Illinois Health and Hospital Association

Kelly Cunningham
Medicaid Administrator
Division of Medical Programs
Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield, IL 62763

Dear Ms. Cunningham:

On behalf of its over 200 member hospitals and nearly 40 member health systems, the Illinois Health and Hospital Association (IHA) applauds the Dept. of Healthcare and Family Services (HFS) for its ambitious vision and strong leadership to address health inequity and build an equitable and sustainable healthcare delivery system. As we learned during the COVID-19 pandemic, strong hospitals, and the healthcare heroes
who serve in them, make for a strong healthcare delivery system. So, we commend HFS for its innovative and comprehensive application to extend and reimagine the state's current 1115 Waiver (Waiver).

For several years, Illinois has been actively focused on improving health equity and how the healthcare delivery system, including Safety Net Hospitals and Critical Access Hospitals, can improve access to quality healthcare for individuals in all communities. However, we can only make progress by acknowledging our current reality. Residents in one Chicago neighborhood have a documented 30-year lower life expectancy than those in a neighborhood just eight miles away. In several Illinois counties outside of Chicago, this disparity in life expectancy persists as Black residents have a five to eight year shorter life expectancy than white residents. Health disparities also exist in rural areas of Illinois, where individuals have higher incidences of chronic conditions, including obesity, diabetes and certain cancers.

This Illinois environment is particularly challenging as, on average, the State Medicaid program reimburses hospitals about 80% of what it costs to provide care, while the Medicare program covers about 90% of costs. Medicaid and Medicare account for twothirds of hospital inpatient stays and over half of all hospital outpatient services. Today, the Illinois Medicaid program is the largest single insurer in the state, insuring 3.6 million or three in 10 Illinoisans, compared to one in 10 Illinoisans in 1995. Illinois ranks 48th out of the 50 states and Washington, D.C. in Medicaid spending per enrollee.

Therefore, to the extent that the proposed 1115 Waiver will increase the investment of state and federal Medicaid funds into the Illinois healthcare delivery system and programs to address health-related social needs, it will be another step forward to achieving IHA's vision for Illinois healthcare: that all individuals and communities have access to high-quality healthcare at the right time, in the right setting, in order to support each person's quest for optimum health. To achieve this vision, Illinois hospitals and health systems are committed to eliminating health disparities and advancing health equity.

Based on the Waiver documentation released to date, IHA supports the concepts included in the proposed Waiver programs and the request to use federal Medicaid funds to address health-related social needs. Such investments will be a step forward in reducing health disparities and advancing health equity in Illinois.

IHA recognizes that many of the details of the pilots in the proposed Waiver remain to be determined and we greatly appreciate

HFS' commitment to engage IHA, the hospital community and other stakeholders on the details and implementation strategies for the proposed Waiver pilots. We believe the active collaboration among HFS, IHA and other stakeholders will be critical to the ultimate success of the proposed Waiver. In that spirit of
collaboration, IHA appreciates the opportunity to offer the following comments and questions for consideration as the details and implementation strategies for the Waiver programs are developed.

Health-Related Social Needs Benefits and Pilots Addressing SDOH (pp. 15 – 18)

IHA strongly supports the Department in addressing root causes of health disparities by focusing on social determinants of health (SDOH) to address structural inequities (i.e., housing insecurity, food insecurity and violence) in tangible ways that will improve health outcomes by funding health-related social needs (HRSN) benefits. IHA offers the following comments for consideration:

1. Housing: The Housing Support Service Pilot will greatly benefit individuals and families who are homeless or housing insecure and will allow them to increase their health status. We appreciate the Department's broad and inclusive approach to eligibility overall and suggest reducing the criteria for housing support, and specifically, the criteria of having received care in emergency departments (ED), hospitals or crisis centers on multiple occasions. Many of our hospitals are already screening for social needs, including housing, and should be able to refer for services regardless of the number of visits. It is also unclear whether or not substance use disorders (SUD) would count as a behavioral or mental health need requiring improvement or stabilization to prevent deteriorated function. We strongly suggest that SUDs are included.
2. Medical Respite: We support medical respite benefits as respite patients typically require ongoing medical support that is not available in a shelter or on the street. The top two challenges facing medical respite programs are lack of sustainable funding and a lack of supportive housing. Currently, there is no sustainable reimbursement funding model to support medical respite. A stable funding source through Medicaid coverage would allow for effective medical respite programs and the potential expansion of bed capacity to serve more clients. Respite patients typically stay multiple months in the program not because of medical needs, but rather due to a lack of supportive housing. We are hopeful the medical respite benefits included in the waiver with the housing supports will alleviate these issues.
3. Food and Nutrition Services: We strongly support the inclusion of food and nutrition services as a HRSN benefit, and encourage the Department to extend the benefit to 12 months (versus the proposed six) as other states have done in their Waivers.

Healthcare Transformation Collaborative (HTC) Program (pp. 24 – 25)

IHA continues to support the HTC program which currently provides about $150 million per year to incentivize partnerships and collaboration among hospitals, FQHCs, behavioral health and other providers and community-based organizations (CBOs) to find innovative ways to increase access to quality care and address HRSN. In general, IHA supports HFS' request that federal Medicaid matching funds be provided for the activities of the HTCs that are not traditionally included under the Medicaid state plan.

As Illinois hospitals pursue innovative partnerships with other providers and CBOs to increase access to quality healthcare and improve the health of their communities, the costs of those activities should be eligible for federal Medicaid matching funds. This funding is especially critical for HTCs that include Safety Net Hospitals, Critical Access Hospitals and other hospitals serving vulnerable urban and rural communities. Many of these hospitals are financially struggling to simply maintain current services, let alone transform the health and healthcare delivery systems in these communities. To reduce health disparities and advance health equity
in communities that have experienced disinvestment for decades will require long-term, predictable and enhanced investment of state and federal Medicaid funds into these communities.
Based on the information available on the HTC proposal, IHA offers the following comments for
consideration:

1. Funding Level: It is our understanding that HFS intends to continue the funding of the current HTCs at the current level of $150 million per year. If new HTCs are to be approved, is it anticipated that this funding allocation will be increased?
2. Scope of the Program: It is not clear if the proposed HTC program under the Waiver would apply to existing HTCs or only to new HTCs.

We suggest that existing HTCs continue to receive funding and that new HTCs be enrolled as additional funding is available. We also support the statement in the Waiver application that priority will be given to HTCs that include Safety Net Hospitals or Critical Access Hospitals. (See p. 24)

3. Impact of HTC Payments on Hospital Spending Limits: Under the Waiver, it is not clear if the payments will be made directly to the HTC, or if they will be paid to a Medicaid provider, such as a hospital. This issue should be clarified as the HTC program is finalized. In either case, to the extent that payments to the HTC are for services other than hospital inpatient or outpatient care, such payments should not be counted as payments to a hospital for purposes of determining compliance with the applicable federal Medicaid spending limits for hospitals, such as the upper payment limit under fee-for-service or the average commercial rate demonstration under managed care. This is especially important for Safety Net Hospitals, as any expenditure authority under the applicable hospital spending limit needs to be used to provide additional support for the hospital services that they are directly providing to patients.

4. HTC Measures: The Waiver application identifies possible measures for HTCs (e.g., completed SDOH assessment, HRSN service use, ED utilization, control of chronic conditions (stratified by race/ethnicity)) (pp. 43 – 44). It is not clear from the application what the process will be for developing the measures that are applicable to each HTC. It will be important that measures are developed in collaboration with the HTCs, so that they are both meaningful and attainable. In many instances it will require sustained, long-term investment to reduce the existing health disparities in many communities and the program measures need to recognize this reality.

5. Capital Funding: It is not clear if the proposed HTC program will include capital funding to enable the HTCs to invest in technology or infrastructure needed to achieve their goals, such as electronic health records and other technology solutions. For example, for the participants in an HTC to most effectively coordinate care and services for a patient, it is necessary for them to be able to share information across providers, which often requires upgrades to existing technology platforms. Illinois has recognized this need by allocating $200 million to the Healthcare Transformation Capital Investment Program. Consequently, it is suggested that capital payments to HTCs be included under the Waiver as eligible for federal Medicaid matching funds.

Illinois Safety Net Hospital Health Equity Transformation Program (pp. 29 – 30)

IHA supports the concept proposed in the Waiver application to develop a Safety Net Hospital Health Equity Transformation (SNH HET) pilot program that "will also test additional innovations that enhance the work of the HEAL Grant Program, to further support Illinois' Safety Net Hospitals. The state is requesting expenditure authority to support projects identified through this pilot." (Waiver application, p. 29)

As the Waiver application points out, the Illinois General Assembly has recognized that Illinois Safety Net Hospitals require additional funding support in order to fulfill their key role as anchors of the healthcare system for many underserved communities that otherwise lack sufficient access to high quality care and face high healthcare disparities. Through the Safety Net Hospital Health Equity and Access Leadership (HEAL) Grant Program, Illinois has taken an important step to begin to address the long-term disinvestment in Black and Brown communities served by the Safety Net Hospitals that have deep roots in and are strongly
committed to serving their communities.

However, annual, ad hoc grant funding that is subject to state budget pressures is not a reliable and stable source of funding that will enable Safety Net Hospitals to develop strategies to achieve long-term sustainability. In order to assure equitable access to quality healthcare services, IHA supports the Waiver's request for the investment of federal Medicaid matching funds to provide additional support to Safety Net Hospitals so they can thrive and improve the health of their communities.

The general concept of the Safety Net Hospital Health Equity Transformation Program is very encouraging and its success will depend on the details of the final program. Based on the information available on the SNH HET proposal, IHA offers the following comments for consideration:

1. Provide New Funding: Funding for Safety Net Hospitals under the Health Equity Transformation program should supplement, not supplant, current Safety Net Hospital funding. Similarly, HET funding should not be the result of redirecting current funds provided to other hospitals. Given the current state of Medicaid underfunding, redistributing scarce hospital Medicaid resources would amount to "robbing Peter to pay Paul."

2. Eligibility Criteria: As HFS explores the criteria that will be used to define Safety Net Hospitals that are eligible for the program, the

Department should consider avoiding criteria that have hard cutoffs/thresholds. Instead, HFS should consider scaling funding to the hospitals in proportion to the factor (or factors) that may ultimately be used to define eligibility for the program. Also, to avoid year-to-year funding swings, HFS should consider using a multi-year data approach in order to increase stability of any factor(s) used to define eligibility.

3. Impact of SNH HET Payments on Hospital Spending Limits: Payments under the SNH HET program are intended to provide additional support to Safety Net Hospitals to support their efforts to reduce health disparities, advance health equity and improve access to or the quality of healthcare services. This program should recognize that these hospitals and the vulnerable communities they serve require additional investment to remedy the decades of disinvestment that many of them have experienced as a result of racial inequity. Consequently, SNH HET payments should not be counted as payments to a hospital for purposes of determining compliance with the applicable federal Medicaid spending limits for hospitals, such as the upper payment limit test under fee-for-service or the average commercial rate test under managed care.

4. SNH HET Measures: The Waiver application identifies measures for the SNH HET program (e.g., hospital quality indicators, ED utilization, length of stay, control of chronic conditions, maternal and infant morbidity and mortality (stratified by race/ethnicity)) (p. 46). It is not clear from the application what the process will be for developing the measures that are applicable to the program overall, or particular hospital projects funded through the program. It will be important that measures are developed in collaboration with the Safety Net Hospitals, so that they are reasonable, meaningful and attainable. In many instances, progress will require sustained, long-term investment to reduce the existing health disparities in many communities. Therefore, the program measures need to recognize this reality.

Outreach and Engagement (pp. 27 – 28)

IHA supports the pilot initiative providing hospitals, as well as other providers, with the funding and tools to expand current patient navigator programs and create a pathway for community health workers (CHWs) to provide meaningful services to individuals in the Medicaid program. With that said, we do have concerns that the proposed patient navigators may be an added layer to Medicaid managed care organizations (MCOs) that may impose additional administrative burden and complexity for providers, such as having to obtain authorization for services from the MCOs. The Waiver proposal is unclear if this is the approach the Department proposes to take or if the pilot is proposing services more similar to CHWs and building on patient navigators that many providers are increasingly utilizing.

IHA also has concerns that this pilot initiative will only be implemented in areas of the state not currently served by a Healthcare Transformation Collaborative. Limiting the pilot initiative to areas without a current Collaborative may exclude most parts of Cook County, which has numerous communities that experience health disparities and have limited access to primary and preventative health services that would greatly benefit from culturally and linguistically appropriate health navigators.

Community Health Workers (pp. 28 – 29)

IHA strongly supports the Department's efforts to fund the recruitment, training and certification of community health workers given the critical role they play in the healthcare delivery system. In addition, as the proposal states, this funding will provide a pathway to meaningful employment in resource-scarce communities throughout the state.

With that said, IHA is seeking clarification on the following two questions:

1. Does the Department anticipate funding organizations not currently participating in a Healthcare Transformation Collaborative project? The pilot description says they "may" be eligible for funding.

2. Can the Department elaborate on what it means to collaborate with the MCOs to "integrate systems and implement a seamless process for members to access physical, behavioral, and HRSN services?"

Treatment for Individuals with Substance Use Disorder Pilot (pp. 30 – 31)

Section 1905(a) of the Social Security Act continues to prohibit states from using federal funds to reimburse behavioral health hospitals that provide care to non-elderly adult Medicaid consumers (known as IMDs), while Medicaid managed care rules only permit limited federal financial participation in monthly capitation payments to health plans for coverage of Medicaid consumers accessing care in these hospitals. Although the last 1115 Waiver covered substance use disorder treatment in IMDs, these

benefits only extended to 25 residential, non-hospital treatment settings, six of which are no longer in operation. These limitations create a persistent
barrier for Medicaid consumers to access care.

At the same time, the COVID-19 pandemic has had lasting impacts on the healthcare supply chain and workforce capacity, resulting in persistent staffing shortages and an overall reduction in Illinois' hospital inpatient beds for behavioral health services. In addition, provisional 2021 data from the Illinois Dept. of Public Health indicates that fatal opioid overdoses have increased 36% since 2019, largely attributable to the rise of synthetic opioids like fentanyl, while non-fatal overdoses are up 15% during the same period.

Therefore, we urge the Department to consider expanding the Waiver benefit for SUD Services in IMDs to include hospital-based, Medicaid fee-for-service coverage for Medically Monitored High-Intensity Inpatient Services for adolescents, Medically Monitored Intensive Inpatient Withdrawal Management for adults, and Medically Managed Intensive Inpatient Treatment (i.e. the American Society of Addiction Medicine's levels 3.7 and 4.0 of care).

Violence Prevention and Intervention (p. 27)

In addition to the existing, community-based violence prevention and intervention benefit, we encourage the Department's consideration of parallel, hospital-based benefits. The Chicago Hospital Engagement Action and Leadership (HEAL) Initiative is a collaborative of 10 leading health systems working in concert with U.S. Senator Dick Durbin to leverage their roles as community anchors and work together to reduce gun violence and improve health in the 18 Chicago neighborhoods with the highest rates of violence, poverty and inequality.

In 2022, this effort has led to 11 hospitals dedicating 204 full-time employees to establishing violence recovery programs, and resulted in 17,623 individuals served2 by these programs. More recently, the Illinois Dept. of Public Health has announced two grant opportunities for hospitals to advance training and expand these programs. However, more long-term funding for Medicaid consumers experiencing violence linked to episodes of care associated with trauma would create a sustainable pathway to fund these programs in the long term. Also, we encourage coverage of hospital-based violence recovery programs, including case management
and coordination for healthcare services associated with violence (e.g., behavioral and physical health services associated with a violent or traumatic incident). For these reasons, we urge the Department to consider coverage of hospital-based violence prevention and intervention benefits linked to applicable episodes of care for Medicaid beneficiaries, in addition to violence case management that incorporates healthcare service coordination following an episode of care.

Cook County DSH/Community Reinvestment Pool (pp. 33-34)

IHA has long supported financing approaches which seek to maximize the return of federal funds to support the Illinois Medicaid program and maximize cost coverage for the hospital community, thereby providing greater access to the communities they serve. Over the years, the changing federal regulatory limits on spending and reimbursement methodologies have required states, including Illinois, to find innovative approaches to achieving this goal of maximizing federal investment in the Illinois healthcare system. Such creative approaches have
included inter-governmental transfer agreements, healthcare related tax programs, and prioritizing the use of Medicaid Disproportionate Share Hospital (DSH) funding to the state's largest county owned hospital and health system.

We understand that under the Cook County DSH/Community Reinvestment Pool proposal, the CCH DSH payments would continue to be used as reimbursement for uncompensated care costs at hospitals operated by CCH and would not diminish the use of Illinois' full annual DSH allotment. IHA is seeking confirmation that our understanding, as outlined above, is accurate and that this "re-purposing" would not diminish the maximum use of the state's annual DSH allotment to cover hospital uncompensated care costs.

If the current DSH allotment used by CCH is no longer going to be used to cover hospital uncompensated care costs at CCH, or if this component of the Waiver proposal is not granted, IHA would appreciate the opportunity to discuss with the Department if some portion of these DSH dollars could be re-allocated back to the private hospital community to help cover their

uncompensated care costs, possibly through the development of an uncompensated care pool.

Budget Neutrality (pp. 50-51)

A historic principle of 1115 Waivers is the concept of budget neutrality, whereby a state proposes to shift current annual spending levels between new and old initiatives, spending more in the initial years and less in the out years, with the overall goal of remaining budget neutral over the five-year demonstration period. This temporary reallocation principle is advantageous to states that wish to transform well-funded delivery models, in recognition of new and innovative approaches and the likely increased cost during the initial start-up years.

It is our understanding that any budget neutrality demonstration would be limited to those services and populations directly affected by the Waiver proposal, and would not be applied on a more global basis to the entire Medicaid program. A global demonstration requirement could place unwanted financial constraints on the Illinois Medicaid program and could inhibit future investments into the Illinois Medicaid program, such as those recently passed by the Illinois General Assembly in Senate Bill 1298, the 2023 Medicaid Omnibus bill.

IHA would appreciate confirmation from the Department that our understanding of the budget neutrality demonstration requirement is correct and that the approval of this Waiver will not constrain future state Medicaid investments, particularly rate increases. Specifically, we request confirmation from HFS that should the waiver be approved, the budget neutrality demonstration requirements will not preclude or limit future investment in hospital rates or the overall spending level of the Illinois Medicaid program.

As stated at the outset, IHA supports the concepts included in the proposed Illinois Healthcare Transformation Section 1115 Waiver programs and the request to use federal Medicaid funds to address health-related social needs as an important step forward in reducing health disparities and advancing health equity in Illinois. IHA appreciates the opportunity to comment on the Waiver and looks forward to receiving additional details on its impact on hospitals and the ability of the Waiver to achieve its stated goals.

Sincerely,
A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association

Your trusted voice and resource

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