DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

January 19, 2021

Theresa Eagleson
Director
Department of Healthcare and Family Services
201 South Grand Ave. East
Springfield, IL 62763-0002

Dear Ms. Eagleson:

Under section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services (HHS) may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act, including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. As relevant here, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving Illinois' request to test an approach to reducing the churning of coverage between fee-for-service (FFS) and managed care, and whether greater efficiencies, and benefits to beneficiaries, can be achieved through a waiver of hospital presumptive eligibility (HPE), through a section 1115 demonstration project entitled, "Illinois Continuity of Care and Administrative Simplification" (Project Number 11-W-00341/5), in accordance with section 1115(a) of the Act. Approval of this demonstration will enable the state to test the effects of automatically re-enrolling a beneficiary into the same managed care organization (MCO) in which they were enrolled when they lost eligibility if the beneficiary's coverage was terminated due to failure to complete the renewal process and the beneficiary submits his/her redetermination paperwork within 90 days after termination. This demonstration will also test the efficacy of waiving the requirement that the state permit hospitals to complete presumptive determinations of eligibility for patients, their family members, and individuals from the broader community, while still ensuring that up to three months of retroactive coverage is available for individuals who receive Medicaid covered services, including hospital services, prior to application if retroactively Medicaid eligible when the services were received. The state will continue to operate Medicaid presumptive eligibility for children and pregnant women under the Medicaid state plan.

This approval is effective January 19, 2021 through December 31, 2025, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable under the demonstration.

Extent and Scope of the Demonstration

This demonstration provides authority for the state to test an approach to reducing churning of coverage between FFS and managed care due to late Medicaid redetermination paperwork. Currently, if someone who was enrolled in a Medicaid MCO when they lost Medicaid eligibility due to failure to complete the renewal process submits his/her Medicaid eligibility redetermination paperwork more than 60 days after his/her Medicaid termination date, the state places that person into a FFS program and cannot reenroll the individual into their previous MCO. Such a situation leads to churn between managed care and FFS, adversely affecting continuity of care. The expenditure authority allows the state to re-enroll a beneficiary into the managed care plan, if the individual returns their renewal form or other required information within 90 days from the date their Medicaid coverage was terminated. The demonstration also allows the state to focus its administrative Medicaid eligibility functions on processing full Medicaid eligibility determinations and redeterminations by waiving the requirement to operate a HPE program.

Illinois informed CMS that it is not currently able to meet the HPE requirement because the state currently has a backlog of eligibility determinations and is focusing its limited resources on addressing this backlog. The state also has expressed its view that implementing HPE would add administrative complexity that can contribute to consumer confusion. This is due to Illinois' current systems difficulty in easily connecting a presumptive eligibility (PE) determination with a full Medicaid eligibility application if one is filed prior to the end of the PE period. This could result in PE coverage being improperly terminated before the full Medicaid determination is complete, potentially resulting in providers not receiving timely reimbursement for services provided during the time when an individual should have been in a PE coverage period. The state argues that for individuals who would ordinarily apply for HPE as patients in a hospital, full Medicaid eligibility will always cover any Medicaid covered outpatient or inpatient service a beneficiary might receive during a hospital presumptive eligibility period, provided that the individual applies up to three months following the service. The state will continue to operate Medicaid presumptive eligibility for children and pregnant women.

CMS is approving a waiver of 1902(a)(47)(B) that would allow the state to test, gather data on, and evaluate its thesis that focusing its limited resources on promoting continuity of care by enrolling individuals in MCOs based on an approved application is in the best interests of the Medicaid program and Medicaid beneficiaries. CMS has determined that testing this thesis would promote the objectives of Medicaid because it could help Illinois, and potentially other

states, if the results of this demonstration justify a legislative change, focusing limited administrative resources on making full Medicaid determinations and redeterminations.

Element of the Demonstration Request that CMS is Not Approving at this Time

In its application, Illinois requested authority to provide 12 months of coverage for postpartum women with income up to 213 percent of the federal poverty level. CMS is not approving this proposal at this time, but is continuing to work with Illinois on this request.

Determination that the Demonstration Project is Likely to Assist in Promoting Medicaid's Objectives

Under section 1901 of the Act, the Medicaid program provides federal funding to participating states "[f]or the purpose of enabling each state, as far as practicable under the conditions "in such state, to furnish (l) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."

While this statutory text is not necessarily an exhaustive source of Medicaid objectives, it makes clear that at least one objective of Medicaid is to enable states to "furnish… medical assistance" to certain vulnerable populations (i.e., payment for certain healthcare services defined at section 1905 of the Act, the services themselves, or both).

CMS has determined that approval of the "Illinois Continuity of Care and Administrative Simplification Demonstration" is likely to promote the objectives of the Medicaid program for the following reasons:

- This demonstration will assist Illinois in providing continuity of care to beneficiaries whose coverage was terminated for failure to return their renewal form or other required information at renewal by automatically enrolling them in the same managed care plan they were previously enrolled in as long as the beneficiary submits their Medicaid redetermination paperwork within 90 days from the date of termination; and
- This demonstration will enable Illinois to focus its administrative resources on processing full Medicaid applications and redeterminations rather than spending administrative resources on implementing a hospital presumptive eligibility program.

CMS is approving the request to allow Medicaid managed care clients whose coverage was terminated for failure to return their renewal form or requested information and who submit their Medicaid eligibility redetermination paperwork within 90 days of their termination date to re-enroll in their managed care plan without requiring a the client to submit a new application to test the effects on continuity of care, and for the reasons set forth above, the request to waive HPE. Children and pregnant women will still be eligible for Medicaid presumptive eligibility under the Medicaid state plan.

Consideration of Public Comments

To increase the transparency of demonstration projects, sections 1115(d)(1) and (2) of the Act direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary.

Section 1115(d)(2)(A) and (C) of the Act further specify that comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposed no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not necessarily provide written responses to all public comments (42 CFR 431.416(d)(2)).
The state held two public hearings on its application on December 9, 2019, and December 10, 2019. During these hearings, the state received a total of twelve comments and questions about the proposal, including the benefits to hospitals of the hospital presumptive eligibility period and support of extending benefits to postpartum women. The state also received written comments from eleven organizations in response to its proposal. All written comments, except one that did not address the extension of the postpartum coverage, expressed support for extending Medicaid to postpartum women.

Commenters also expressed support for the 90 day managed care reinstatement. There was some lack of support for the HPE proposal, and some commenters expressed that they thought the state should ultimately utilize hospital presumptive eligibility. Specifically, one commenter shared that HPE can be a crucial avenue into treatment for people experiencing a mental health crisis. Another commenter stated that immediate eligibility for Medicaid in a hospital setting, especially for women who are pregnant, would protect the health of communities. Finally, a third commenter asked that Illinois carve out behavioral health hospitalizations or a plan to implement HPE as soon as possible. While CMS is approving the waiver of HPE under this demonstration, children and pregnant women will still be eligible for Medicaid presumptive eligibility under the Medicaid state plan.

Waiving HPE would allow the state to test its hypothesis that it can promote continuity of care by promoting full Medicaid applications in lieu of a duplicative process that also includes hospital presumptive eligibility determinations without any effect on eligibility, as any outpatient or inpatient services would be covered as long as the individual is found to have been eligible during the hospital stay and applied for Medicaid coverage within 3 months of the incurred service. This also would benefit beneficiaries by facilitating long-term Medicaid coverage that allows beneficiaries to enroll in an MCO and receive care coordination, instead of temporary FFS coverage without care coordination that comes with HPE. The state reported that it has determined that the burdens associated with HPE administration outweigh the advantages to implementing the program at this time.

The federal public comment period opened on January 15, 2020 and closed on February 13, 2020. CMS received 35 comments regarding the application during the federal comment period. Twenty-seven of these responses expressed support for the proposal to extend Medicaid eligibility to new mothers to 12 months. There were 14 comments that addressed the managed care proposal and all commenters expressed support for re-enrolling beneficiaries into the same managed care plan if the beneficiary submitted their redetermination paperwork within 90 days. None of the comments addressed the request to waive HPE.

The award is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer is Mr. Jonathan Morancy. Mr. Morancy is available to answer any questions concerning implementation of the state's section 1115(a) demonstration and his contact information is as follows:

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Center for Medicaid and CHIP Services
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Baltimore, Maryland 21244-1850
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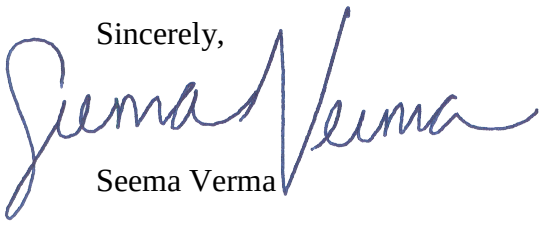
We appreciate your state's commitment to improving the health of people in Illinois, and we look forward to our continued partnership on the Continuity of Care and Administrative Simplification section 1115(a) demonstration. If you have any questions regarding this approval, please contact Ms. Teresa DeCaro, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,



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Enclosures

cc: Courtney Savage, State Monitoring Lead, Medicaid and CHIP Operations Group