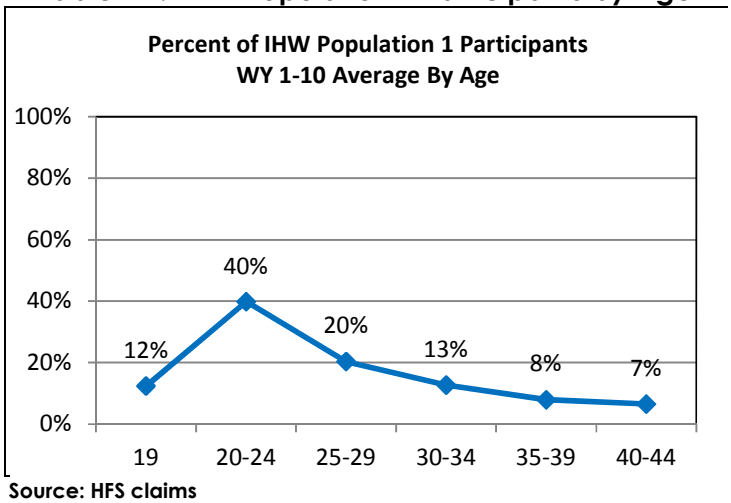
**Objective 1: To increase the number of Medicaid eligible women who, after delivery or after leaving another more comprehensive HFS health care benefit program, participate in the waiver.**

**Results:**

**Population 1: Automated-Enrollment Participants**

Population 1 was IHW's original targeted population and is comprised of women who lost coverage from a more comprehensive HFS medical program. These women entered IHW through a passive enrollment process and most who utilized services subsequently enrolled to extend their IHW coverage. As demonstrated in Table 1A, approximately 12 percent of these women were age 19 and entered IHW because they aged out of HFS' All Kids program. Of the remaining women, 40 percent were between ages 20 to 24, and 48 percent were ages 25 through 44. Most of these women age 20 and older either recently delivered or had a dependent child.

**Table 1A: IHW Population 1 Participants by Age**



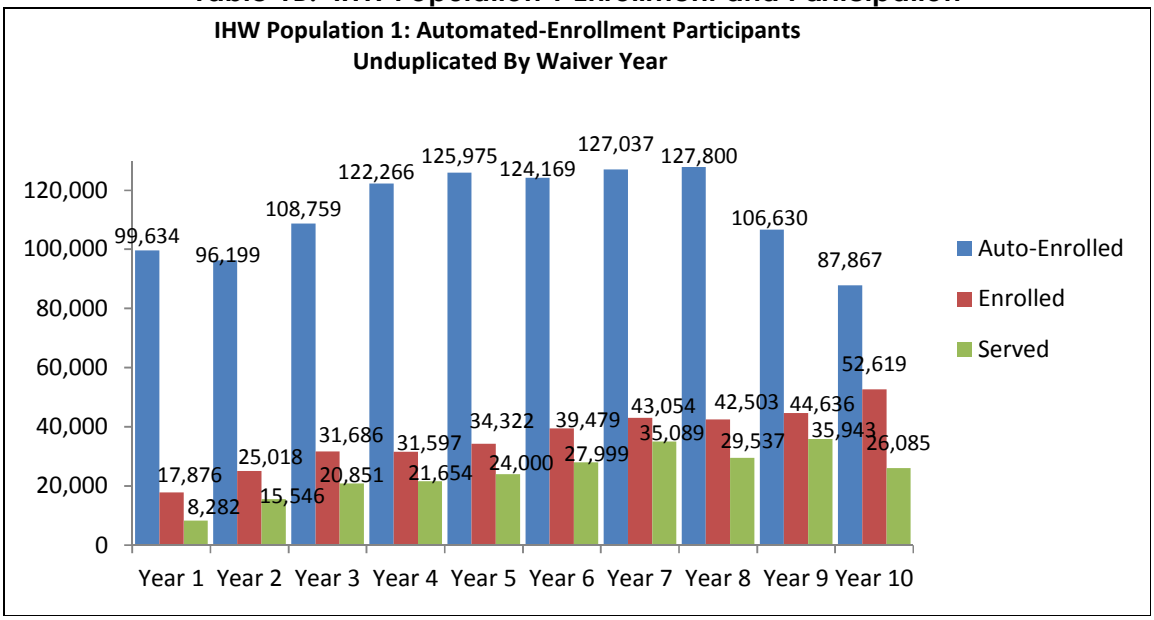

**Source: HFS claims**

As illustrated in Table 1B, for the first eight years of the waiver, there was a fairly steady increase in both participation and enrollment of women who initially entered IHW through the auto-enrollment process is demonstrated by:

- an 85.5 percent increase in women who were auto-enrolled for 3-months and subsequently enrolled for a full year of coverage from Year 1 (17.9%) to Year 8 (33.2%);
- nearly a 1.3 fold increase in auto enrollment and a 2.4 fold increase in enrollment from Year 1 to Year 8; and
- a 76.0 percent increase in enrolled women served from Year 1 (46.3%) to Year 7 (76.8%) based on HFS paid claims data.

During waiver years nine and ten, there were decreases in auto-enrollment and enrollment compared to the previous annual increases seen through the first eight waiver years. In waiver year eight there was a substantial decrease in services delivered compared to waiver year seven. This reversed the trend which previously showed annual increases in services delivered through the first seven waiver years. However, services increased in waiver year nine and again decreased in waiver year ten. This is likely due to the uncertainty around continuation of the waiver program in the era of the Affordable Care Act (ACA). Through ACA provisions, women would be able to access family planning services available through expanded insurance coverage and provisions for women's preventive health care, including contraceptive services. Additionally, variation in payment cycles crossing waiver years means services delivered in one waiver year were counted in the following waiver year.

**Table 1B: IHW Population 1 Enrollment and Participation**



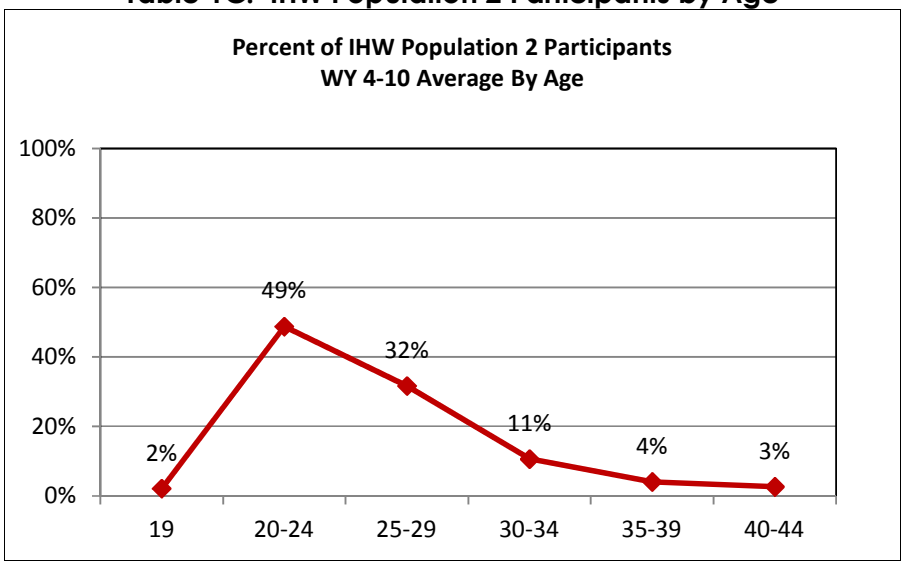

**Source: HFS claims data**

**Population 2: Application-Enrollment Participants**

In May 2007, IHW expanded to serve a new target population (Population 2), women with an income at or below 200 percent FPL. These women actively enrolled in IHW by completing an application, and most had not previously received Medicaid assistance. Based on information collected from the IHW application, a majority (75%) of these women had never been pregnant. As shown in Table 1C, 51 percent of Population 2

women were ages 19 through 24, which is the age group that has the highest unintended pregnancy rates according to a Guttmacher Institute report.[4] However, only 2.0 percent of these participants were age 19, which identified an opportunity to improve targeted outreach efforts to this group. Of the remaining women, 32 percent were ages 25 through 29 and 18 percent were between the ages of 30 through 44.

**Table 1C: IHW Population 2 Participants by Age**




**Source: HFS claims**

Experience suggests that it takes at least two to three years for a new program to be institutionalized, and especially one that has limited benefits. Even so, Population 2 grew rapidly and had high participation rates, as demonstrated in Table 1D. Population 2 utilized family planning services at a higher rate relative to their population size compared to Population1. Population 2 had annual increases in service utilization each year from Year 4 to Year 7. Similar to Population 1, there was a decrease in service utilization in Year 8, an increase in Year 9 and another decrease in Year 10. As we speculated for Population 1, we believe this is likely due to the uncertainty around continuation of the waiver program in the era of the Affordable Care Act (ACA). Through ACA provisions, women would be able to access family planning services available through expanded insurance coverage and provisions for women's preventive health care, including contraceptive services. Additionally, variation in payment cycles crossing waiver years means services delivered in one waiver year were counted in the following waiver year.

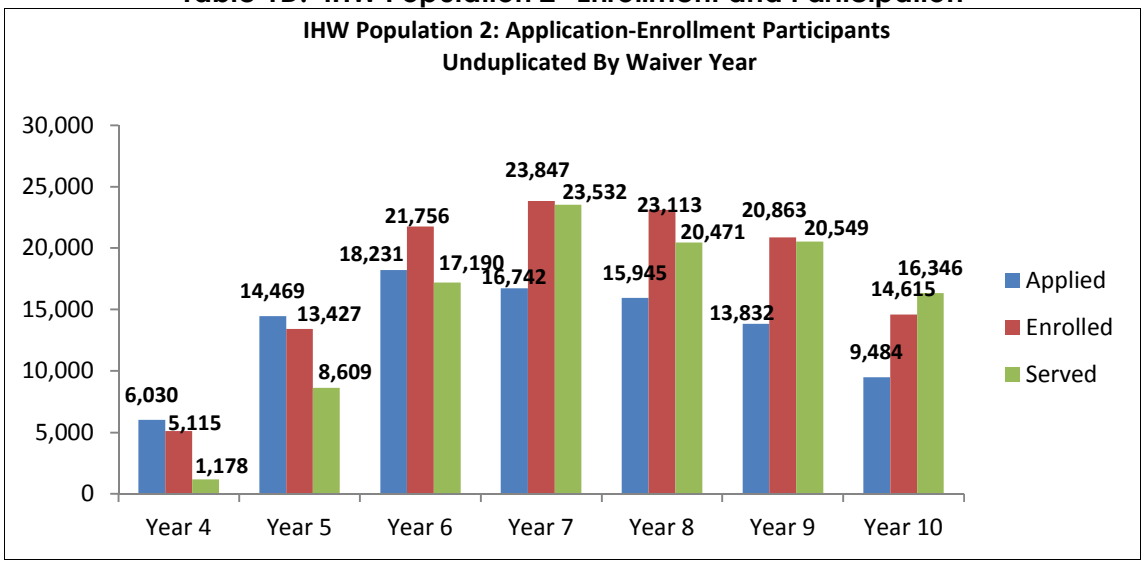
Other Population 2 successes are indicated below:

- from Year 4 (first year of Population 2) to its highest point in Year 6 women applying for IHW nearly tripled;
- enrollment grew over four-fold from Year 4 to its height in Year 7, then showed annual decreases through year 10;
- there is an inverse relationship between application vs. enrollment with applications being higher in the first two years and enrollment being higher in remaining five years; and

[4] Frost JJ, Darroch JE and Remez L, Improving Contraceptive Use in the United States, *In Brief*, New York: Guttmacher Institute, 2008, No. 1.

- family planning utilization increased annually from Year 4 through Year 7. From Year 8 through Year 10 utilization decreased as the population size also decreased. Year 10 utilization is higher than enrollment likely because of payment delays where services were delivered in the previous year, but counted in the subsequent year after payment was made.

**Table 1D: IHW Population 2- Enrollment and Participation**




**Source: HFS claims data**

There were decreases in applications and enrollment beginning in waiver year 8, but most notably during both waiver years 9 and 10. This is likely due to the uncertainty around continuation of the waiver program in the era of the Affordable Care Act (ACA). Through ACA provisions, women would be able to access family planning services available through expanded insurance coverage and provisions for women's preventive health care, including contraceptive services. Additionally, we see services delivered in Year 10 are higher than enrollment numbers which is likely due to variation in payment cycles crossing waiver years means services delivered in one waiver year were counted in the following waiver year.

**Population 1 & 2 IHW Program Participants**

Table 1E shows overall, the IHW program has far exceeded the expectation in providing necessary family planning services to thousands of women annually during the first 10 years of the waiver, which is demonstrated by:

- nearly four-fold growth in enrollment from 17,876 in Year 1 to 67,234 in Year 10;
- in Year 1 46.3 percent of enrolled women received a service, by Year 10 this grew to 63.1 percent or an increase of 36.3 percent, and
- 193,715 unduplicated women received services during the life of the waiver.

IHW continued to see a steady growth in enrollment and participation for both populations during most of this evaluation period.

In summary, Illinois has met its goal in increasing the number of low-income women who participated in the waiver.

**Table 1E: IHW Population 1 & 2 - Enrollment and Participation**
**Total Unduplicated Waiver Participation for Population 1 & 2, Years 1 – 10 = 193,715***

| Waiver Year | Actual Number Enrolled | Actual Number Served* |
|---|---|---|
| Year 1 | 17,876 | 8,282 |
| Year 2 | 25,018 | 15,546 |
| Year 3 | 31,686 | 20,851 |
| Year 4** | 36,712 | 22,832 |
| Year 5 | 47,749 | 32,609 |
| Year 6 | 61,235 | 45,189 |
| Year 7 | 66,901 | 58,621 |
| Year 8 | 65,616 | 50,008 |
| Year 9 | 65,499 | 56,492 |
| Year 10 | 67,234 | 42,431 |

**Source: HFS claims data**
***Annual totals are the number of unduplicated women who received services during that year. Therefore, cumulative yearly totals will not equal the unduplicated participation total for WY 1-10.**
****Population 2 began Year 4**

**Access:**

**Objective 2: To increase the number of low-income women who obtain publicly-funded (Title X, Title V, Title XX or Title XIX) family planning services pre-waiver as compared to each year during the waiver.**

**Results:**
Table 2A shows the unduplicated number of low-income women in Illinois who used the following publicly-funded entities for family planning services: Medicaid, IHW, and DHS' Title X Family Planning Program (non-Medicaid Title X, Title V, Title XX). During the year prior to the waiver (2003), a total of 315,572 low-income women received publicly-funded family planning services. From 2004 through 2010 there were annual increases in family planning utilization for the combined program total. However, the increases can be attributed to increased utilization within the HFS-funded and IHW program that each showed increases while the Title X program showed annual decreases. From 2011 through 2013 the trend reverses with the program total and each individual program showing lower utilization (IHW showed higher utilization in 2012, but 2013 is lower than 2011 utilization).

Also shown in Table 2A, the number of non-Medicaid women served by the DHS Title X Family Planning Program declined steadily from 2002 through 2013. A few factors contributed to this downward trend, which included the DHS Title X Family Planning Program experiencing a sizeable decrease in Federal and State funding, a 30 percent reduction in the number of funded delegate agencies, and the rising costs in pharmaceuticals and personnel which all impacted their capacity to provide services. Although there is a troubling decline in the use of family planning services within more recent years, 2013 shows a cumulatively higher number of women using family planning services compared to pre-waiver years.

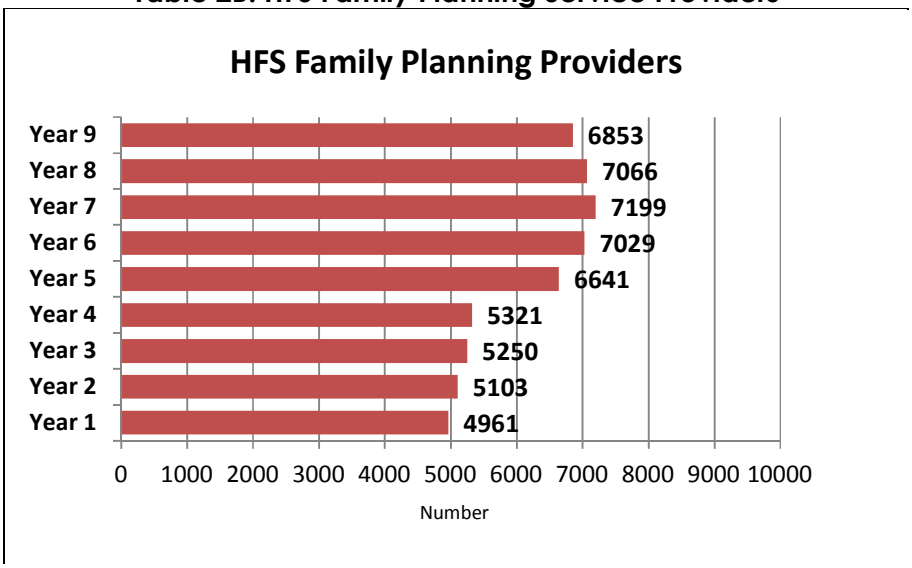
**Table 2A: Family Planning Services to Low-Income Women Ages 19-44, Years 2002 – 2013**

| Year | HFS-funded (Full-Medical) | Illinois Healthy Women | Title X- funded* (Non- Medicaid) | Total |
|---|---|---|---|---|
| **2002** | 198,559 | N/A | 108,191 | 306,750 |
| **2003** | 208,447 | N/A | 107,125 | 315,572 |
| **2004** | 266,041 | 8,282 | 96,813 | 371,136 |
| **2005** | 300,077 | 15,546 | 90,414 | 406,037 |
| **2006** | 303,720 | 20,851 | 79,936 | 404,507 |
| **2007** | 311,906 | 22,832 | 72,834 | 407,572 |
| **2008** | 323,448 | 32,609 | 68,278 | 424,335 |
| **2009** | 342,745 | 45,189 | 58,128 | 446,062 |
| **2010** | 351,472 | 58,621 | 57,552 | 467,645 |
| **2011** | 355,643 | 50,008 | 42,662 | 448,313 |
| **2012** | 336,830 | 56,492 | 37,482 | 430,804 |
| **2013** | 289,835 | 42,431 | 37,088 | 369,354 |

**Source: HFS claims data and Ahlers**
***Inclusive of Title X, Title V and Title XX**

Another approach to measure increased access to family planning services is to review HFS' claims data regarding trends in the number of providers who provided family planning services since the implementation of IHW (see Table 2B). The data demonstrate a 45 percent increase in the number of HFS-enrolled providers serving women ages 19 through 44 for family planning from Year 1 through Year 7, the year with the highest number of family planning providers. During years 8 and 9 there were annual decreases in the number of family planning providers. However, by year 9 there were 38 percent more family planning providers compared to year 1. This shows greater access to family planning providers compared to baseline.

**Table 2B: HFS Family Planning Service Providers**




**Source: HFS claims data**

**Interpregnancy Interval:**

**Objective 3: To increase the proportion of women with a Medicaid financed delivery with an interpregnancy interval of 24 months or greater, from the baseline of 65.5 percent in 2001.**

**Results:**

There were no births in IHW for the first year of implementation (2004). For this objective, therefore, the birth intervals analysis comparing IHW women to Medicaid is for the period beginning in 2005 and ending in 2009(the last year birth spacing data are available for the Medicaid population). As shown in Table 3A, during the baseline year (2001), 65.5 percent of Medicaid paid deliveries among women ages 20 through 44, had a birth spacing interval of 24 months or greater. The rate for Medicaid paid deliveries stayed relatively stable from 2005 through 2009. For Medicaid enrolled women the rate during this period ranged from a low of 65.2 (2008) to a high of 67.5 (2006) and the five year (2005-2009) annual average was 66.6 percent.

Annually from 2006 through 2009, IHW showed a higher rate of women with a 24 month or greater birth interval compared to Medicaid enrolled women. The rate of IHW women with a 24 month or greater birth interval grew from 65.1 percent (2005) to 72.0 percent (2009) an increase of 20.3 percent compared to the 1.8 percent decrease evidenced by Medicaid enrolled women (67.4%, 2005; 66.2%, 2009) for the same period. By 2011, 78.3 percent of IHW women had a 24 month or greater birth interval and the seven year annual average (2005-2011) was 71.5 percent. These data suggest that IHW participation increased birth spacing.

During the baseline year (2001), 20.4 percent of Medicaid enrolled women ages 20 through 44 had a birth spacing interval of less than 18 months. For the 2005-2009 period, the five year annual average was 19.6 percent. There was an increase of 4.6 percent from 2005 (19.4%) to 2009 (20.3%) in the rate of Medicaid enrolled women having a birth spacing interval less than 18 months.

Annually, for the same period (2005-2009), IHW showed a lower rate of women with a birth spacing interval less than 18 months compared to Medicaid enrolled women. There also was an inverse trend between these two groups. From 2005 to 2009, IHW had a decreasing rate of women delivering with a birth interval of less than 18 months and Medicaid enrolled women had an increasing rate. The five year annual average (2005–2009) of IHW women who subsequently delivered in less than 18 months was 10.7 percent compared to the Medicaid rate of 19.6 percent for the same period. During 2010 and 2011, there was an increase in IHW women having a less than 18 month birth interval, which is cause for some concern. Overall, however, IHW had a substantially lower rate of women having a <18 month birth interval compared to Medicaid women. These data indicate that increased use of birth control may have impacted the timing of births among IHW women more than among women in the general Medicaid population.

**Table 3A: Birth Interval of IHW Compared to Illinois Medicaid-Covered Women Ages 20 through 44* - Years 2001 – 2011**

| | | | Percentage of 2nd and Higher Births | | | | | |
|---|---|---|---|---|---|---|---|---|
| Group | Total 2nd and Higher Births | | Less Than 18 | | 18 to Less than 24 | | 24 Mos. or Greater | |
| Year | Medicaid | IHW | Medicaid | IHW | Medicaid | IHW | Medicaid | IHW |
| 2001 | 43,072 | N/A | 20.4 | N/A | 14.1 | N/A | 65.5 | N/A |
| 2002 | 43,316 | N/A | 20.3 | N/A | 13.6 | N/A | 66.0 | N/A |
| 2003 | 45,010 | N/A | 19.8 | N/A | 13.3 | N/A | 66.9 | N/A |
| 2004 | 46,072 | N/A | 20.0 | N/A | 13.3 | N/A | 66.7 | N/A |
| 2005 | 47,625 | 212 | 19.4 | 13.2 | 13.2 | 21.7 | 67.4 | 65.1 |
| 2006 | 46,817 | 340 | 19.7 | 15.0 | 12.9 | 16.8 | 67.5 | 68.2 |
| 2007 | 49,215 | 380 | 17.6 | 10.0 | 15.7 | 19.2 | 66.7 | 70.8 |
| 2008 | 47,138 | 310 | 21.0 | 9.7 | 13.8 | 21.0 | 65.2 | 69.4 |
| 2009 | 47,242 | 368 | 20.3 | 5.4 | 13.6 | 22.6 | 66.2 | 72.0 |
| 2010 | N/A | 279 | N/A | 6.1 | N/A | 17.2 | N/A | 76.7 |
| 2011 | N/A | 314 | N/A | 6.7 | N/A | 15.0 | N/A | 78.3 |

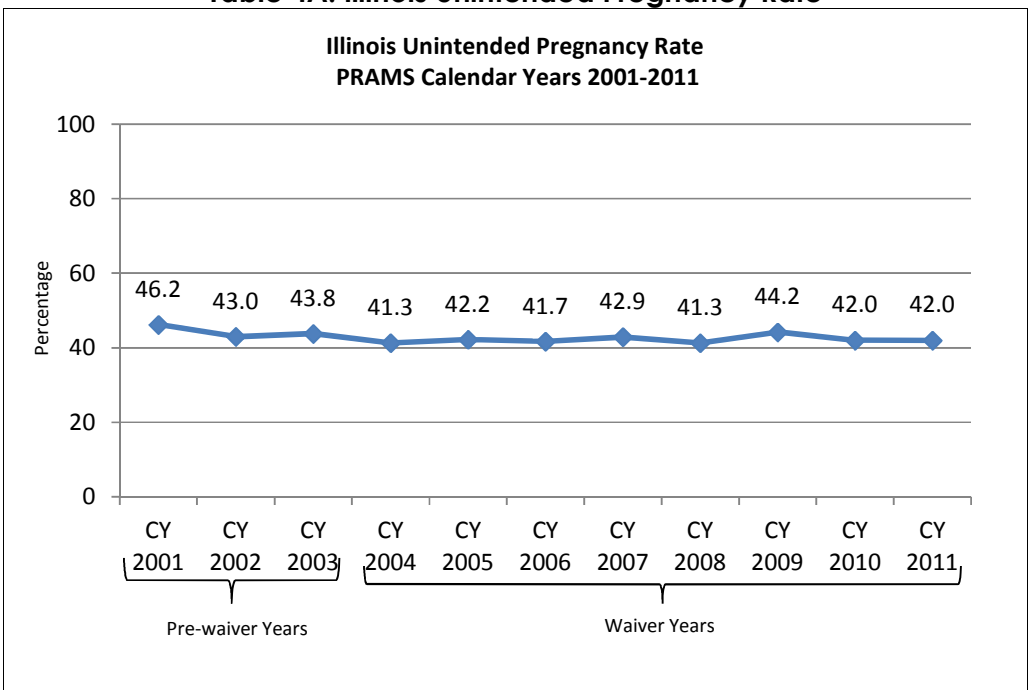
**Source: Vital Records**
*19 year olds were excluded from the IHW data due to lack of comparable Medicaid data
2005 – First year that includes births of Population 1 women
2008 – First year that includes births of Population 2 women

**Unintended Pregnancies with a Medicaid-financed Delivery:**

**Objective 4: To reduce the incidence of unintended pregnancies of women with a Medicaid financed delivery from the baseline of 64.7 percent (PRAMS).**

**Results:**
According to PRAMS data, during the baseline year (2001) the Illinois unintended pregnancy rate was 46.2 percent as illustrated in Table 4A. By 2011, the unintended pregnancy rate in Illinois dropped to 42.0 percent (a 9.1% decrease from the baseline). During the waiver years, the average annual unintended pregnancy rate was 42.2 percent. This demonstrates Illinois has experienced an overall downward trend in unintended pregnancies.

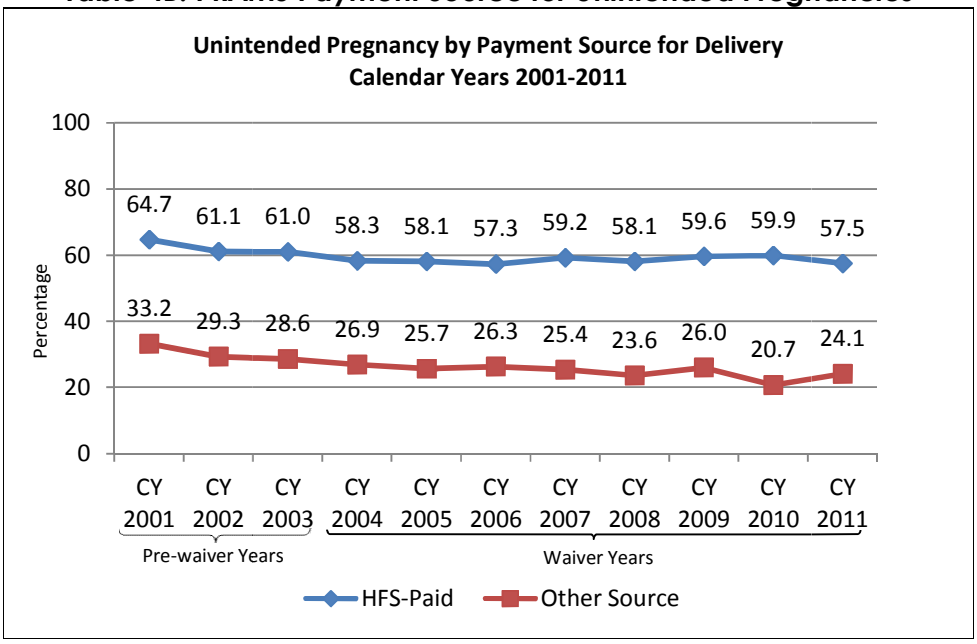
**Table 4A: Illinois Unintended Pregnancy Rate**




**Source: PRAMS**

Based on the PRAMS data, Illinois' efforts have made an impact on the intendedness of pregnancies paid for by HFS. As shown in Table 4B, in the baseline year 2001, HFS paid for 64.7 percent of the unintended births in Illinois. By 2011, this percentage was 58.0 percent, representing a 10.4 percent decrease in the rate of HFS-paid deliveries for women with an unintended pregnancy. Prior to the waiver, the unintended pregnancy rate was decreasing for both the HFS and other payer source. During the pre-waiver period (2001-2003), the HFS rate declined by 5.7 percent and the other payer source rate declined more rapidly at a rate of 13.9 percent. During the waiver period (2004-2011), the rate of decline in unintended pregnancy slowed for HFS to 1.4 percent and for other payer sources to 10.4 percent, compared to 5.7 percent and 13.9 percent, respectively, during the pre-waiver period. While the total unintended pregnancy rate from 2001 through 2011 declined, efforts should be maintained and invigorated to influence more rapid improvement.

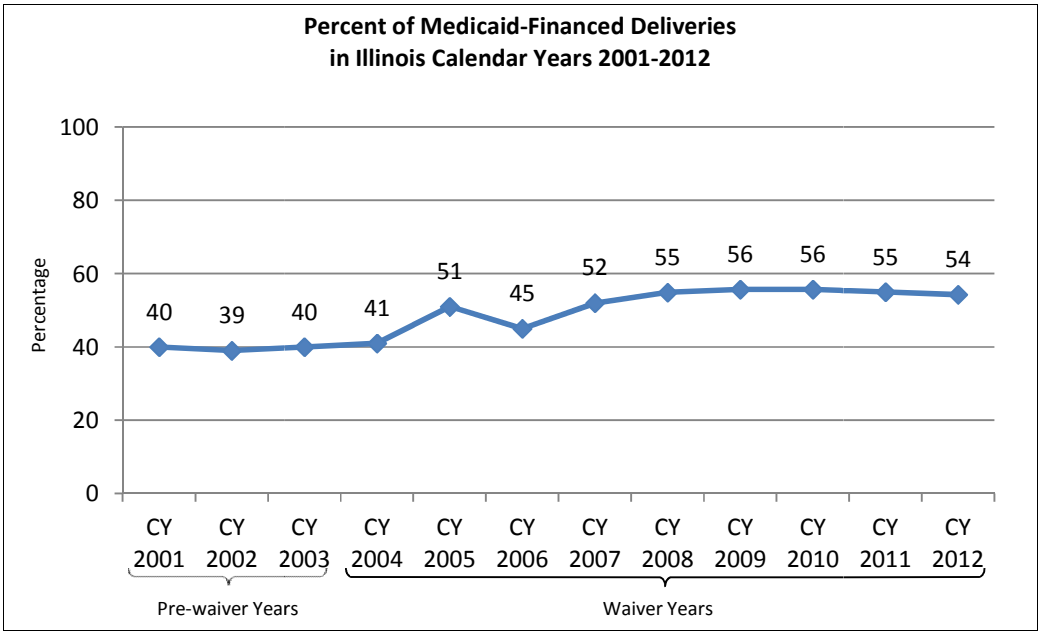
**Table 4B: PRAMS Payment Source for Unintended Pregnancies**




**Source: PRAMS**

Even though Illinois' Medicaid unintended pregnancy rates are decreasing, the Medicaid paid deliveries are increasing as shown in Table 4C. During the baseline year (2001), Medicaid paid for 40 percent of Illinois' deliveries. By 2012, that percentage increased to 54 percent. Some factors that may have contributed to this increase were higher unemployment rates and changes in Medicaid eligibility. Trends show there were more women receiving Medicaid, which means more women were eligible for a Medicaid paid delivery. Considering the increase in deliveries paid for by Medicaid in Illinois, if not for the number of births averted through the waiver, as referenced in Objective 6, this number would be much higher.

**Table 4C: Illinois Medicaid Financed Deliveries**




**Source: Vital Records and HFS claims data**

**Fertility Rates:**

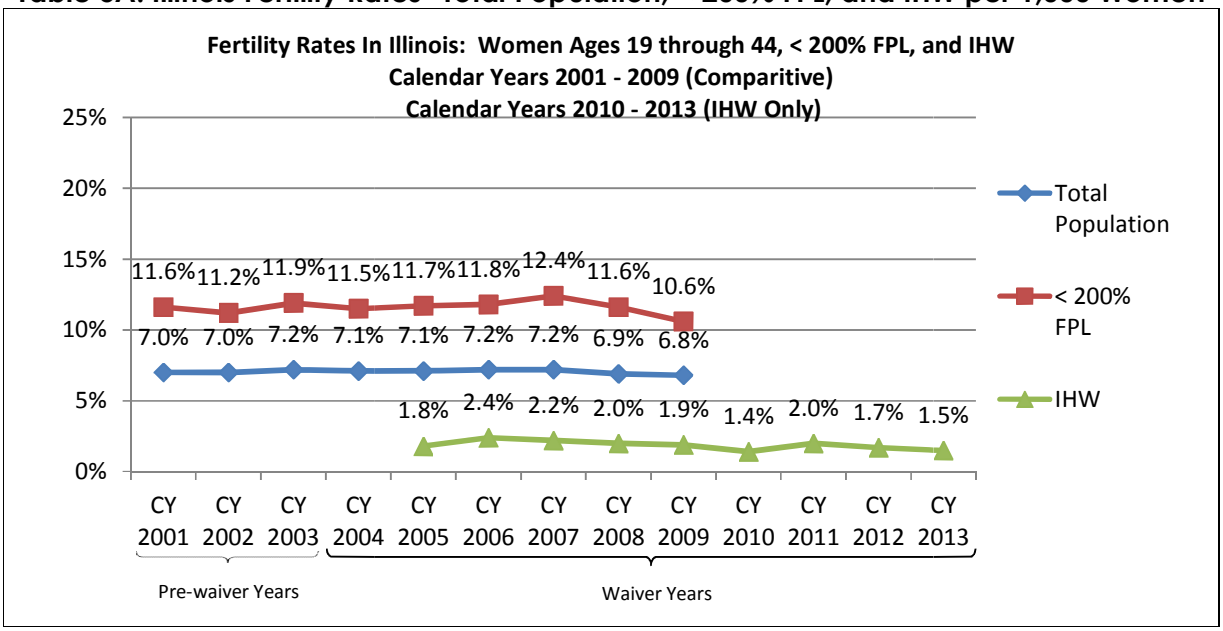
**Objective 5: To reduce the fertility rates for women in families with incomes at or below 200 percent of poverty, as required under CMS Waiver Terms and Conditions, Base-Year Fertility Rate, page 9. (For the purpose of this calculation, births will be counted. Illinois does not have a mandatory reporting system for terminated pregnancies.)**

**Results:**

Illinois fertility rates for all women, low-income women, and IHW women are represented in Table 5A for the periods 2001 through 2009. Additional data are provided for IHW women for CYs2010-2013. During the baseline year (2001), the fertility rate for Illinois women in poverty (<200% FPL) ages 19 through 44, (age group targeted for IHW) was 11.6 percent, compared to 7.0 percent for the total population of women in the same age group. By 2009, the fertility rate for Illinois women in poverty decreased to 10.6 percent (8.6% decrease), and the rate for the total population of women in the same age group decreased to 6.8 percent (2.9% decrease). For IHW women, from 2005 to 2009 the fertility rate fluctuated from a low of 1.8 percent (2005) to a high of 2.4 percent (2006). However, during the 2005-2009 comparison period the annual average fertility rate of 2.1 percent among IHW women was substantially lower than the total population or the population of women <200 percent FPL.

Since the inception of IHW, the fertility rate of IHW women, on average, was 9.5 percentage points less than Illinois women in poverty, and nearly 5 percentage points less than the total Illinois population. From 2010 through 2013, the IHW program experienced further declines in the fertility rate ending with a 1.5 percent rate by 2013. The lower fertility rates among IHW women compared to other women in the same age group can be directly attributed to women utilizing IHW program services to avoid an unintended or mistimed pregnancy. Furthermore, this demonstrates the impact that access to publicly-funded family planning services has on lowering the fertility rate.

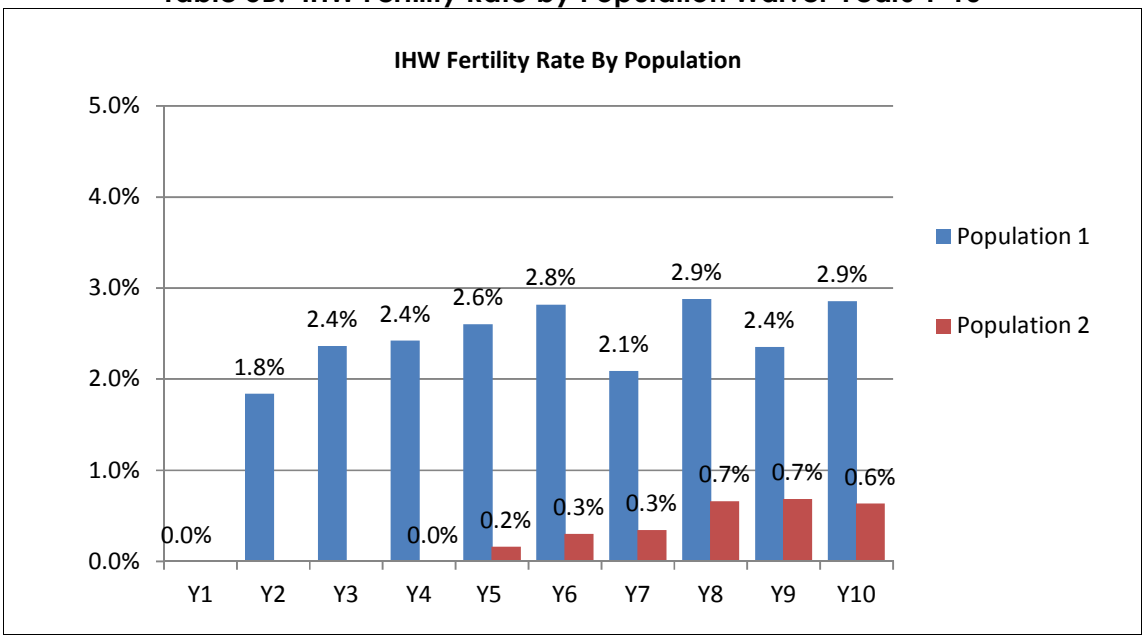
**Table 5A: Illinois Fertility Rates- Total Population, < 200% FPL, and IHW per 1,000 Women**




**Source: Vital Records and American Community Survey**

The fertility rates for IHW Populations 1 and 2 are provided in Table 5B. That chart shows the fertility rate for Population 1 grew by 1.1 percentage points from WY2 through WY10. From WY5 through WY10 Population 2 also experienced a moderate increase of .4 percentage points. The fertility rate of Population 2 women is much lower than Population 1. On average for the same period from WY5 through WY10, Population 2 fertility rate is 0.5 percent compared to 2.6 percent for Population 1. This demonstrates that women who sought family planning benefits have much lower fertility rates than women who auto-enrolled. However, as noted previously, the fertility rate for both IHW populations is substantially below the fertility rates of the total population and of women <200 percent FPL.

**Table 5B: IHW Fertility Rate by Population Waiver Years 1-10**




**Source: Vital Records**

A notable impact is that over time women appear to delay pregnancies to a later age. Table 5C shows for the Illinois population and for women <200 percent FPL, those between 19 and 24 years of age had lower average fertility rates during the waiver period (2005-2009) compared to the pre-waiver period (2001-2003). The fertility rate of 19 year olds decreased 1.9 percentage points (from 10.1% pre-wavier to 8.2% waiver) for the total Illinois population and by 3.2 percentage points (from 24.0% pre-waiver to 20.8% waiver) for women <200 percent FPL. Similarly, women ages 20 through 24 experienced a 1.4 percentage point reduction in fertility rates for the total Illinois population, and 1.2 percent point reduction for women <200 percent FPL.

Conversely, among Illinois women and women <200 percent FPL ages 30 through 44 there was an increase in births during the waiver compared to pre-waiver period. Among those 25 to 44 years of age, comparing pre-waiver to waiver periods, the only population to show a decreased average fertility rate is the Total Population of women ages 25-29 who had a 0.2 percentage point decrease. For the total Illinois population, among women 30 through 34 years of age there was a 0.4 percentage point average fertility rate increase from pre-waiver to the waiver period, an increase of 0.5 percentage points among those 35-39 years, and an increase of 0.2 percentage points

among those 40-44 years. Among women <200 percent FPL ages 30 through 34, there was a 1.3 percentage point increase in fertility, a 0.6 percent point increase for the 35 through 39 years, and 0.1 percentage points among those 40-44 years from pre-waiver to wavier periods. These data among 19-24 year olds compared to those 30-44 years of age seem to show that women are delaying pregnancy to later ages.

The IHW fertility rates across all age categories are substantially lower compared to the total Illinois population and to the population of women <200 percent FPL. According to the Guttmacher Institute, the 19 through 24 year-old age group has been identified as having the highest rates of unintended pregnancies. The average IHW fertility rate is 0.1 among 19 year olds and 3.0 among those 20 through 24 years. These rates are 20.7 and 15.3 percentage points lower, respectively, compared to women of the same age during the waiver period who are <200 percent FPL. Therefore, IHW reduced the fertility rate among younger women who are most likely to have an unintended pregnancy. To summarize, IHW impacted the birth rates across all age groups and among younger women with the highest rate of unintended pregnancy.

**Table 5C: Illinois Women Ages 19 through 44, < 200% FPL, and IHW Average Fertility Rate by Age Group – Per 1,000 Women**

**Pre-Waiver Average**

| Years 2001 – 2003 | 19-44 | 19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 20-44 |
|---|---|---|---|---|---|---|---|---|
| IL - Total Population | 7.1 | 10.1 | 10.2 | 11.0 | 9.7 | 4.5 | 0.1 | 7.0 |
| IL- < 200% FPL | 11.6 | 24.0 | 18.3 | 16.0 | 9.6 | 4.5 | 1.1 | 11.0 |

**Waiver Average**

| Years 2005 – 2009 | 19-44 | 19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 20-44 |
|---|---|---|---|---|---|---|---|---|
| IL - Total Population | 7.0 | 8.2 | 8.8 | 10.8 | 10.1 | 5.0 | 0.3 | 7.0 |
| IL- < 200% FPL | 11.6 | 20.8 | 17.1 | 16.4 | 10.9 | 5.1 | 1.2 | 11.2 |
| IHW | 2.1 | 0.1 | 3.0 | 2.2 | 1.5 | 0.3 | 0.0 | 2.2 |

**Source: American Community Survey and Vital Records**

**Cost savings:**

**Objective 6a: Reduce Medicaid expenditures for pregnancy-related and infant health care costs.**

**Objective 6b: Reduce Medicaid expenditures for pregnancy-related and child health care costs during the first five years of life.**

**Results:**

The average annual cost of IHW's family planning services was **$309***, while the average annual cost for prenatal care, delivery, postpartum and first year of infant's life was **$11,198***. The BN/ABL demonstrated that during Years 1-10, expanded access to contraceptive services through IHW has averted an estimated **48,369*** births, which resulted in a savings of approximately **$391.7M*** in pregnancy-related and infant health care expenditures. *Source: IHW Budget Neutrality

Another approach to looking at cost savings is reflected in Table 6A. This analysis represents the cost *difference* of pregnancy-related and infant health care (includes prenatal care, delivery, 60 days postpartum and first year of infant's life), without the

waiver and with the waiver, which resulted in an even greater overall savings of more than **$559M** over the ten year period.

**Table 6A: Cost of Pregnancy-Related and Infant Health Care**
**(Includes prenatal care, delivery, 60 days postpartum and 1st year of infant's life)**
**Waiver Years 1 - 10**

**Prenatal, Delivery, 60 days Postpartum and First Year of Infant Life**

| Year | Without the Waiver | With Waiver | Cost Savings | Accumulative Savings | Births Averted | Accumulative BA |
|---|---|---|---|---|---|---|
| **WY 1** | $761,371,884 | $748,487,240 | ($12,884,645) | ($12,884,645) | 1,333 | 1,333 |
| **WY 2** | $846,224,716 | $824,481,068 | ($21,743,649) | ($34,628,293) | 2,128 | 3,461 |
| **WY 3** | $941,010,510 | $912,112,772 | ($28,897,738) | ($63,526,032) | 2,698 | 6,159 |
| **WY 4** | $968,983,967 | $935,937,957 | ($33,046,010) | ($96,572,042) | 3,075 | 9,234 |
| **WY 5** | $991,453,254 | $942,385,959 | ($49,067,295) | ($145,639,337) | 4,453 | 13,687 |
| **WY 6** | $1,035,682,089 | $963,594,515 | ($72,087,574) | ($217,726,911) | 6,294 | 19,981 |
| **WY 7** | $1,081,728,521 | $981,242,551 | ($100,485,970) | ($318,212,881) | 8,380 | 28,361 |
| **WY 8** | $1,026,161,192 | $944,772,845 | ($81,388,347) | ($399,601,228) | 6,844 | 35,205 |
| **WY 9** | $1,039,945,781 | $949,359,781 | ($90,586,000) | ($490,187,228) | 7,584 | 42,789 |
| **WY10** | $1,054,441,040 | $985,592,097 | ($68,848,943) | ($559,036,171) | 5,580 | 48,369 |
| **Total** | **$9,747,002,955** | **$9,187,966,784** | **($559,036,171)** | | 48,369 | |

**Source: HFS claims data/IHW Budget Neutrality**

**Referrals to Primary Care:**

**Objective 7: Enrolled women who need primary care will receive referrals to accessible primary care, as needed.**

**Results:**

Referrals to primary care were assessed in several ways, including through:

- **Customer Satisfaction Survey -** addressed primary care referrals and access
- **Medical Record Review -** assessed whether quality care had been delivered according to the guidelines for the provision of family planning services, including appropriate referrals
- **Data Collection –** reported data from the state's hotlines and other organizations relative to IHW participants requesting referral information. Reporting entities included: HFS' and DHS' hotlines; the State's Breast and Cervical Cancer Screening Program; HFS' Primary Care Case Management (PCCM) Program-Illinois Health Connect, and Title X-funded family planning agencies

The focus of the evaluation of this objective was the **customer satisfaction survey**. HFS' Office of Inspector General (OIG) administered telephonic customer satisfaction surveys on an ongoing basis to review and assess IHW participants' satisfaction. Since the inception of IHW, a customer satisfaction survey was conducted on IHW participants from waiver years 1, 3, 5, and 6, addressing service delivery, accessibility, referrals, confidentiality and quality of care. The participants were asked questions related to primary care referrals, which included how to access other medical services needed for illness, such as a sore throat, and if able to access additional health care services from the provider to which they were referred. Additionally participants who

received a referral were asked to rate the assistance received in obtaining a referral for primary care.

A summary of the approval ratings that were excellent or good for the customer satisfaction surveys are shown in Table 7A. According to the survey results, the ratings improved for access to primary care, however, the approval rating for referrals fluctuated throughout the span of the surveys. Most of these women did not have any other health insurance. When referrals were needed for services not covered under IHW, many of these women were subject to limited medical programs that may have required a fee or special qualifications to participate. Even though this objective does not address quality of care, it was noted that the quality of care was consistently high.

**Table 7A: IHW Customer Satisfaction Survey**
**Approval Rating**

| | Year 1 | Year 3 | Year 5 | | Year 6 | |
|---|---|---|---|---|---|---|
| | Population 1 | Population 1 | Population 1 | Population 2 | Population 1 | Population 2 |
| **Access to Primary Care** | 63% | 57% | 65% | 73% | 91% | 92% |
| **Referrals to Primary Care** | 70% | 53% | 93% | 95% | 89% | 76% |
| **Quality of Service** | 92% | 90% | 90% | 91% | 96% | 97% |
| **Surveys Completed** | **253** | **256** | **165** | **147** | **152** | **152** |

**Source: HFS' OIG**

HFS used this information to educate providers on improving services delivered to IHW clients by revising the IHW Web site and outreach materials to include referral information to low-cost clinics, providing updated information to hotline staff and other state program staff, and providing webinars on topics, such as service delivery, access to primary care providers and referrals.

As stated above, quality of care was not a focus for this objective; however, it is an important component of the waiver that should not go unaddressed. A standard approach to examine the quality of care delivered by enrolled providers was to conduct focused quality studies, or in other words, **medical record reviews**. During the ten year evaluation period, HFS' contracted Quality Improvement Organization, eQHealth Solutions, conducted three focused quality studies (December 2006, November 2009 & March 2012) for Populations 1 and 2.

The study evaluated whether IHW participants were receiving appropriate medical care, according to the family planning clinical guidelines, and whether IHW women were being appropriately referred to, or provided with needed primary care. The IHW patient medical records were randomly selected, with attention to distribution of participants by site of care which included physician offices, Federally Qualified Health Centers, nurse practitioners, local health departments, and hospital clinics. Medical record documentation from the providers was for the following categories:

- History and physical
- Current medications
- Contraceptive history including current usage

- History of last menses
- Pelvic examinations
- Pap Testing
- Mammograms
- Promotion of contraceptive use
- Treatment of abnormal laboratory examinations

While not specifically captured by the abstraction tool, eQHealth Solutions observed the following:

- Screening for domestic violence and partner abuse with referrals when necessary
- Dietary assessment for calcium intake
- Depression screening and referral
- An emphasis by non obstetrical physicians to align the family planning physical with a traditional medical annual visit. For example a complete head and neck examination was often performed in the absence of a breast exam or STI screening.
- In local health departments and FQHC's it was noted preconception assessments were being performed and women were being queried about pregnancy intent. This was not noted in physician and hospital clinics.
- Gaps in contraception were often related to side effects of vaginal bleeding, abdominal discomfort or weight gain.
- Patients with unintended pregnancies during the study period opted for alternate, typically long acting contraceptives either an implant or intrauterine device.

Consistent across all three reviews was a lack of documentation for STI education and screening, HIV risk assessment and screening, and folic acid education. However, as noted in the March 2012 study, there were marked improvements in all aspects of provider education, STI screening, and HIV testing, which suggests increasing awareness of the importance of screening and counseling. As previously stated, HFS used these findings to educate providers on improving services delivered to IHW clients.

**Pregnancy Intendedness:**

**Objective 8: The proportion of pregnancy intendedness for women experiencing a first-time birth will increase.**

**Results:**

The Evaluation Design was revised when IHW expanded (Amendment 2) to an application enrollment process (Population 2). Objective 8 was added to determine whether expanded access to birth control for women not otherwise eligible for Medicaid would increase the proportion of waiver participants experiencing a first-time birth.

To measure this objective, HFS conducted a pregnancy intendedness survey of waiver years 4 and 5 Population 2 participants who became pregnant while enrolled in IHW and subsequently qualified for another HFS medical program due to pregnancy. The purpose of the survey was to determine whether highly effective contraceptive

methods were being used by these women, whether their pregnancy was intended, and whether the program helped the women plan their pregnancy.

Due to the low number of births of Population 2 women, 14 in total for the two-year period (Years 4 and 5), and considering the fact that several women were unable to be reached even after a minimum of three phone call attempts, there was not enough data available for analysis and reporting.

Another approach to evaluating pregnancy intendedness was examined using data collected from the IHW applications (page 5) and HFS-paid claims and enrollment data. Based on this data, 75% of the women in Population 2 self-reported they had never been pregnant. Population 2 comprised 41.3% of the total IHW population served, and had an average fertility rate of 0.25%, which represented only 4% of the total IHW births. This low birth rate can be directly attributed to the high rate of family planning utilization of Population 2 women at approximately 98% compared to 76.8% for Population 1.

Even though HFS does not have sufficient data at this time to evaluate this objective, the above information suggests that the efforts to expand IHW to a population of women who would not normally be eligible for Medicaid coverage was successful. The administrative data strongly suggest that these women are accessing birth control services and are aware of the usefulness of birth control to prevent an unintended pregnancy.

## Summary

The results of this evaluation reflect improvements in Illinois' fertility rate, birth interval rate, unintended pregnancy rate, and Medicaid-paid deliveries during the first ten years of the waiver. The waiver was a learning experience in which we improved IHW, for example:

- expanded targeted outreach efforts, especially to 19 year olds enrolling through the application process;
- increased activity to improve awareness of and access to the IHW program;
- ensured providers educated women on the most effective methods of contraception; and
- expanded benefits package to the fullest extent allowed by CMS, allowing waiver women access to more comprehensive reproductive health care.

The overall assessment based on an analysis of the ten year period of IHW is positive. Not only did IHW increase the number of low-income women in Illinois who accessed family planning services, this increase in contraceptive utilization appears to have led to an increase in birth spacing, a decline in birth rates, a decrease in unintended pregnancies among Medicaid enrolled women, and an increase in averted births. These changes resulted in a reduction in Medicaid costs each waiver year.

A brief synopsis of the successes experienced during the ten years of IHW is recapped below:

- 193,715 unduplicated women received family planning services through IHW
- more low-income women received *publicly-funded* family planning services with IHW experiencing a five-fold increase
- IHW showed a lower rate of women with a birth spacing interval of <18 months compared to Medicaid women
- IHW showed a higher rate of women with a birth spacing interval of 24 months or greater compared to Medicaid women
- the Illinois unintended pregnancy rate decreased 9.1percent (2001-2011), while the HFS rate for the same period decreased 10.4 percent
- the IHW fertility rate is substantially lower than the total population and population of women ≤200 percent FPL. From 2005 to 2009, the fertility rate of IHW women on average (2.1%) was 9.5 percentage points less than Illinois women in poverty (11.6%) and nearly 5 percentage points less than the total Illinois population (7.0%)
- reduction in births among low-income women under age 25
- delays in pregnancies demonstrated by an increase in low-income women delivering between ages 30 through 39
- 48,369 averted births resulting in an estimated $559M in cost savings

In conclusion, the results of this analysis have clearly illustrated that having a family planning waiver reduced unplanned pregnancies and provided financial benefits to the State by reducing the amount of dollars spent on costly prenatal care, delivery and first-year of infant's life. However, additional benefits that are not easily measured include enabling women to obtain essential preventive reproductive healthcare services, the opportunity to make better-educated decisions regarding the timing of pregnancies which leads to enhanced self-sufficiency, and ultimately improved birth and health outcomes.

## Data Sources:

**Enterprise Data Warehouse (EDW)**: HFS' EDW is a centralized repository of HFS' Medicaid Management Information System (MMIS) claims data along with concomitant recipient and provider information. The EDW also includes data from other state agencies providing information about resources Medicaid recipients receive from social service providers, and including Vital Records. The primary function of the EDW is bringing medical services information directly to the desktop computers of health care program planners, fraud investigators and budget analysts, and making it accessible via easy-to-use graphical software. This allows analysis of data for purposes such as performance measurement, budgeting, rate setting, trend analysis, lawsuit defense, fraud and abuse discovery and responding to requests for information.

**Pregnancy Risk Assessment Monitoring System (PRAMS)**: IDPH's PRAMS was used to report the results of the analysis on unintended Medicaid births. The Illinois Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing population-based survey of women who have recently delivered a live born infant in Illinois. PRAMS is located in the Illinois Center for Health Statistics and is an important part of the Illinois Department of Public Health's surveillance activities, and is part of a national initiative by the U.S. Centers for Disease Control and Prevention (CDC) to reduce infant morbidity and mortality. PRAMS information is collected from mothers about their behaviors and experiences before, during and immediately after pregnancy. The unique information collected by the PRAMS program is used by health professionals, administrators, policy makers, and researchers to develop and to modify programs and policies to improve the health of women and children in Illinois.

**Vital Records/Birth File Match**: DHS' Vital Records birth file match was used to compare pre-waiver and during the waiver interpregnancy spacing and fertility data specific to this waiver population as compared to the Medicaid population (prior to the waiver).

**Ahlers**: IDHS/IDPH's Title X Family Planning Program's encounter data system manager, Ahlers and Associates of Waco, Texas, was used to report utilization of non-Medicaid participants using the Title X clinics, the numbers of women being served with Title X funding to compare utilization before and during the waiver, as well as referrals of waiver participants to other sources of care by Title X or Title V publicly-funded clinics. Aggregate data derived from the clinic visit record submitted by each Title X delegate agency for each family planning client served was retrieved from Ahlers.

**Focused Quality Studies**: HFS' and IDHS' medical record reviews, as part of the quality assurance component of family planning, were used to assess the quality of services/provision of clinical standards of care, and whether appropriate referrals were made. eQHealth Solutions, HFS' contracted Quality Improvement Organization, conducted the reviews for the IHW family planning client services, and DHS' MCH Nurse Consultants conducted the reviews for the Title X family planning clients services.

**Customer Satisfaction Survey**: Customer Satisfaction Survey findings were used to assess the extent to which women believed they received referrals to sources of care for medical services that are not covered under the waiver. HFS' Office of Inspector General (OIG) administered these telephonic customer satisfaction surveys.

**Pregnancy Intendedness Survey**: A survey was conducted of the women in the expansion population (Population 2) who became pregnant while enrolled in *Illinois Healthy Women* and were subsequently enrolled in the Moms & Babies Program to determine whether the pregnancy was intended. HFS Bureau of Maternal and Child Health Promotion staff conducted the surveys.

**Referral data**: IDHS' Family Case Management and WIC data tracking system, Cornerstone, was used to track contacts and referrals. The Title X program tracked and reported referrals, through Ahlers. HFS' Client Hotline, IDHS' Help Me Grow/Future for Kids, and IDPH's Women's Healthcare Hotline as well as Federally Qualified Health Centers (FQHCs) and others such as the Breast and Cervical Cancer Screening Program, tracked referrals made for waiver program participants, to the extent possible.

**Illinois Family Planning Demonstration Waiver**
**Evaluation Design**

## Introduction/Background:

Most women and men in the United States want to have children. However, most want to have children when they are able to care for them and they want to limit the number they have.[1] Approximately 40 percent of Illinois births are Medicaid-funded. According to Illinois Department of Public Health's (IDPH's) Pregnancy Risk Assessment Monitoring System data, in 1998, approximately two-thirds of the Medicaid births in Illinois were unintended (mistimed or unwanted), and the percentage of unintended Medicaid births appears to be rising. In 2000, 71 percent of the Medicaid births were unintended (PRAMS).

Illinois ranks 47th in the provision of contraceptive services to women in need, according to the Alan Guttmacher Institute, a non-profit corporation for reproductive health research, policy analysis and public education. According to Guttmacher, while the 173 publicly-supported family planning providers in Illinois serve 211,660 women, this represents only 30 percent of all women in need of family planning services. The use of family planning services reduces a low-income woman's probability of unintended pregnancy by 79 percent during any year that she uses family planning services.[2]

Uninsured women are less likely to receive essential preventive health care services. [3] Access to family planning services not only gives women access to contraceptive care, but also allows them the option of choosing more effective methods of contraceptives.[4]

The five-year family planning waiver allows Illinois the opportunity to demonstrate improved reproductive health care outcomes in its low-income women's population. The primary hypothesis of the waiver is that expanded eligibility will enable those women of childbearing age who are leaving Medicaid to obtain essential women's health care services for preventive health, reproductive education and subsequent contraceptive choices. Thus, a reduction in unplanned or inappropriately spaced pregnancies (less than 24 months apart) will be realized. This translates into improved health outcomes for these women and fewer Medicaid dollars spent on higher risk prenatal care and the lessened potential for lifelong problems. Additionally, for those women who are enabled with the ability to make better-educated decisions regarding the timing of pregnancies, their sense of self-sufficiency may be enhanced.

This waiver is designed to allow an eligible woman the freedom of choice in deciding to obtain family planning services from her usual physician or from any other Medicaid provider of family planning services. ***The number of women obtaining publicly funded family planning services is expected to increase with the implementation of this waiver.*** An estimated 15,942 are eligible to participate in the waiver each year. They will have the opportunity to receive annual and follow-up visits for reproductive health care. Contraceptive services, sexually transmitted disease education, detection, and treatment as well as screening and referral care for breast and cervical cancer are covered services under the waiver.

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[1] Harlap, Susan, Kathryn Kost and Jacqueline Darroch Forrest. *Preventing Pregnancy, Protecting Health: A New Look at Birth Control Choices in the United States*, page 12, 1991.
[2] Lopez, G., Westoff, W., Perrin, K., and Remmel, R. *Pregnancies Averted in Publicly-Funded Family Planning Services in Florida.* The University of South Flordia College of Public Health and the Department of Community and Family Health, 1995.
[3] Kaiser Commission on Uninsured Facts, "Medicaid and the Uninsured," May 2000.
[4] Illinois Planned Parenthood, "Responsible Choices."

Providing family planning services are critical in order to:

- Reduce the number of short interpregnancy intervals or unintended pregnancies in this population of women. ***The proportion of women who wait at least 24 months before having another child is expected to increase compared to other low-income women who obtain Medicaid coverage for pregnancy/delivery.*** This analysis will be performed through a historical birth file match. Many experts believe that short interpregnancy intervals are potentially more harmful among poor women, who are often less well-nourished and under more physical, economic, emotional and social stress than their middle and high income women counterparts, who have the resources to minimize the impact of the short interval.[5]

- Provide detection, treatment and education regarding sexually transmitted diseases. The diagnosis and treatment of sexually transmitted diseases that are discovered during the family planning visit will be covered under this waiver. This is essential to help maintain the reproductive health of the waiver participant.

- Promote the early detection of breast cancer through the use of screening mammography. Uninsured women are 60% less likely to have mammograms, the best way to detect breast cancer early when it is treatable. Breast cancer is the second leading cause of cancer deaths among women in the United States and accounts for one-fourth of all cancer cases, one fifth of cancer deaths in women. A woman's lifetime risk of breast cancer, assuming no other cause for premature mortality, is about 1 in 9.[6] Suspicious mammographic lesions require referral to a physician outside of the waiver for follow up and final disposition. These women will be referred to the Breast and Cervical Cancer Screening Program for diagnosis and treatment.

- Encourage annual pelvic examination for the early detection of cancer. Ovarian cancer is the fifth most common cancer among American women. The early detection of pre-malignant cervical lesions by Pap smear prevents at least 70% of potential cancers.[7] Abnormal Pap smear results or other suspect benign or malignant lesions will need referral outside the waiver for definitive evaluation and management. These women will be referred to the Breast and Cervical Cancer Screening Program for diagnosis and treatment.

The Medicaid program is expected to experience a ***cost savings*** secondary to the utilization of the waiver services. This will be realized as a decrease in the expenditures for prenatal, delivery, newborn and infant care than what would have been expected without the waiver. The women in the waiver will be those who would be eligible for Medicaid coverage should they become pregnant.

***Referrals to primary care services will occur as a result of the provision of family planning services.*** Those services which are not covered under the waiver that require definitive treatment outside of the family planning environment should be noted in the medical record by the family planning provider. The referral process will be evaluated in the medical record review, Customer Satisfaction Survey and tracking system that will be utilized by Family Case Management, WIC and state hotline staff.

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[5] Klerman, DrPH, Suzanne P. Cliver, BA and Robert L. Goldenberg, MD, "The Impace of Short Interpregnancy Intervals on Pregnancy Outcomes in a Low-Income Population," *American Journal of Public Health*, August 1998, Vol. 88, No. 8.

[6] Hatcher, Trussel, Steward, Cates, Steward, Guest and Kowal. *Contraceptive Technology*. Ardent Media. 1998.

[7] Hatcher, Trussel, Steward, Cates, Steward, Guest and Kowal. *Contraceptive Technology*. Ardent Media. 1998.

## Evaluation Design:

The evaluation for Illinois family planning waiver will focus on measurements defined by the program objectives. Attainment of the objectives will be examined through a series of comparisons to determine if outcomes differ from those that would be expected without the waiver and compared to those of a historical group. The evaluation will meet the requirements specified in the Centers for Medicare & Medicaid Services Special Terms and Conditions, June 23, 2003.

The evaluation will be conducted under the guidance of Anne Marie Murphy, Ph.D. Dr. Murphy is the Administrator of Medical Programs for the Illinois Department of Public Aid (IDPA), Illinois' Medicaid (Title XIX) single State agency. IDPA's Bureaus of Program and Reimbursement Analysis and Rate Development and Analysis will provide staff support to the evaluation. Illinois' Title V (MCH) and Title X, (Family Planning Program) Associate Director, Illinois Department of Human Services (IDHS), Stephen E. Saunders, M.D., M.P.H., will be a consultant to the project evaluation in addition to IDPH administrators from various programs within the Illinois Department of Public Health (IDPH) under the direction of Eric Whittaker, M.D., M.P.H.

A portion of the quality assurance component (medical record reviews for non-Title V or Title X funded providers) will be contracted to IDPA's Peer Review Organization (PRO), HealthSystems of Illinois (HSI). IDHS will perform the medical record reviews for its Title V and Title X contracting providers.

Title V and Title X program providers currently conduct customer satisfaction surveys for their clinic patients and will continue to conduct these surveys after implementation of the waiver program. Those surveys ask about referrals. Additionally, the customer satisfaction survey performed in years one, three and five of the waiver conducted by IDPA's Office of the Inspector General (OIG) will assist in identifying participant satisfaction with the waiver as well as whether needed referrals were made. For first-time births, a pregnancy intendedness survey will be conducted by the OIG in conjunction with the customer satisfaction survey in year 5. If additional assistance is needed to conduct or analyze the customer satisfaction surveys, IDPA may enlist the services of HSI or its subcontractor, Health Systems Advisory Group (HSAG). IDPA has experience with HSAG as it serves as IDPA's External Quality Assurance Organization for Managed Care. HSAG has many years of experience in conducting and analyzing customer satisfaction. HSAG is an NCQA-certified, Customer Satisfaction Survey vendor.

IDPA does not envision outsourcing the evaluation. However, IDPA may consult with state university-based experts through the course of the evaluation as needed.

Data Sources:

Reports will be produced on an ongoing basis in order to assist with the monitoring of the program and evaluation of its effectiveness. Some of the reports envisioned at the current time are outlined in Attachment 1.

MMIS: IDPA's Medicaid Management Information System (MMIS) will be used to track program participants and assess utilization, cost of services and repeat pregnancies. Utilization will be measured by an analysis of the claims (e.g., CPT Procedure Codes, NDC pharmacy codes). Prior authorization for services requiring such authorization, such as transportation will be reviewed and matched to paid claims. (Attachment 2 provides a detailed description of IDPA's MMIS system. The automated process

performed by the Client Information System (CIS) is also described in Attachment 2.)

PRAMS: IDPH's Pregnancy Risk Assessment Monitoring System (PRAMS) will be used to report the results of the analysis on unintended Medicaid births (Attachment 3 provides a description of IDPH's PRAMS.)

Vital records: IDHS' birth file match will be used to compare pre-waiver and during the waiver interpregnancy spacing and fertility data specific to this waiver population as compared to the Medicaid population (prior to the waiver).

Ahlers: IDHS' Title X Family Planning Program's encounter data system manager, Ahlers, will be used to report utilization of Medicaid participants using the Title X clinics, the numbers of women being served with Title X funding to compare utilization before and during the waiver, as well as referrals of wavier participants to other sources of care by Title X or Title V publicly-funded clinics. Aggregate data derived from the clinic visit record submitted by each Title X delegate agency for each family planning client served can be retrieved from Ahlers and Associates of Waco, Texas. (Attachment 4 provides a description of Ahlers for family planning data and information about IDHS' contract with them for managing Title X Family Planning Program data.)

Focused studies: IDPA's and IDHS' medical record reviews, as part of the quality assurance component of family planning, will assess the quality of services/provision of clinical standards of care and whether appropriate referrals were made. (The Focused Study design will be provided to CMS in early 2004.)

Customer Satisfaction Survey: Customer Satisfaction Survey findings will be used to assess the extent to which women believe they received referrals to sources of care for medical services that are not covered under the waiver. (The Customer Satisfaction Survey design will be provided to CMS in early 2004.)

Pregnancy Intendedness Survey: A survey will be conducted of the women in the expansion population (Population 2) who became pregnant while enrolled in *Illinois Healthy Women* and were subsequently enrolled in the Moms & Babies Program to determine whether the pregnancy was intended. The results will be compared to the unintendedness rate for the Medicaid population to determine whether the rate for this population is less.

Referral data: IDHS' Family Case Management and WIC data tracking system, Cornerstone, will be used to track contacts and referrals.

The Title X program will track and report referrals, through Ahlers.

IDPA's Client Hotline, IDHS' Help Me Grow/Future for Kids, and IDPH's Women's Healthcare Hotline as well as Federally Qualified Health Centers (FQHCs) and others such as the Breast and Cervical Cancer Screening Program, will track referrals made for waiver program participants, to the extent possible.

Primary Goal:
Increase the number of low-income women who receive voluntary, confidential family planning services.

Objectives:

Each objective is presented below, under four major topic areas:

- Number of Enrolled Women Using Family Planning Services
- Interpregnancy Spacing of Enrolled Women Using Family Planning Services
- Cost savings demonstrated by the reduction in unplanned pregnancies
- Client satisfaction with referrals and access to primary care
- Pregnancy intendedness for women experiencing first-time births

Number of Enrolled Women Using Family Planning Services:

Objective 1: To increase the number of Medicaid eligible women who, after delivery or after leaving transitional Medicaid participate in the waiver.

Measurements:

- The number of women participating in the waiver each year, by demographics: age, race/ethnicity and county of residence.

- The number of women participating in the waiver during the life of the waiver, by demographics: age, race/ethnicity and county of residence.

Data Source: MMIS

Objective 2: To increase the number of low-income women who obtain publicly-funded (Title X, Title V or Title XIX) family planning services pre-waiver as compared to each year during the waiver, from the baseline of 211,660.

Measurements:

- An analysis of the number of low-income non-Medicaid women (less than 200 percent of poverty) served in the publicly funded, Title X and Title V family planning system.

- An analysis of the number of Medicaid women served for family planning (traditional Medicaid and waiver).

Data Source: MMIS, Ahlers

Interpregnancy Interval:

Objective 3: To increase the proportion of women with a Medicaid financed delivery with an interpregnancy interval of 24 months or greater, from the baseline of 67.9 percent in CY 2001 (Attachment 5).

Measurements:

- Calculation of the following, stratified by Census Data age groupings and race/ethnicity

    - Numerator: The number of women who had a Medicaid-financed delivery during the year and had at least one prior delivery 24 or more months earlier.

- Denominator: The number of women who had a Medicaid-financed delivery during the year and had at least one prior delivery.

Data Sources: MMIS and Illinois Vital Records (Illinois Vital Records will be used to verify that the women selected for the analysis had a prior delivery, regardless of the funding source for that delivery. The analysis will be repeated for all Medicaid funded births, participants who became eligible for the waiver (using waiver-covered services) and for the general population, regardless of Medicaid eligibility.)

Objective 4: To reduce the incidence of unintended pregnancies of women with a Medicaid financed delivery from the baseline of 71 percent (PRAMS).

Measurements:

- Perform an analysis of the proportion of Medicaid women giving birth who report their birth was unintended.

Data Source: PRAMS

Objective 5: To reduce the fertility rates for women in families with incomes at or below 200 percent of poverty, as required under CMS Waiver Terms and Conditions, Base-Year Fertility Rate, page 9. (For the purpose of this calculation, births will be counted. Illinois does not have a mandatory reporting system for terminated pregnancies.)

Measurements:

- Perform an analysis of the fertility rate of low-income women pre-waiver and during the life of waiver. Data will be stratified by age categories as used in the 2000 US Census.

  - Numerator: The number of Medicaid financed deliveries of women, ages 19-44.

  - Denominator: The number of low income women from age 19-44 who are less than 200 percent of poverty, as estimated by the most recent data published by the US Census.

Data Sources: US Census, MMIS, Birth File Match

Cost savings:

Objective 6a: Reduce Medicaid expenditures for pregnancy-related and infant health care costs.

Measurements:

- An annual comparison analysis will be performed measuring the expenditures for prenatal, delivery, newborn and infant care of family planning waiver participants as compared to the estimated Medicaid expenditures for these, based on the baseline fertility rate of low-income women (less than 200 percent of poverty).

  - Numerator: The actual Medicaid expenditures for pregnancy-related and infant health care costs of waiver program participants (per thousand).

- Denominator: The estimated/expected Medicaid expenditures for pregnancy-related and infant health care services for a "hypothetical", age adjusted cohort of the same number of women, based on the fertility rate baseline data (Objective 5) (per thousand).

(The denominator will be a calculation of: the fertility rate (x) the number of women in the cohort (x) the average Medicaid expenditures.)

Objective 6b: Reduce Medicaid expenditures for pregnancy-related and child health care costs during the first five years of life.

Calculation: See CMS Terms and Conditions (page 9)
BC = (cost of prenatal services + delivery and pregnancy related costs for infants through year 5 of life)/number of deliveries, where the costs and number of deliveries pertains to Illinois' Medicaid Fee-For-Service program.

Facilitate the referral of enrolled women in need of primary care services to accessible sources of primary care:

Objective 7: Enrolled women who need primary care will receive referrals to accessible primary care, as needed.

Measurements: Perform an analysis of the following:

1. The number of waiver participants who respond positively to question # 13 of the Customer Satisfaction Survey compared to the number of waiver participants who respond positively to part 2 of question # 24 of the Customer Satisfaction Survey (Attachment 6).

2. The number of waiver participants who needed and received a referral, as identified during the medical record reviews

3. The number of waiver participants who contacted one of the state's hotlines to request referral information.

4. The number of waiver participants who were referred to the State's Breast and Cervical Cancer Screening Program.

5. The number of waiver participants who have been referred to the FQHCs by other family planning providers.

Data Sources: Ahlers, Customer Satisfaction Survey, hotline tracking analysis, Breast and Cervical Cancer Screening Program enrollment, FQHC referral tracking forms

Objective 8: The proportion of pregnancy intendedness for women experiencing a first-time birth will increase.

Measurement: A survey will be conducted of the women in the expansion population (Population 2) who became pregnant while enrolled in *Illinois Healthy* Women and are subsequently enrolled in the Moms & Babies Program to determine whether the pregnancy was intended. The

results will be compared to the unintendedness rate for the Medicaid population to determine if the rate for this population is lower.

Data Source: The Pregnancy Intendedness Survey

**Attachment 1 - Monitoring Reports**

**Questions to be answered – Performance Indicators and Monitoring Reports:**

**1. Has the Illinois Family Planning Waiver Program expanded access to family planning services among low-income women in Illinois?**

Waiver Enrollees*:

- Number of women invited to participate in the waiver, each year (3-month card)
- Number of women who enroll in the waiver, each year (initial 12-month card)
- Number of women who re-enroll in the waiver, each year (2nd, 3rd, or 4th 12-month card)

*By age, race/ethnicity (same cohorts as Census data)

Providers*:

- Number of providers who provide family planning services to Medicaid and waiver population, compared to Calendar Year 2003, baseline year
  - Private*:
  - Public*:

*By Provider Type

- Number of providers who increase the number of low-income family planning women that they serve each year, compared to Calendar Year 2003, baseline year
  - Statewide
  - Cook County
  - Downstate

Wavier Participants* (Family Planning Utilization Experience):

- Number of family planning waiver participants who receive an annual exam
- Number of family planning waiver participants who have birth control methods reimbursed
- Cost of family planning services: aggregate costs and per participant cost
- Utilization and Cost of other reproductive health services covered by the waiver:
  - Mammography: number of waiver participants who receive mammograms and aggregate costs, per participant cost, each year
  - Treatment of Sexually Transmitted Infections (STIs): number of waiver participants who receive treatment for STIs as determined by antibiotic treatment or STI diagnosis and aggregate costs, per participant cost, each year
  - Transportation Costs: number of waiver participants who receive transportation and aggregate costs, per participant cost, each year

*Participants – Defined as a waiver participant who uses at least one family planning service, per year

**2. Has the Illinois Family Planning Waiver Program been delivered in a manner consistent with the program standards?**

- Monitoring Reports:
  - Enrollment Procedures – system edit checks for enrollment
  - Utilization – system edit checks for service payment for services not requiring prior approval
  - Prior-Approval – system edit checks for drugs and transportation costs requiring prior approval

- Evaluation of quality of care – **focused quality studies** on application of clinical care standards for preventive reproductive health care and contraceptive management including patient education, follow-up and referral, as needed
    - Title V and Title X funded agencies
    - Providers not funded by Title V and Title X (e.g. some of the Federally Qualified Health Centers and Rural Health clinics, private physicians, other outpatient clinics)

- **Customer Satisfaction Surveys** including whether quality health care services were provided and whether they were available, accessible, confidential, satisfactory, and necessary referrals were made.

**3. Has the Illinois Family Planning Waiver Program reduced the number of unintended pregnancies among low-income women?**

- Number of Medicaid-financed deliveries that occur to the family planning waiver participants, per year* (This number will be used to calculate a rate in the final analysis)
    *stratified by age

**4. Did the Illinois Family Planning Waiver Program have an impact on interpregnancy intervals among waiver participants?**

- DHS report of interpregnancy interval (birth file match)

- MMIS delivery data (each year of the waiver, particularly last year of the waiver as birth file data are tabulated up to two years after the birth)

**5. Is the Illinois Family Planning Waiver Program a cost-effective program for reducing pregnancy-related costs to the state.**

- Cost Calculation Reports (by year, and over life of waiver):
    - Average costs (per woman) - Medicaid experience for prenatal, pregnancy-related, delivery, newborn and infant costs, per year = **A**
    - Number of family planning waiver participants who have a Medicaid-financed delivery, per year (tracked and calculated independently)
    - Actual costs of family planning waiver participants for their Medicaid-financed prenatal, pregnancy-related, delivery, newborn and infant costs, per year = **B**
    - Actual costs of family planning (and other waiver services) expended on waiver participants = **C**
    - Fertility rate of low-income women, based on Census Data, stratified by age = **D**
    - Number of family planning waiver participants, per year = **E**

    <u>*Calculation (to assess cost effectiveness) - Comparison:</u>
    **A x D x E** (the expected birth related costs, based on fertility rate = expected Medicaid costs, without the waiver services)
    **compared to**
    **B + C** (actual Medicaid costs, with the waiver)

    * **Cost Neutrality Calculation** – (repeat, using the formula, per CMS' Terms and Conditions, page 9)

**6. What is the Medicaid reenrollment experience of waiver participants?**

- Tracking Reports: family planning waiver participants by Medicaid eligibility group

**Attachment 2**

**Illinois Department of Public Aid**
**Data System**

**Medicaid Management Information System:**

The Illinois Medicaid Management Information System (MMIS) operates as an integrated system. MMIS was certified by the federal government in 1982. Since that time, it has served as the primary data processing system for the Illinois Medical Assistance Program. It provides a comprehensive system for managing information relative to the Medical Assistance Program, in general. Therefore, it will manage information specifically related to this Family Planning Waiver.

MMIS will manage information related to the services covered under this waiver and their associated costs as well as information pertaining to the providers and program participants of each service. The interrelated subsystems of MMIS are summarized as follows:

A. Recipient Subsystem

This subsystem requires close coordination with the Family Assistance Management Information System (FAMIS). The Client Information System (CIS) is Illinois' version of FAMIS. This subsystem maintains a consolidated recipient eligibility file containing recipient identification numbers, eligibility information, data to identify prior approved services and information related to third party liability (TPL) information. Its primary features are:

1. A Recipient Database (RDB) organized by the unique recipient identification number and updated via FAMIS transactions and additional sources.

2. An on-line terminal inquiry using the recipient ID number as the key. This inquiry is used in conjunction with the ability to determine the recipient number via a name file inquiry or by an inquiry in the Client Database.

For this waiver, CIS will:

- establish a family planning case when Medicaid is terminated for a woman who meets the Family Planning Waiver Program eligibility criteria;
- send the three-month initial Family Planning card to the eligible woman;
- send the Enrollment Form (invitation) to participate in the Family Planning Waiver Program;
- allow for entry by a worker to authorize the first year card for the eligible woman as well as entry for change in address and terminating coverage for women who request such termination from the program;
- send the yearly Reenrollment Form to the woman;
- send the Family Planning yearly card to the eligible woman who returns the Reenrollment Form;
- terminate benefits for the woman, such as when she reaches age 45 or the waiver ends.

B. Provider Subsystem

This subsystem maintains a database of all Illinois medical assistance providers. The information maintained includes a unique provider number, name, address, license information, provider types, allowable categories of service, and various other elements. The main features are:

1. On-line update of the database that provides direct entry of new provider enrollments, changes and terminations.

2. On-line inquiry into the database using provider number, name or Soundex of the name.

System-generated provider information sheets are produced to inform the provider of all relevant enrollment data and updates to such data. These provider information sheets are the turnaround documents the provider uses to notify IDPA when changes occur.

C. Reference Subsystem

This subsystem maintains a database of information on allowable medical assistance services. Additionally, this subsystem provides diagnosis codes, procedure codes and allowable prices for individual services.

D. Claims Subsystem

This subsystem, which is the primary subsystem of MMIS, consists of the integrated batch-processing modules which process all claim types such as pharmacy, institutional, and non-institutional. In addition, the Claims Subsystem allows on-line suspense correction of invalid claim information. This subsystem increased IDPA's ability to process and control the reimbursement to providers by verifying that a recipient is eligible for medical assistance (or this waiver), the provider is eligible to receive payment for the services, the service is allowable, a third party is not liable, and the claim has not previously been paid for each service. Claims processing schedules occur approximately 7 nights per week, 360 days per year. The primary features are:

1. Electronic Claims Processing of pharmacy claims submitted by providers via Point of Sale terminals and personal computers. This capability may be expanded to other providers in the future.

2. Electronic Claims Capture of institutional and non-institutional claims in a batch mode from providers, billing services, and Medicare carriers via computer-to-computer file transmissions. This feature is included in the Recipient Verification (REV) system.

3. Automatic Voice Response System processing of prior approvals for medical procedures. This system has been expanded to include recipient eligibility verification.

4. Drug rebate systems produce billings and monitor receipts of rebates due from drug manufacturers.

5. Data entry via the scanning of machine readable claim forms and supplemented by additional key-to-disk systems for the entry of non-scannable claims and the correction of data entry errors.

6. On-line error correction with automatic inquiry into the Provider Database, Recipient Database and Reference databases.

7. Duplication checks against previously paid services.

8. Comprehensive error and payment reporting to the provider via paper and limited tape remittance advices.

9. Claims History Database system which store all paid claims after the date a voucher number is assigned on an IMS database(s). Claims History databases are

provided for institutional, waiver, non-institutional and pharmacy claims and are accessed by recipient identification number.

10. Monitor system which allows on-line inquiry of all claims and adjustments throughout the processing cycle beginning with entry onto the Claims Document Database.

11. Rejected Database system allows on-line inquiry of all rejected claims and adjustments. This system provides more detailed information for rejected claims than the Monitor system.

12. Profile Database system which implements the Maternal and Child Health (MCH) program. The MCH program was designed to help ensure mothers enrolled in IDPA's Medical Assistance Program receive proper prenatal and post-natal care and that their children receive proper immunizations and checkups.

E. Management and Administrative Reporting System (MARS)
This subsystem provides various operational and financial reports relative to the Medical Assistance Program. The primary features are:

1. Daily reports to summarize claims inventory, the aging of claims, claims with errors, and claim receipts by type

2. Monthly reports classified in four broad areas: a) Administrative; b) Operations; c) Provider Relations; d) Recipient Relations

3. Reports required to meet federal reporting requirements. The information appearing on these reports is derived from basic data collected in the Recipient, Provider, and Claims Processing Subsystems. On a daily basis, relevant data is extracted from files in these subsystems and consolidated into summary history files. All reports produced directly by this subsystem are from information maintained on these summary history files.

4. **The Data Warehouse** system provides a central repository of historical services and supporting reference data which is needed to perform inquiry and reporting functions against Medicaid and SCHIP claims and encounter data. This system provides a function to support management and administrative reporting, surveillance and utilization review activities and a broad array of user-generated and ad hoc reporting functions. The Data Warehouse provides access to detailed and summary service, provider, recipient and reference data, and includes both paid and rejected claims data. Five years of historical data is available through this system's interactive and batch processing capabilities. (Currently, the Data Warehouse contains a record of all claims paid by IDPA since July 1, 1996.)

The Data Warehouse will be the primary system for generating reports for this waiver: participant tracking reports including the actual number of births that occur to waiver participants, utilization data and cost reports.

Once a client enters a medical program, he or she is assigned a unique identification number, which carries over to any program in which he or she is subsequently enrolled. All data including enrollment and disenrollment dates, program in which the client is enrolled and demographic data are retained in the Data Warehouse enrollment tables.

- There will be a unique program code to identify women enrolled in the Family Planning waiver, making it easy to identify these women and separate them from the Medicaid population.

- There will be system edits in place to identify the services that these women may receive under the waiver program.

- The claim records in the Data Warehouse include much of the information submitted on a claim, such as the date of service, who provided the service, procedures performed, diagnosis, and the total that IDPA paid for the service. The client is identified on these claim records using the same identification number assigned in the enrollment data, making it very easy to coordinate information between the two sets of data. The unique program code in which the client is enrolled will also be kept on the claim data, so IDPA can easily identify which claims were paid under the waiver and separate those records from claims paid while the client was enrolled in Medicaid (or subsequently again becomes enrolled in Medicaid after participating in the waiver).

- The Data Warehouse programmers are developing a system to track, on a quarterly basis and annual basis, aggregate data reports that will, in part, be used for analyses used in the waiver evaluation.

F. Medical Electronic Data Interchange (MEDI) System

This system allows providers of service and their authorized representatives to access Medicaid and SCHIP data over the Internet.

An enrolled provider of service must go through a registration process with IDPA in order to access this data. A provider is required to register and then authorize the user representatives, who will perform functions on the provider's behalf. Users may be authorized by multiple providers to perform functions in the MEDI System. Users can perform functions only for providers who have granted them access and only for the functions specified by each provider.

Once a provider or user is registered with IDPA, it is assigned a role based on the functions it is allowed to perform. This role can be changed in real-time by a provider or by IDPA even while a user is logged into the MEDI System. A provider must register as a user if it wants to perform user functions.

MEDI is comprised of six (6) parts:

1. Provider Registration is a process which allows a provider to register for access to Medicaid and SCHIP data over the Internet. This process uses IDPA information to verify the identity of a provider.

2. User Authorization is a process whereby a provider authorizes certain persons to perform functions on its behalf.

3. Recipient Eligibility – once a user is authorized by a provider and registered for access to its information, a user can look-up a recipient's eligibility for Medicaid services. If the recipient is eligible for a limited set of services, as with this waiver, that information will be provided.

4. Internet Electronic Claims – this system allows authorized users to submit claims for payment over the Internet.

5. Electronic Remittance Advices – this portion of the Internet Electronic Claims System allows all authorized users to access remittance advices for claims submitted for payment on behalf of the provider they represent and which have been adjudicated by IDPA.

6. Claims Status – this portion of the Internet Electronic Claims System allows all authorized users to access claim status information relevant to claims submitted for adjudication.

Other:

Client Server Surveillance Utilization System (CS SURS)

This is an exception processing system that produces recipient and provider utilization profiles for use in identifying those cases deviating from established norms. It is fed by the data warehouse and also has all of the medical assistance data. The system maintained by IDPA's Office of Inspector General (OIG).

1. All participants, both provider and recipient, are classified into homogeneous groupings according to their particular characteristics. A statistical profile is developed for each such group and also for each individual participant. Individual participant profiles are then measured against the appropriate group profile and a percentage of participants deviating significantly from this group's norms are reviewed.

2. A variety of reports facilitating an analysis of the level and quality of care rendered by individual providers of institutional and non-institutional services.

**Attachment 3**

**Illinois Department of Public Health**
**Pregnancy Risk Assessment Monitoring System (PRAMS)**

The following information has been taken from the Centers for Disease Control and Prevention (CDC) website. It is taken from the PRAMS Surveillance Report Preface, written by John R. Lehnherr, Acting Director, Division of Reproductive Health, CDC and their website.

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project for the CDC and state health departments. It has served as a state-specific data source for maternal and child health (MCH) issues since 1987. CDC publishes PRAMS surveillance reports. The PRAMS Surveillance Report is a compilation of PRAMS results for various MCH indicators.

PRAMS is a population-based survey of women delivering a live-born infant. This survey collects state-specific, population-based data on maternal attitudes and experiences and behaviors before, during and shortly after pregnancy. Thus, states participating in PRAMS gain unique and invaluable information for public health administrators, policy makers, and researchers as they develop programs and policies to improve the health of women and children. The surveillance reports are divided into subgroup analyses by age, race, ethnicity, education, Medicaid status, and annual household income. The Centers for Disease Control and Prevention funded this questionnaire that was sent to a random sample of women giving birth.

PRAMS was initiated in 1987 because infant mortality rates were no longer declining as rapidly as they had in prior years. In addition, the incidence of low birth weight infants had changed little in the previous 20 years. Research has indicated that maternal behaviors during pregnancy may influence infant birth weight and mortality rates. The goal of the PRAMS project is to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity.

PRAMS provides state-specific data for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health. PRAMS allows CDC and the states to monitor changes in maternal and child health indicators (e.g., unintended pregnancy, prenatal care, breast-feeding, smoking, drinking, infant health). PRAMS enhances information from birth certificates used to plan and review state maternal and infant health programs. PRAMS not only provides state-specific data but also allows comparisons among participating states because the same data collection methods are used in all states.

The PRAMS sample is chosen from all women who had a live birth recently, so findings can be applied to the state's entire population of women who have recently delivered a live born infant. Thirty-one states and New York City currently participate in PRAMS. Four other states previously participated. Illinois is a PRAMS participating state and data are available from 1998 onward.

PRAMS provides data not available from other sources about pregnancy and the first few months after birth. These data can be used to identify groups of women and infants at high risk for health problems, to monitor changes in health status, and to measure progress towards goals in improving the health of mothers and infants.

The PRAMS questionnaire includes core questions that are asked by all the states and state-specific questions that are chosen or developed by individual states. The core portion of the questionnaire includes questions about the following: Attitudes and feelings about the most recent pregnancy.

- Content and source of prenatal care.
- Maternal alcohol and tobacco consumption.
- Physical abuse before and during pregnancy.
- Pregnancy-related morbidity.
- Infant health care.
- Maternal living conditions.
- Mother's knowledge of pregnancy-related health issues, such as adverse effects of tobacco and alcohol; benefits of folic acid; and risks of HIV.

Illinois questionnaire includes items on the intendedness of pregnancy and the use of contraception both before and after pregnancy.

The PRAMS questionnaire consists of two parts. First, there are core questions that appear on every states' surveys. Second, states may tailor their questionnaire to meet state needs by drawing additional questions from a pretested list of standard questions or by developing questions on their own.

The PRAMS sample of women who have had a recent live birth is drawn from the state's birth certificate file. Each participating state samples between 1,300 and 3,400 women per year. Women from some groups are sampled at a higher rate to ensure adequate data are available in smaller but higher risk populations. Selected women are first contacted by mail. If there is no response to repeated mailings, women are contacted and interviewed by telephone. Data collection procedures and instruments are standardized to allow comparisons between states.

**Attachment 4**

## Ahlers

Ahlers & Associates (Ahlers) of Waco, Texas is a privately held company designed to provide data processing, billing services and clinic management software to the non-profit health community. They perform the statewide Family Planning Management System for Illinois' Title X family planning program through a contract with IDHS. They process the Clinic Visit Record (CVR) (detailed claim). This information is completed by the Title X delegate agencies that contract with IDHS to provide family planning services. The electronic CVR is completed for each service encounter. This information captures information on participant characteristic, payment source, contraceptive supplies and other family planning services. Ahlers tabulates a variety of management reports on services and service utilization.

**Attachment 5**

**Interpregnancy Interval**
**2000 and 2001 Birth Data Match Report**

**Interpreting Data on Interpregnancy Interval Among Medicaid Women**

Data on the proportion of Medicaid women who give birth during the year are presented in the following tables. Each table represents the number of births, the number of second or higher-order births and the number of second or higher-order births that occurred within 24 months of the end of the previous pregnancy/delivery. Each table presents data for all women and the number of women in each of five five-year age groups. There is a separate table for each major racial or ethnic group.

"Second or higher-order births" ("2nd + Up Births" on the tables) are infants that result from the second, third, fourth, and so on, pregnancy of the woman in question. For example, if a woman had given birth in a prior year and has an infant in year 2000, the birth in year 2000 would be included in both the number of live births and the number of "2nd + Up Births" in the tables for the year 2000. The number of "second or higher-order births" excludes plural births (twins, triplets, etc.) and births with an unknown interpregnancy interval. (Plural births are excluded because of the way in which the interpregnancy interval is coded.)

The interval between births is calculated as the number of complete months between the birth that occurred in the year covered by the table and the date of the prior live birth.

Two percentages are presented on each table. First, the column labeled "% of Repeat Births" compares the number of second or higher-order births to the total number of live births. Looking across racial or ethnic groups, age groups and years, between 40 and 81 percent of Medicaid women in Illinois have a second or higher order birth in any given year.

Second, the column labeled, "% of 2nd + up< 24 Mo." compares the number of second and higher-order births that occurred within 24 months of a prior live birth or fetal death to the number of second and higher-order births. Again looking across racial or ethnic groups, age groups and years, in 2000, between 12.2 and 43.8 percent of Medicaid women in Illinois give birth within 24 months of their prior live birth (32.1% "All Mothers" in 2001; 32.4% "All Mothers" in 2000). It is this proportion that the waiver is designed to reduce.

**2000 Medicaid Total Report**

**Birth Data**

| Race / Ethnicity | Age Ranges | Live Births: | 2nd + Up Births | % of Repeat Births | IPX < 24 Months | % of 2nd+up <24 Mo. |
|---|---|---|---|---|---|---|
| All Mothers | 20-44 Year Olds | 53,257 | 36,593 | 68.70% | 11,861 | 32.40% |
| All Mothers | 20-24 Year Olds | 26,433 | 16,107 | 60.90% | 6,555 | 40.70% |
| All Mothers | 25-29 Year Olds | 15,361 | 11,467 | 74.70% | 3,307 | 28.80% |
| All Mothers | 30-34 Year Olds | 7,551 | 5,894 | 78.10% | 1,371 | 23.30% |
| All Mothers | 35-39 Year Olds | 3,199 | 2,562 | 80.10% | 540 | 21.10% |
| All Mothers | 40-44 Year Olds | 713 | 563 | 79.00% | 88 | 15.60% |

Annual Medicaid Total Report - TestBirth.mdb

**2000 Medicaid Total Report**

**Birth Data**

| Race / Ethnicity | Age Ranges | Live Births: | 2nd + Up Births | % of Repeat Births | IPX < 24 Months | % of 2nd+up <24 Mo. |
|---|---|---|---|---|---|---|
| WHITE Mothers | 20-44 Year Olds | 36,259 | 24,181 | 66.70% | 7,533 | 31.20% |
| WHITE Mothers | 20-24 Year Olds | 17,687 | 10,115 | 57.20% | 4,003 | 39.60% |
| WHITE Mothers | 25-29 Year Olds | 10,822 | 7,951 | 73.50% | 2,201 | 27.70% |
| WHITE Mothers | 30-34 Year Olds | 5,207 | 4,085 | 78.50% | 919 | 22.50% |
| WHITE Mothers | 35-39 Year Olds | 2,098 | 1,679 | 80.00% | 357 | 21.30% |
| WHITE Mothers | 40-44 Year Olds | 445 | 351 | 78.90% | 53 | 15.10% |

Annual Medicaid Total Report - TestBirth.mdb

**2000 Medicaid Total Report**

**Birth Data**

| Race / Ethnicity | Age Ranges | Live Births: | 2nd + Up Births | % of Repeat Births | IPX < 24 Months | % of 2nd+up <24 Mo. |
|---|---|---|---|---|---|---|
| BLACK Mothers | 20-44 Year Olds | 15,516 | 11,608 | 74.80% | 4,084 | 35.20% |
| BLACK Mothers | 20-24 Year Olds | 8,309 | 5,816 | 70.00% | 2,475 | 42.60% |
| BLACK Mothers | 25-29 Year Olds | 4,030 | 3,248 | 80.60% | 1,018 | 31.30% |
| BLACK Mothers | 30-34 Year Olds | 1,992 | 1,580 | 79.30% | 397 | 25.10% |
| BLACK Mothers | 35-39 Year Olds | 950 | 773 | 81.40% | 164 | 21.20% |
| BLACK Mothers | 40-44 Year Olds | 235 | 191 | 81.30% | 30 | 15.70% |

Annual Medicaid Total Report - TestBirth.mdb

**2000 Medicaid Total Report**
**Birth Data**

| Race / Ethnicity | Age Ranges | Live Births: | 2nd + Up Births | % of Repeat Births | IPX < 24 Months | % of 2nd+up <24 Mo. |
|---|---|---|---|---|---|---|
| OTHER Mothers | 20-44 Year Olds | 1,482 | 804 | 54.30% | 244 | 30.30% |
| OTHER Mothers | 20-24 Year Olds | 437 | 176 | 40.30% | 77 | 43.80% |
| OTHER Mothers | 25-29 Year Olds | 509 | 268 | 52.70% | 88 | 32.80% |
| OTHER Mothers | 30-34 Year Olds | 352 | 229 | 65.10% | 55 | 24.00% |
| OTHER Mothers | 35-39 Year Olds | 151 | 110 | 72.80% | 19 | 17.30% |
| ~~*OTHER Mothers~~ | ~~40-44 Year Olds~~ | ~~33~~ | ~~21~~ | ~~63.60%~~ | ~~5~~ | ~~23.80%~~ |

Annual Medicaid Total Report - TestBirth.mdb

*There were not enough births to 'other Mothers 40-44years old' to come up with a reliable percentage

**2000 Medicaid Total Report**
**Birth Data**

| Race / Ethnicity | Age Ranges | Live Births: | 2nd + Up Births | % of Repeat Births | IPX < 24 Months | % of 2nd+up <24 Mo. |
|---|---|---|---|---|---|---|
| Hispanic Mothers | 20-44 Year Olds | 19,380 | 12,753 | 65.80% | 3,621 | 28.40% |
| Hispanic Mothers | 20-24 Year Olds | 8,714 | 4,784 | 54.90% | 1,780 | 37.20% |
| Hispanic Mothers | 25-29 Year Olds | 6,221 | 4,437 | 71.30% | 1,137 | 25.60% |
| Hispanic Mothers | 30-34 Year Olds | 3,047 | 2,387 | 78.30% | 486 | 20.40% |
| Hispanic Mothers | 35-39 Year Olds | 1,157 | 948 | 81.90% | 194 | 20.50% |
| Hispanic Mothers | 40-44 Year Olds | 241 | 197 | 81.70% | 24 | 12.20% |

Annual Medicaid Total Report - TestBirth.mdb

**2000 Medicaid Total Report**
**Birth Data**

| Race / Ethnicity | Age Ranges | Live Births: | 2nd + Up Births | % of Repeat Births | IPX < 24 Months | % of 2nd+up <24 Mo. |
|---|---|---|---|---|---|---|
| Non-Hispanic Mothers | 20-44 Year Olds | 33,877 | 23,840 | 70.40% | 8,240 | 34.60% |
| Non-Hispanic Mothers | 20-24 Year Olds | 17,719 | 11,323 | 63.90% | 4,775 | 42.20% |
| Non-Hispanic Mothers | 25-29 Year Olds | 9,140 | 7,030 | 76.90% | 2,170 | 30.90% |
| Non-Hispanic Mothers | 30-34 Year Olds | 4,504 | 3,507 | 77.90% | 885 | 25.20% |
| Non-Hispanic Mothers | 35-39 Year Olds | 2,042 | 1,614 | 79.00% | 346 | 21.40% |
| Non-Hispanic Mothers | 40-44 Year Olds | 472 | 366 | 77.50% | 64 | 17.50% |

Annual Medicaid Total Report - TestBirth.mdb

**2001 Medicaid Total Report**

**Birth Data**

| Race / Ethnicity | Age Ranges | Live Births: | 2nd + Up Births | % of Repeat Births | IPX < 24 Months | % of 2nd+up <24 Mo. |
|---|---|---|---|---|---|---|
| All Mothers | 20-44 Year Olds | 63,510 | 43,591 | 68.60% | 14,010 | 32.10% |
| All Mothers | 20-24 Year Olds | 30,022 | 18,143 | 60.40% | 7,471 | 41.20% |
| All Mothers | 25-29 Year Olds | 18,559 | 13,789 | 74.30% | 3,918 | 28.40% |
| All Mothers | 30-34 Year Olds | 9,775 | 7,604 | 77.80% | 1,776 | 23.40% |
| All Mothers | 35-39 Year Olds | 4,294 | 3,379 | 78.70% | 720 | 21.30% |
| All Mothers | 40-44 Year Olds | 860 | 676 | 78.60% | 125 | 18.50% |

Annual Medicaid Total Report - TestBirth.mdb

**2001 Medicaid Total Report**

**Birth Data**

| Race / Ethnicity | Age Ranges | Live Births: | 2nd + Up Births | % of Repeat Births | IPX < 24 Months | % of 2nd+up <24 Mo. |
|---|---|---|---|---|---|---|
| WHITE Mothers | 20-44 Year Olds | 43,337 | 28,832 | 66.50% | 8,860 | 30.70% |
| WHITE Mothers | 20-24 Year Olds | 20,085 | 11,310 | 56.30% | 4,552 | 40.20% |
| WHITE Mothers | 25-29 Year Olds | 12,981 | 9,490 | 73.10% | 2,563 | 27.00% |
| WHITE Mothers | 30-34 Year Olds | 6,837 | 5,316 | 77.80% | 1180 | 22.20% |
| WHITE Mothers | 35-39 Year Olds | 2,891 | 2,290 | 79.20% | 476 | 20.80% |
| WHITE Mothers | 40-44 Year Olds | 543 | 426 | 78.50% | 89 | 20.90% |

Annual Medicaid Total Report - TestBirth.mdb

**2001 Medicaid Total Report**

**Birth Data**

| Race / Ethnicity | Age Ranges | Live Births: | 2nd + Up Births | % of Repeat Births | IPX < 24 Months | % of 2nd+up <24 Mo. |
|---|---|---|---|---|---|---|
| BLACK Mothers | 20-44 Year Olds | 18,215 | 13,698 | 75.20% | 4,809 | 35.10% |
| BLACK Mothers | 20-24 Year Olds | 9,390 | 6,610 | 70.40% | 2,823 | 42.70% |
| BLACK Mothers | 25-29 Year Olds | 4,863 | 3,919 | 80.60% | 1,224 | 31.20% |
| BLACK Mothers | 30-34 Year Olds | 2,480 | 1,993 | 80.40% | 517 | 25.90% |
| BLACK Mothers | 35-39 Year Olds | 1210 | 957 | 79.10% | 213 | 22.30% |
| BLACK Mothers | 40-44 Year Olds | 272 | 219 | 80.50% | 32 | 14.60% |

Annual Medicaid Total Report - TestBirth.mdb

**2001 Medicaid Total Report**

**Birth Data**

| Race / Ethnicity | Age Ranges | Live Births: | 2nd + Up Births | % of Repeat Births | IPX < 24 Months | % of 2nd+up <24 Mo. |
|---|---|---|---|---|---|---|
| OTHER Mothers | 20-44 Year Olds | 1,958 | 1061 | 54.20% | 341 | 32.10% |
| OTHER Mothers | 20-24 Year Olds | 547 | 223 | 40.80% | 96 | 43.00% |
| OTHER Mothers | 25-29 Year Olds | 715 | 380 | 53.10% | 131 | 34.50% |
| OTHER Mothers | 30-34 Year Olds | 458 | 295 | 64.40% | 79 | 26.80% |
| OTHER Mothers | 35-39 Year Olds | 193 | 132 | 68.40% | 31 | 23.50% |
| ~~*OTHER Mothers~~ | ~~40-44 Year Olds~~ | ~~45~~ | ~~31~~ | ~~68.90%~~ | ~~4~~ | ~~12.90%~~ |

Annual Medicaid Total Report - TestBirth.mdb

*There were not enough births to 'other Mothers 40-44years old' to come up with a reliable percentage

**2001 Medicaid Total Report**

**Birth Data**

| Race / Ethnicity | Age Ranges | Live Births: | 2nd + Up Births | % of Repeat Births | IPX < 24 Months | % of 2nd+up <24 Mo. |
|---|---|---|---|---|---|---|
| Hispanic Mothers | 20-44 Year Olds | 23,297 | 15,356 | 65.90% | 4,312 | 28.10% |
| Hispanic Mothers | 20-24 Year Olds | 9,896 | 5,399 | 54.60% | 2,075 | 38.40% |
| Hispanic Mothers | 25-29 Year Olds | 7,524 | 5,364 | 71.30% | 1,325 | 24.70% |
| Hispanic Mothers | 30-34 Year Olds | 3,973 | 3,070 | 77.30% | 609 | 19.80% |
| Hispanic Mothers | 35-39 Year Olds | 1,627 | 1308 | 80.40% | 260 | 19.90% |
| Hispanic Mothers | 40-44 Year Olds | 277 | 215 | 77.60% | 43 | 20.00% |

Annual Medicaid Total Report - TestBirth.mdb

**2001 Medicaid Total Report**

**Birth Data**

| Race / Ethnicity | Age Ranges | Live Births: | 2nd + Up Births | % of Repeat Births | IPX < 24 Months | % of 2nd+up <24 Mo. |
|---|---|---|---|---|---|---|
| Non-Hispanic Mothers | 20-44 Year Olds | 40,213 | 28,235 | 70.20% | 9,698 | 34.30% |
| Non-Hispanic Mothers | 20-24 Year Olds | 20,126 | 12,744 | 63.30% | 5,396 | 42.30% |
| Non-Hispanic Mothers | 25-29 Year Olds | 11,035 | 8,425 | 76.30% | 2,593 | 30.80% |
| Non-Hispanic Mothers | 30-34 Year Olds | 5,802 | 4,534 | 78.10% | 1167 | 25.70% |
| Non-Hispanic Mothers | 35-39 Year Olds | 2,667 | 2,071 | 77.70% | 460 | 22.20% |
| Non-Hispanic Mothers | 40-44 Year Olds | 583 | 461 | 79.10% | 82 | 17.80% |

Annual Medicaid Total Report - TestBirth.mdb

**Attachment 6**

## Customer Satisfaction Survey - DRAFT

Our records indicate that you expressed a desire to participate in the State's Family Planning Program. Please take a few minutes to complete this evaluation of the Family Planning Program. Your responses will be strictly confidential. Thank you for your help in improving this program.

1. If you received your Family Planning Card, did you use your card to obtain family planning services?
____Yes ____ No
(If you answered YES Proceed to question #3.)
(If you answered NO Proceed to question #2.)

2. Please check the reason(s) that you did not use your Family Planning Card to obtain family planning services:
___I was unable to find a provider in my area
___I was unable to get an appointment with a provider in my area
___I needed more information about this program
___I decided I did not want family planning services at this time
___Other: _____
(If you answered NO to question #1, you are now done with this evaluation.)

If you answered YES to question #1, Rate the following:

3. The person on the phone making my appointment was helpful and courteous:
Excellent_____ Good _____ Fair_____ Poor _____

4. The receptionist was helpful and courteous:
Excellent_____ Good _____ Fair_____ Poor _____

5. The nursing staff was friendly and courteous:
Excellent_____ Good _____ Fair_____ Poor _____

6. The provider treated me with dignity and respect:
Excellent_____ Good _____ Fair_____ Poor _____

7. The overall appearance of the office:
Excellent_____ Good _____ Fair_____ Poor _____

8. On average, after checking in, how many minutes did you have to wait before seeing the person you came to see?
___ 10 minutes or less ___11-20 minutes ___21-30 minutes
___ 31-45 minutes ___ 46 minutes to 1 hour ___ more than 1 hour

9. Were all procedures explained to you before they were done?
___ Yes ___ No

10. Do you feel that your privacy was protected?
___Yes ___ No

11. What is your age range?
___Under 19 ___19-30 ___30-40 ___ 40 years and older

12. If you needed an interpreter to help you speak with doctors or other health providers, were you given one?
___ Yes __ No ___ Did not need an interpreter

13. Were you told how to access primary health care services if you needed them for an illness (such as a sore throat)?
___ Yes * ___ No __ Did not need to access additional care at this time
* If you answered Yes, were you able to access additional health care services from the provider to which you were referred?
___ Yes ___ No

14. Were you given information about how to reach the provider at any time of the day or night in an emergency?
____ Yes ___ No

<u>Please rate the following:</u>

15. Your choices regarding family planning services were clearly explained:
Excellent_____ Good _____ Fair_____ Poor _____

16. Your questions were answered:
Excellent_____ Good _____ Fair_____ Poor _____

17. You received clear and easy to understand instructions about prescriptions/drugs:
Excellent_____ Good _____ Fair_____ Poor _____

18. You received clear and easy to understand instructions about follow-up care:
Excellent_____ Good _____ Fair_____ Poor _____

19. Overall, your satisfaction with the family planning visit(s) you received was:
Excellent_____ Good _____ Fair_____ Poor _____

20. Do you plan to continue to use the Family Planning Program?
____Yes ____No

21. Do you have any other health insurance?
____Yes ____No

If yes, does your insurance cover any family planning services
____Yes ____No

22. How many children do you have? _____

23. What are the ages of your children? _____

24. Have you ever needed (please check all that apply):

___Assistance in locating a provider for family planning services
Where did you go for assistance?_____
Rate the assistance you received:
Excellent_____ Good _____ Fair _____ Poor _____

___Assistance in getting a referral for primary care
Where did you go for assistance?_____
Rate the assistance you received:
Excellent_____ Good _____ Fair _____ Poor _____

___Assistance with transportation to your family planning provider
Where did you go for assistance?_____
Rate the assistance you received:
Excellent_____ Good _____ Fair _____ Poor _____

___Pharmacy items for family planning

Where did you go for assistance?_____
Rate the assistance you received:
Excellent_____ Good _____ Fair _____ Poor _____

____Other, please specify: _____
Where did you go for assistance? _____
Rate the assistance you received:
Excellent_____ Good _____ Fair _____ Poor _____

Comments:

# Appendix E

# IHW Budget Neutrality Worksheet

| | Percent change in CPI Medical Care | |
|---|---|---|
| 2004-2005 | 4.2% | |
| 2005-2006 | 4.0% | |
| 2006-2007 | 4.4% | |
| 2007-2008 | 3.7% | |
| 2008-2009 | 3.2% | |
| 2009-2010 | 3.4% | |
| 2010-2011 | 3.0% | |
| 2011-2012 | 4.0% | |
| 2012-2013 | 2.8% | |
| 5 yr Avg | **3.3%** | (Using this average for future projections) |

***Source:***

**CPI Data: http://www.bls.gov/cpi/cpi_dr.htm**

**ALL COSTS**

**Healthcare and Family Services**
**Illinois Healthy Women Budget Neutrality Worksheet**

**Using CMS Averted Births Methodology**

# *IHW Model Budget Neutrality Worksheet for: ALL COSTS*

## WITHOUT DEMONSTRATION

| Updated 06/18/14 | | Waiver Yr 1 | Waiver Yr 2 | Waiver Yr 3 | Waiver Yr 4 | Waiver Yr 5 | Waiver Yr 6 | Waiver Yr 7 | Waiver Yr 8 | Waiver Yr 9 | Waiver Yr 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr04-Mar05 | Apr05-Mar06 | Apr06-Mar07 | Apr07-Mar08 | Apr08-Mar09 | Apr09-Mar10 | Apr10-Mar11 | Apr11-Mar12 | Apr12-Mar13 | Apr13-Mar14 |
| | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Estimate |
| FAMILY PLANNING SERVICES | Persons | 266,041 | 300,077 | 303,720 | 311,906 | 323,448 | 342,775 | 351,595 | 355,786 | 333,138 | 343,132 |
| UNDER MEDICAID STATE PLAN | Cost per Person | $311.89 | $301.32 | $309.00 | $310.44 | $317.31 | $327.37 | $336.87 | $325.38 | $268.35 | $277.20 |
| All current Medicaid eligibles/participants | Total | $82,975,527 | $90,419,202 | $93,849,480 | $96,828,099 | $102,633,285 | $112,214,252 | $118,442,238 | $115,764,339 | $89,397,207 | $95,117,735 |
| ESTIMATED AVERTED BIRTHS *(Due to IHW Waiver)* | | 1,333 | 2,128 | 2,698 | 3,075 | 4,453 | 6,294 | 8,380 | 6,844 | 7,584 | 5,580 |
| Estimated DELIVERIES UNDER MEDICAID | Persons | 83,623 | 87,518 | 91,949 | 95,023 | 94,217 | 95,869 | 95,204 | 90,377 | 91,206 | 89,620 |
| STATE PLAN (Include costs for prenatal care, | Cost per Person | $3,549.40 | $3,801.03 | $3,993.54 | $3,990.67 | $3,961.94 | $4,119.89 | $4,194.50 | $4,207.63 | $4,201.88 | $4,340.54 |
| deliveries, and 60-days postpartum -- Deliveries Plus Estimated Averted Births Due to IHW | Total | $296,811,476 | $332,658,544 | $367,202,009 | $379,205,435 | $373,282,101 | $394,969,734 | $399,332,718 | $380,273,188 | $383,236,544 | $388,999,730 |
| FIRST YEAR INFANT COSTS UNDER | Persons | 75,952 | 80,034 | 85,423 | 87,297 | 87,597 | 87,368 | 87,524 | 84,053 | 84,819 | 83,201 |
| MEDICAID STATE PLAN | Cost per Person | $6,116.50 | $6,416.85 | $6,717.26 | $6,756.00 | $7,056.99 | $7,333.49 | $7,796.67 | $7,684.29 | $7,742.48 | $7,997.98 |
| (Infants Plus Estimated Averted Births Due to waiver) | Total | $464,560,408 | $513,566,173 | $573,808,501 | $589,778,532 | $618,171,153 | $640,712,354 | $682,395,802 | $645,888,004 | $656,709,237 | $665,441,310 |
| TOTAL WITHOUT-WAIVER COSTS | | $844,347,412 | $936,643,918 | $1,034,859,990 | $1,065,812,066 | $1,094,086,539 | $1,147,896,340 | $1,200,170,758 | $1,141,925,531 | $1,129,342,989 | $1,149,558,775 |

## WITH DEMONSTRATION

| | | Waiver Yr 1 | Waiver Yr 2 | Waiver Yr 3 | Waiver Yr 4 | Waiver Yr 5 | Waiver Yr 6 | Waiver Yr 7 | Waiver Yr 8 | Waiver Yr 9 | Waiver Yr 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr04-Mar05 | Apr05-Mar06 | Apr06-Mar07 | Apr07-Mar08 | Apr08-Mar09 | Apr09-Mar10 | Apr10-Mar11 | Apr11-Mar12 | Apr12-Mar13 | Apr13-Mar14 | TOTAL |
| | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Estimate | |
| FAMILY PLANNING SERVICES | Persons | 266,041 | 300,077 | 303,720 | 311,906 | 323,448 | 342,775 | 351,595 | 355,786 | 333,138 | 343,132 | |
| UNDER MEDICAID STATE PLAN | Cost per Person | $311.89 | $301.32 | $309.00 | $310.44 | $317.31 | $327.37 | $336.87 | $325.38 | $268.35 | $277.20 | |
| All current Medicaid eligibles/participants | Total | $82,975,527 | $90,419,202 | $93,849,480 | $96,828,099 | $102,633,285 | $112,214,252 | $118,442,238 | $115,764,339 | $89,397,207 | $95,117,735 | |
| Estimate (in red) | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | 3.0% | |
| Actual DELIVERIES UNDER MEDICAID | Persons | 82,290 | 85,390 | 89,251 | 91,948 | 89,764 | 89,575 | 86,824 | 83,533 | 83,622 | 84,040 | |
| STATE PLAN (Include costs for prenatal care, | Cost per Person | $3,549.40 | $3,801.03 | $3,993.54 | $3,990.67 | $3,961.94 | $4,119.89 | $4,194.50 | $4,207.63 | $4,201.88 | $4,340.54 | |
| deliveries, and 60-days postpartum) | Total | $292,080,126 | $324,569,952 | $356,427,439 | $366,934,125 | $355,639,582 | $369,039,147 | $364,182,849 | $351,476,152 | $351,369,497 | $364,779,514 | |
| Estimate (in red) | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | 0.05% | |
| FIRST YEAR INFANT COSTS UNDER | Persons | 74,619 | 77,906 | 82,725 | 84,222 | 83,144 | 81,074 | 79,144 | 77,209 | 77,235 | 77,621 | |
| MEDICAID STATE PLAN | Cost per Person | $6,116.50 | $6,416.85 | $6,717.26 | $6,756.00 | $7,056.99 | $7,333.49 | $7,796.67 | $7,684.29 | $7,742.48 | $7,997.98 | |
| | Total | $456,407,114 | $499,911,116 | $555,685,334 | $569,003,832 | $586,746,377 | $594,555,368 | $617,059,702 | $593,296,693 | $597,990,284 | $620,812,583 | |
| Estimate (in red) | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | 0.05% | |
| EXPANDED FAMILY PLANNING | Persons | 8,282 | 15,546 | 20,851 | 23,432 | 32,609 | 45,263 | 58,621 | 50,008 | 56,492 | 42,431 | |
| | Cost per Person | $218.68 | $200.67 | $226.92 | $295.76 | $338.55 | $336.15 | $313.30 | $389.93 | $315.12 | $325.52 | |
| | Total | $1,811,108 | $3,119,616 | $4,731,509 | $6,930,248 | $11,039,777 | $15,215,157 | $18,365,881 | $19,499,791 | $17,801,621 | $13,811,988 | |
| Estimate (in red) | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | *****Prov/Est. | |
| TOTAL WITH WAIVER COSTS | | $833,273,875 | $918,019,885 | $1,010,693,761 | $1,039,696,304 | $1,056,059,021 | $1,091,023,924 | $1,118,050,670 | $1,080,036,974 | $1,056,558,609 | $1,094,521,819 | |

| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2013 | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Reduction in Growth*** | ($11,073,537) | ($18,624,033) | ($24,166,229) | ($26,115,762) | ($38,027,518) | ($56,872,416) | ($82,120,089) | ($61,888,556) | ($72,784,379) | ($55,036,956) | ($391,672,520) |
| Accumulative Total | ($11,073,537) | ($29,697,570) | ($53,863,799) | ($79,979,561) | ($118,007,080) | ($174,879,496) | ($256,999,584) | ($318,888,141) | ($391,672,520) | | |

**See Next Page for Parameter Assumptions and Notes**

# ALL COSTS

## Healthcare and Family Services
## Illinois Healthy Women Budget Neutrality Worksheet

### PARAMETER ASSUMPTIONS

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Expanded Family Planning Actual cost per person is based on a blended FMAP and FFP rate | | | | | | | | | | |
| FP FMAP | | | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| REGULAR FMAP | | | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% |
| **Estimated persons are based on historical HFS trends** | | | | | | | | | | |
| **Cost estimates are based on the MCPI annual percent increase** | | | | | | | | | | **3.3%** |
| DELIVERY REDUCTION** | | **1.6%** | **2.4%** | **2.9%** | **3.2%** | **4.7%** | **6.6%** | **8.8%** | **7.6%** | **8.3%** | **6.2%** |
| DELIVERY TO FIRST YEAR PERSON FACTOR*** | | 90.7% | 91.2% | 92.7% | 91.6% | 92.6% | 90.5% | 91.2% | 92.4% | 92.4% | 92.4% |
| BASE YEAR FERTLITY RATE | 115.5 | | | | | | | | | | |
| STATE | | | | | | | | | | | |
| PLAN ENROLLEES/PARTICIPANTS**** | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Estimate |
| AVERAGE GROWTH RATE FOR | | | | | | | | | | | |
| DEMONSTRATION PARTICIPANTS | | | 87.7% | 34.1% | 12.4% | 39.2% | 38.8% | 29.5% | -14.7% | 13.0% | -24.9% |

Note: Estimated averted births are due to the IHW waiver
1st year averted birth calculations was reduced to one-quarter due program start-up
*ALL ANTICIPATED REDUCTIONS IN COSTS HAVE BEEN PREVIOUSLY ACCOUNTED FOR IN THE HFS BUDGET
**% Decrease in deliveries with waiver
***# of First Year Persons Per Deliveries
****Medicaid Users of Family Planning
***** # of family planning users is provisional/expenditures are estimated

**CPI Data: http://www.bls.gov/cpi/cpi_dr.htm**

# FEDS COSTS

**Healthcare and Family Services**
**Illinois Healthy Women Budget Neutrality Worksheet**
**Using CMS Averted Births Methodology**

## *IHW Model Budget Neutrality Worksheet for: FEDS COSTS*

### WITHOUT DEMONSTRATION

| Updated 06/18/14 | | Waiver Yr 1 Apr04-Mar05 | Waiver Yr 2 Apr05-Mar06 | Waiver Yr 3 Apr06-Mar07 | Waiver Yr 4 Apr07-Mar08 | Waiver Yr 5 Apr08-Mar09 | Waiver Yr 6 Apr09-Mar10 | Waiver Yr 7 Apr10-Mar11 | Waiver Yr 8 Apr11-Mar12 | Waiver Yr 9 Apr12-Mar13 | Waiver Yr 10 Apr13-Mar14 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Estimate |
| FAMILY PLANNING SERVICES | Persons | 266,041 | 300,077 | 303,720 | 311,906 | 323,448 | 342,775 | 351,595 | 355,786 | 366,460 | 377,453 |
| UNDER MEDICAID STATE PLAN | Cost per Person | $280.70 | $271.19 | $278.10 | $279.40 | $285.58 | $294.63 | $303.18 | $292.84 | $241.51 | $225.33 |
| All current Medicaid eligibles/participants | Total | $74,677,975 | $81,377,281 | $84,464,532 | $87,145,289 | $92,369,956 | $100,992,827 | $106,598,014 | $104,187,905 | $88,505,114 | $85,052,530 |
| ESTIMATED AVERTED BIRTHS *(Due to IHW Waiver)* | | 1,333 | 2,128 | 2,698 | 3,075 | 4,453 | 6,294 | 8,380 | 6,844 | 7,584 | 5,580 |
| Estimated DELIVERIES UNDER MEDICAID | Persons | 83,623 | 87,518 | 91,949 | 95,023 | 94,217 | 95,869 | 95,204 | 90,377 | 91,206 | 89,620 |
| STATE PLAN (Include costs for prenatal care, | Cost per Person | $1,774.70 | $1,900.52 | $1,996.77 | $1,995.34 | $1,980.97 | $2,059.95 | $2,097.25 | $2,103.82 | $3,842.15 | $3,968.94 |
| deliveries, and 60-days postpartum -- Deliveries Plus Estimated Averted Births Due to IHW | Total | $148,405,738 | $166,329,272 | $183,601,005 | $189,602,718 | $186,641,050 | $197,484,867 | $199,666,359 | $190,136,594 | $350,426,881 | $355,696,669 |
| FIRST YEAR INFANT COSTS UNDER | Persons | 75,952 | 80,034 | 85,423 | 87,297 | 87,597 | 87,368 | 87,524 | 84,053 | 84,819 | 83,201 |
| MEDICAID STATE PLAN | Cost per Person | $3,058.25 | $3,208.43 | $3,358.63 | $3,378.00 | $3,528.50 | $3,666.75 | $3,898.34 | $3,842.15 | $3,871.24 | $3,998.99 |
| (Infants Plus Estimated Averted Births Due to waiver) | Total | $232,280,204 | $256,783,086 | $286,904,250 | $294,889,266 | $309,085,577 | $320,356,177 | $341,197,901 | $322,944,002 | $328,354,618 | $332,720,655 |
| TOTAL WITHOUT-WAIVER COSTS | | $455,363,917 | $504,489,640 | $554,969,787 | $571,637,272 | $588,096,583 | $618,833,871 | $647,462,274 | $617,268,501 | $767,286,614 | $773,469,854 |

### WITH DEMONSTRATION

| | | Waiver Yr 1 Apr04-Mar05 | Waiver Yr 2 Apr05-Mar06 | Waiver Yr 3 Apr06-Mar07 | Waiver Yr 4 Apr07-Mar08 | Waiver Yr 5 Apr08-Mar09 | Waiver Yr 6 Apr09-Mar10 | Waiver Yr 7 Apr10-Mar11 | Waiver Yr 8 Apr11-Mar12 | Waiver Yr 9 Apr12-Mar13 | Waiver Yr 10 Apr13-Mar14 | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FAMILY PLANNING SERVICES | Persons | 266,041 | 300,077 | 303,720 | 311,906 | 323,448 | 342,775 | 351,595 | 355,786 | 366,460 | 377,453 | |
| UNDER MEDICAID STATE PLAN | Cost per Person | $280.70 | $271.19 | $278.10 | $279.40 | $285.58 | $294.63 | $303.18 | $292.84 | $241.51 | $225.33 | |
| All current Medicaid eligibles/participants | Total | $74,677,975 | $81,377,281 | $84,464,532 | $87,145,289 | $92,369,956 | $100,992,827 | $106,598,014 | $104,187,905 | $88,505,114 | $85,052,530 | |
| Estimate (in red) | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | 3.0% | |
| Actual DELIVERIES UNDER MEDICAID | Persons | 82,290 | 85,390 | 89,251 | 91,948 | 89,764 | 89,575 | 86,824 | 83,533 | 83,622 | 84,040 | |
| STATE PLAN (Include costs for prenatal | Cost per Person | $1,774.70 | $1,900.52 | $1,996.77 | $1,995.34 | $1,980.97 | $2,059.95 | $2,097.25 | $2,103.82 | $3,842.15 | $3,968.94 | |
| care, deliveries, and 60-days postpartum) | Total | $146,040,063 | $162,284,976 | $178,213,719 | $183,467,063 | $177,819,791 | $184,519,573 | $182,091,424 | $175,738,076 | $321,288,037 | $333,549,994 | |
| Estimate (in red) | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | 0.05% | |
| FIRST YEAR INFANT COSTS UNDER | Persons | 74,619 | 77,906 | 82,725 | 84,222 | 83,144 | 81,074 | 79,144 | 77,209 | 77,235 | 77,621 | |
| MEDICAID STATE PLAN | Cost per Person | $3,058.25 | $3,208.43 | $3,358.63 | $3,378.00 | $3,528.50 | $3,666.75 | $3,898.34 | $3,842.15 | $3,871.24 | $3,998.99 | |
| | Total | $228,203,557 | $249,955,558 | $277,842,667 | $284,501,916 | $293,373,188 | $297,277,684 | $308,529,851 | $296,648,346 | $298,995,142 | $310,406,292 | |
| Estimate (in red) | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | 0.05% | |
| EXPANDED FAMILY PLANNING | Persons | 8,282 | 15,546 | 20,851 | 23,432 | 32,609 | 45,263 | 58,621 | 50,008 | 56,492 | 42,431 | |
| | Cost per Person | $167.19 | $153.71 | $168.38 | $220.57 | $252.72 | $256.72 | $239.24 | $282.52 | $224.59 | $209.54 | |
| | Total | $1,384,668 | $2,389,576 | $3,510,891 | $5,168,396 | $8,240,946 | $11,619,917 | $14,024,212 | $14,128,474 | $12,687,438 | $8,891,026 | |
| Estimate (in red) | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | *****Prov/Est. | |
| TOTAL WITH WAIVER COSTS | | $450,306,262 | $496,007,391 | $544,031,809 | $560,282,664 | $571,803,882 | $594,410,001 | $611,243,501 | $590,702,801 | $721,475,731 | $737,899,842 | |

| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Reduction in Growth*** | ($5,057,655) | ($8,482,249) | ($10,937,978) | ($11,354,609) | ($16,292,701) | ($24,423,870) | ($36,218,773) | ($26,565,700) | ($45,810,883) | ($35,570,012) | ($185,144,416) |
| Accumulative Total | ($5,057,655) | ($13,539,903) | ($24,477,881) | ($35,832,490) | ($52,125,191) | ($76,549,061) | ($112,767,834) | ($139,333,533) | ($185,144,416) | | |

**See Next Page for Parameter Assumptions and Notes**

# FEDS COSTS

## Healthcare and Family Services
## Illinois Healthy Women Budget Neutrality Worksheet

### PARAMETER ASSUMPTIONS

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Expanded Family Planning Actual cost per person is based on a blended FMAP and FFP rate | | | | | | | | | | |
| FP FMAP | | | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| REGULAR FMAP | | | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% | 50% |
| **Estimated persons are based on historical HFS trends** | | | | | | | | | | |
| **Cost estimates are based on the MCPI annual percent increase** | | | | | | | | | | **3.3%** |
| DELIVERY REDUCTION** | | **1.6%** | **2.4%** | **2.9%** | **3.2%** | **4.7%** | **6.6%** | **8.8%** | **7.6%** | **8.3%** | **6.2%** |
| DELIVERY TO FIRST YEAR PERSON FACTOR*** | | 90.7% | 91.2% | 92.7% | 91.6% | 92.6% | 90.5% | 91.2% | 92.4% | 92.4% | 92.4% |
| BASE YEAR FERTLITY RATE | 115.5 | | | | | | | | | | |
| STATE | | | | | | | | | | | |
| PLAN ENROLLEES/PARTICIPANTS**** | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Estimate |
| AVERAGE GROWTH RATE FOR DEMONSTRATION PARTICIPANTS | | | 87.7% | 34.1% | 12.4% | 39.2% | 38.8% | 29.5% | -14.7% | 13.0% | -24.9% |

Note: Estimated averted births are due to the IHW waiver

1st year averted birth calculations was reduced to one-quarter due program start-up

*ALL ANTICIPATED REDUCTIONS IN COSTS HAVE BEEN PREVIOUSLY ACCOUNTED FOR IN THE HFS BUDGET

**% Decrease in deliveries with waiver

***# of First Year Persons Per Deliveries

****Medicaid Users of Family Planning

***** # of family planning users is provisional/expenditures are estimated

**CPI Data: http://www.bls.gov/cpi/cpi_dr.htm**

# Appendix F

# IHW Annual Budget Limit Worksheets

**Illinois Department of Healthcare and Family Services**
**Averted Births and Annual Budget Limits**
**Illinois Healthy Women, Waiver Years 1 - 10, April 2004 - March 2014**

| | Age 19[1] | Ages 20-24 | Ages 25-29 | Ages 30-34 | Ages 35-39 | Ages 40-44 | Totals | FFP |
|---|---|---|---|---|---|---|---|---|
| **Waiver Year 1 (April 2004-March 2005)** | | | | | | | | |
| **Estimated Base-Year Delivery Rate[3]** | 245.5 | 185.6 | 165.7 | 95.1 | 41.7 | 10.1 | 160.98 [2] | |
| **Waiver Participants[4]** | 1,431 | 2,874 | 1,956 | 1,013 | 566 | 442 | 8,282 | |
| **Expected Births[5]** | 351 | 533 | 324 | 96 | 24 | 4 | 1,333 | |
| **Actual Births[6]** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| **Births Averted** | 351 | 533 | 324 | 96 | 24 | 4 | 1,333 | |
| **Average Prenatal/Delivery Cost** | $3,549.40 | $3,549.40 | $3,549.40 | $3,549.40 | $3,549.40 | $3,549.40 | $3,549.40 | |
| **Average Birth to 1 Yr Cost** | $6,116.50 | $6,116.50 | $6,116.50 | $6,116.50 | $6,116.50 | $6,116.50 | $6,116.50 | |
| **Costs Averted/Annual Budget Limit[7]** | $3,395,732.16 | $5,155,930.25 | $3,132,807.12 | $931,177.04 | $228,136.50 | $43,150.51 | $12,886,933.59 | |
| | | | | | | | **FFP** | **$1,384,683** |
| | | | | | | | **Waiver Expenditures** | **$1,811,139** |
| | | | | | | | **% Annual Budget Limit** | **14.1%** |
| **Waiver Year 2 (April 2005-March 2006)** | | | | | | | | |
| **Estimated Base-Year Delivery Rate[3]** | 245.5 | 185.6 | 165.7 | 95.1 | 41.7 | 10.1 | 155.3 [2] | |
| **Waiver Participants[4]** | 1,675 | 6,263 | 3,667 | 1,841 | 1,146 | 954 | 15,546 | |
| **Expected Births[5]** | 411 | 1,162 | 608 | 175 | 48 | 10 | 2,414 | |
| **Actual Births[6]** | 8 | 174 | 72 | 23 | 8 | 1 | 286 | |
| **Births Averted** | 403 | 988 | 536 | 152 | 40 | 9 | 2,128 | |
| **Average Prenatal/Delivery Cost** | $3,801.03 | $3,801.03 | $3,801.03 | $3,801.03 | $3,801.03 | $3,801.03 | $3,801.03 | |
| **Average Birth to 1 Yr Cost** | $6,416.85 | $6,416.85 | $6,416.85 | $6,416.85 | $6,416.85 | $6,416.85 | $6,416.85 | |
| **Costs Averted/Annual Budget Limit[7]** | $4,119,976.94 | $10,099,483.38 | $5,472,920.30 | $1,553,925.99 | $406,551.05 | $88,235.48 | $21,741,093.15 | |
| | | | | | | | **FFP** | **$2,389,542** |
| | | | | | | | **Waiver Expenditures** | **$3,119,511** |
| | | | | | | | **% Annual Budget Limit** | **14.3%** |
| **Waiver Year 3 (April 2006-March 2007)** | | | | | | | | |
| **Estimated Base-Year Delivery Rate[3]** | 245.5 | 185.6 | 165.7 | 95.1 | 41.7 | 10.1 | 153.0 [2] | |
| **Waiver Participants[4]** | 2,087 | 8,082 | 5,092 | 2,696 | 1,561 | 1,333 | 20,851 | |
| **Expected Births[5]** | 512 | 1,500 | 844 | 256 | 65 | 13 | 3,191 | |
| **Actual Births[6]** | 15 | 306 | 116 | 40 | 12 | 4 | 493 | |
| **Births Averted** | 497 | 1,194 | 728 | 216 | 53 | 9 | 2,698 | |
| **Average Prenatal/Delivery Cost** | $3,993.54 | $3,993.54 | $3,993.54 | $3,993.54 | $3,993.54 | $3,993.54 | $3,993.54 | |
| **Average Birth to 1 Yr Cost** | $6,717.26 | $6,717.26 | $6,717.26 | $6,717.26 | $6,717.26 | $6,717.26 | $6,717.26 | |
| **Costs Averted/Annual Budget Limit[7]** | $5,327,107.42 | $12,788,900.85 | $7,794,724.72 | $2,317,705.73 | $568,676.00 | $101,359.51 | $28,898,474.23 | |
| | | | | | | | **FFP** | **$3,510,639** |
| | | | | | | | **Waiver Expenditures** | **$4,731,096** |
| | | | | | | | **% Annual Budget Limit** | **16.4%** |

*See page 2 for Waiver Years 4, 5 and 6*

**Illinois Department of Healthcare and Family Services**
**Averted Births and Annual Budget Limits**
**Illinois Healthy Women, Waiver Years 1 - 10, April 2004 - March 2014**

| | Age 19[1] | Ages 20-24 | Ages 25-29 | Ages 30-34 | Ages 35-39 | Ages 40-44 | Totals | FFP |
|---|---|---|---|---|---|---|---|---|
| **Waiver Year 4 (April 2007-March 2008)** | | | | | | | | |
| **Estimated Base-Year Delivery Rate[3]** | 245.5 | 185.6 | 165.7 | 95.1 | 41.7 | 10.1 | 153.6 [2] | |
| **Waiver Participants[4]** | 2,216 | 9,399 | 5,584 | 3,116 | 1,848 | 1,269 | 23,432 | |
| **Expected Births[5]** | 544 | 1,744 | 925 | 296 | 77 | 13 | 3,600 | |
| **Actual Births[6]** | 7 | 315 | 140 | 43 | 17 | 3 | 525 | |
| **Births Averted** | 537 | 1,429 | 785 | 253 | 60 | 10 | 3,075 | |
| **Average Prenatal/Delivery Cost** | $3,990.67 | $3,990.67 | $3,990.67 | $3,990.67 | $3,990.67 | $3,990.67 | $3,990.67 | |
| **Average Birth to 1 Yr Cost** | $6,756.00 | $6,756.00 | $6,756.00 | $6,756.00 | $6,756.00 | $6,756.00 | $6,756.00 | |
| **Costs Averted/Annual Budget Limit[7]** | $5,771,262.70 | $15,361,874.72 | $8,439,024.65 | $2,722,471.11 | $645,462.19 | $105,498.98 | $33,045,594.35 | |
| | | | | | | | **FFP** | **$5,167,798** |
| | | | | | | | **Waiver Expenditures** | **$6,929,181** |
| | | | | | | | **% Annual Budget Limit** | **21.0%** |
| **Waiver Year 5 (April 2008-March 2009)** | | | | | | | | |
| **Estimated Base-Year Delivery Rate[3]** | 245.5 | 185.6 | 165.7 | 95.1 | 41.7 | 10.1 | 156.2 [2] | |
| **Waiver Participants[4]** | 2,647 | 14,568 | 7,595 | 3,869 | 2,288 | 1,642 | 32,609 | |
| **Expected Births[5]** | 650 | 2,704 | 1,258 | 368 | 95 | 17 | 5,092 | |
| **Actual Births[6]** | 22 | 365 | 162 | 58 | 23 | 9 | 639 | |
| **Births Averted** | 628 | 2,339 | 1,096 | 310 | 72 | 8 | 4,453 | |
| **Average Prenatal/Delivery Cost** | $3,961.94 | $3,961.94 | $3,961.94 | $3,961.94 | $3,961.94 | $3,961.94 | $3,961.94 | |
| **Average Birth to 1 Yr Cost** | $7,056.99 | $7,056.99 | $7,056.99 | $7,056.99 | $7,056.99 | $7,056.99 | $7,056.99 | |
| **Costs Averted/Annual Budget Limit[7]** | $6,918,108.48 | $25,771,302.68 | $12,082,163.08 | $3,415,228.10 | $797,876.31 | $83,569.77 | $49,068,248.43 | |
| | | | | | | | **FFP** | **$8,226,656** |
| | | | | | | | **Waiver Expenditures** | **$11,017,098** |
| | | | | | | | **% Annual Budget Limit** | **22.5%** |
| **Waiver Year 6 (April 2009-March 2010)** | | | | | | | | |
| **Estimated Base-Year Delivery Rate[3]** | 245.5 | 185.6 | 165.7 | 95.1 | 41.7 | 10.1 | 157.7 [2] | |
| **Waiver Participants[4]** | 3,559 | 20,628 | 10,851 | 5,198 | 2,919 | 2,108 | 45,263 | |
| **Expected Births[5]** | 874 | 3,829 | 1,798 | 494 | 122 | 21 | 7,138 | |
| **Actual Births[6]** | 13 | 479 | 227 | 100 | 24 | 1 | 844 | |
| **Births Averted** | 861 | 3,350 | 1,571 | 394 | 98 | 20 | 6,294 | |
| **Average Prenatal/Delivery Cost** | $4,119.89 | $4,119.89 | $4,119.89 | $4,119.89 | $4,119.89 | $4,119.89 | $4,119.89 | |
| **Average Birth to 1 Yr Cost** | $7,333.49 | $7,333.49 | $7,333.49 | $7,333.49 | $7,333.49 | $7,333.49 | $7,333.49 | |
| **Costs Averted/Annual Budget Limit[7]** | $9,858,319.31 | $38,363,746.86 | $17,993,382.53 | $4,516,409.04 | $1,119,250.64 | $232,398.24 | $72,083,506.62 | |
| | | | | | | | **FFP** | **$11,508,317** |
| | | | | | | | **Waiver Expenditures** | **$15,043,043** |

## Illinois Department of Healthcare and Family Services
## Averted Births and Annual Budget Limits
## Illinois Healthy Women, Waiver Years 1 - 10, April 2004 - March 2014

*See page 3 for Waiver Years 7, 8 and 9*

| | Age 19[1] | Ages 20-24 | Ages 25-29 | Ages 30-34 | Ages 35-39 | Ages 40-44 | Totals | FFP |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | **% Annual Budget Limit** | **20.9%** |
| **Waiver Year 7 (April 2010-March 2011)** | | | | | | | | |
| **Estimated Base-Year Delivery Rate[3]** | 245.5 | 185.6 | 165.7 | 95.1 | 41.7 | 10.1 | 156.8 [2] | |
| **Waiver Participants[4]** | 5,178 | 25,476 | 14,151 | 6,912 | 3,814 | 3,090 | 58,621 | |
| **Expected Births[5]** | 1,271 | 4,728 | 2,345 | 657 | 159 | 31 | 9,192 | |
| **Actual Births[6]** | 16 | 486 | 195 | 93 | 18 | 4 | 812 | |
| **Births Averted** | 1,255 | 4,242 | 2,150 | 564 | 141 | 27 | 8,380 | |
| **Average Prenatal/Delivery Cost** | $4,194.50 | $4,194.50 | $4,194.50 | $4,194.50 | $4,194.50 | $4,194.50 | $4,194.50 | |
| **Average Birth to 1 Yr Cost** | $7,796.67 | $7,796.67 | $7,796.67 | $7,796.67 | $7,796.67 | $7,796.67 | $7,796.67 | |
| **Costs Averted/Annual Budget Limit[7]** | $15,051,304.59 | $50,870,687.29 | $25,778,865.48 | $6,766,991.36 | $1,691,280.18 | $326,267.74 | $100,485,396.65 | |
| | | | | | | | **FFP** | **$13,997,541** |
| | | | | | | | **Waiver Expenditures** | **$18,321,914** |
| | | | | | | | **% Annual Budget Limit** | **18.2%** |
| **Waiver Year 8 (April 2011-March 2012)** | | | | | | | | |
| **Estimated Base-Year Delivery Rate[3]** | 245.5 | 185.6 | 165.7 | 95.1 | 41.7 | 10.1 | 156.6 [2] | |
| **Waiver Participants[4]** | 4,418 | 21,681 | 12,035 | 5,945 | 3,237 | 2,692 | 50,008 | |
| **Expected Births[5]** | 1,085 | 4,024 | 1,994 | 565 | 135 | 27 | 7,830 | |
| **Actual Births[6]** | 21 | 594 | 228 | 105 | 27 | 11 | 986 | |
| **Births Averted** | 1,064 | 3,430 | 1,766 | 460 | 108 | 16 | 6,844 | |
| **Average Prenatal/Delivery Cost** | $4,207.63 | $4,207.63 | $4,207.63 | $4,207.63 | $4,207.63 | $4,207.63 | $4,207.63 | |
| **Average Birth to 1 Yr Cost** | $7,684.29 | $7,684.29 | $7,684.29 | $7,684.29 | $7,684.29 | $7,684.29 | $7,684.29 | |
| **Costs Averted/Annual Budget Limit[7]** | $12,648,472.06 | $40,789,209.49 | $21,003,503.16 | $5,474,677.26 | $1,284,124.01 | $192,520.67 | $81,392,506.65 | |
| | | | | | | | **FFP** | **$14,128,474** |
| | | | | | | | **Waiver Expenditures** | **$19,499,791** |
| | | | | | | | **% Annual Budget Limit** | **24.0%** |
| **Waiver Year 9 (April 2012-March 2013)** | | | | | | | | |
| **Estimated Base-Year Delivery Rate[3]** | 245.5 | 185.6 | 165.7 | 95.1 | 41.7 | 10.1 | 151.7 [2] | |
| **Waiver Participants[4]** | 5,077 | 22,697 | 13,179 | 7,474 | 4,297 | 3,768 | 56,492 | |
| **Expected Births[5]** | 1,246 | 4,213 | 2,184 | 711 | 179 | 38 | 8,571 | |
| **Actual Births[6]** | 18 | 533 | 286 | 116 | 28 | 6 | 987 | |
| **Births Averted** | 1,228 | 3,680 | 1,898 | 595 | 151 | 32 | 7,584 | |
| **Average Prenatal/Delivery Cost** | $4,201.88 | $4,201.88 | $4,201.88 | $4,201.88 | $4,201.88 | $4,201.88 | $4,201.88 | |
| **Average Birth to 1 Yr Cost** | $7,742.48 | $7,742.48 | $7,742.48 | $7,742.48 | $7,742.48 | $7,742.48 | $7,742.48 | |
| **Costs Averted/Annual Budget Limit[7]** | $14,672,493.63 | $43,950,027.50 | $22,667,532.22 | $7,104,235.39 | $1,805,806.87 | $382,897.96 | $90,582,993.57 | |
| | | | | | | | **FFP** | **$12,687,438** |

**Illinois Department of Healthcare and Family Services**
**Averted Births and Annual Budget Limits**
**Illinois Healthy Women, Waiver Years 1 - 10, April 2004 - March 2014**

*See page 4 for Waiver Years 10*

| | Age 19[1] | Ages 20-24 | Ages 25-29 | Ages 30-34 | Ages 35-39 | Ages 40-44 | Totals | FFP |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | **Waiver Expenditures** | **$17,801,621** |
| | | | | | | | **% Annual Budget Limit** | **19.7%** |
| **Waiver Year 10 (April 2012-March 2014)** | | | | | | | | |
| **Estimated Base-Year Delivery Rate[3]** | 245.5 | 185.6 | 165.7 | 95.1 | 41.7 | 10.1 | 151.5 [2] | |
| **Waiver Participants[4]** | 3,374 | 17,447 | 10,013 | 5,752 | 3,065 | 2,780 | 42,431 | |
| **Expected Births[5]** | 828 | 3,238 | 1,659 | 547 | 128 | 28 | 6,429 | |
| **Actual Births[6]** | 19 | 456 | 227 | 109 | 30 | 8 | 849 | |
| **Births Averted** | 809 | 2,782 | 1,432 | 438 | 98 | 20 | 5,580 | |
| **Average Prenatal/Delivery Cost** | $4,340.54 | $4,340.54 | $4,340.54 | $4,340.54 | $4,340.54 | $4,340.54 | $4,340.54 | |
| **Average Birth to 1 Yr Cost** | $7,997.98 | $7,997.98 | $7,997.98 | $7,997.98 | $7,997.98 | $7,997.98 | $7,997.98 | |
| **Costs Averted/Annual Budget Limit[7]** | $9,985,773.99 | $34,327,776.29 | $17,670,662.01 | $5,404,459.31 | $1,206,836.81 | $247,732.80 | $68,843,241.20 | |
| | | | | | | | **FFP** | **$8,910,085** |
| | | | | | | | **Waiver Expenditures** | **$13,838,729** |
| | | | | | | | **% Annual Budget Limit** | **20.1%** |

[2]The ***Total*** *Estimated Base-Year Delivery Rates* are age-adjusted to the age distrubution of that year's waiver participants.
[3]The ***numerator*** of the *Estimated Base-Year Delivery Rate* is based on 2001 in-state deliveries to Illinois residents enrolled in Medicaid, TANF, WIC, or Family Case Management. The ***denominator*** of the *Estimated Base-Year Delivery Rate* was obtained from the American Community Survey's estimates of women with an income < 200% of the Federal Poverty Level. All delivery rates are per 1000 women.
[4]As per CMS' Special Terms and Conditions, *Participants* are those who "obtain one or more covered medical family planning service(s) s through the demonstration."
[5]*Expected Births* have been calculated using the base-year age-specific delivery rates and the number of participants in that age group.
[6]*Actual Births* are the number of delivery claims during the waiver year for waiver participants.
[7]*Costs Averted* = (Births Averted X Average Prenatal/Delivery Cost) + (Births Averted X Average Birth to 1 Yr Cost)