HFS
Illinois Department of
Healthcare and Family Services

# ILLINOIS BEHAVIORAL HEALTH TRANSFORMATION 1115 DEMONSTRATION

## WAIVER PROJECT NUMBER 11-W-00316/5

APPLICATION FOR EXTENSION

MAY 12, 2023

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## Summary

The State of Illinois has articulated an ambitious vision of an equitable and sustainable healthcare delivery system and has launched several initiatives designed to bring such a system into existence. The Illinois Department of Healthcare and Family Services (HFS) now seeks to leverage Section 1115 Demonstration authority to secure additional Medicaid resources to sustain the groundbreaking work already underway and seed additional innovations.

HFS is requesting a five-year extension of the Behavioral Health Transformation Section 1115 Demonstration approved by the federal Centers for Medicare and Medicaid Services in 2018. Illinois' extension request seeks broad approval to incorporate pioneering initiatives driving healthcare transformation in Illinois, including HFS' Healthcare Transformation Collaborative Program. Accordingly, HFS proposes to rename the demonstration program extension the "Illinois Healthcare Transformation Section 1115 Demonstration."

This Section 1115 demonstration was originally approved on May 7, 2018, to pilot the provision of targeted services aimed at treating addictions to opioids and other substances that were not directly available to Illinois Medicaid beneficiaries. Through the implementation of 10 pilot programs, the state intended to test how the provision of additional opioid use disorder/substance use disorder (OUD/SUD) services informed its efforts to transform the behavioral health system in Illinois. These OUD/SUD pilots provided access to less costly community-based services that were anticipated to help beneficiaries improve their health and avoid more costly services provided through an institution. Illinois implemented the demonstration effective July 1, 2018, and the demonstration is currently set to end on June 30, 2023.

The proposed demonstration extension request outlines a revamped program design broadens the focus of the original demonstration to enhance Illinois' healthcare delivery system to address root causes of health disparities by focusing on social determinants of health (SDOH) to address structural inequities including housing insecurity, food insecurity, and violence in tangible ways that will improve health outcomes. If approved, the extension will bring focus and resources to a broad range of health-related social needs (HRSN) benefits through sustainable, community-driven solutions that incorporate non-traditional providers into the Medicaid enterprise and managed care service delivery system.

The following proposed benefits will be implemented through this Illinois Healthcare Transformation Section 1115 Demonstration:

- SUD Services in Institutions for Mental Diseases (IMD)
- SUD Case Management
- Housing Supports
- Employment Assistance
- Medical Respite
- Food and Nutrition Services
- Violence Prevention and Intervention
- Non-Medical Transportation
- Justice-Involved Community Reintegration: Transitioning from Incarceration
- Community Reintegration: Transitioning from Institutions

# I. Introduction

The Illinois Department of Healthcare and Family Services (hereinafter "HFS", "Illinois", or "the state") is requesting a five-year extension of the **Behavioral Health Transformation Section 1115 Demonstration** approved by the Centers for Medicare & Medicaid Services (CMS). In accordance with CMS requirements for section 1115 demonstration proposals, Illinois is putting forth the following draft extension proposal for public input and comment through June 12, 2023.

> **Definitions**
> *Social Determinants of Health*: The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
> *Health-Related Social Needs*: An individual's social needs, such as housing and food security, that may exacerbate poor health and quality-of-life outcomes when they are unmet.

As described therein, Illinois proposes to implement a revamped program design that broadens the focus of this section 1115 demonstration program to address several key social determinants of health (SDOH) by implementing health-related social needs (HRSN) benefits to reduce healthcare disparities in Illinois' healthcare system. Accordingly, the proposed new name for this demonstration program extension is the "**Illinois Healthcare Transformation Section 1115 Demonstration".**

# II. Historical Program Overview

**<u>Original Demonstration Approval</u>**

Illinois originally received CMS approval May 7, 2018, to implement the Behavioral Health Transformation Section 1115 Demonstration to pilot the provision of targeted services aimed at treating dependence on opioids and other substances that were not directly available to Illinois Medicaid beneficiaries. Through the implementation of 10 pilot programs, the state intended to test and evaluate how the provision of additional opioid use disorder/substance use disorder (OUD/SUD) services informed its efforts to transform the behavioral health system in Illinois. These OUD/SUD pilots provided access to less costly community-based services that were anticipated to help beneficiaries improve their health and avoid more costly services provided through an institution. Illinois implemented the demonstration July 1, 2018, and the demonstration is set to end June 30, 2023.

**<u>Program Implementation</u>**

The 10 original pilots to be implemented under the demonstration are described in Table 1.

**Table 1. Original 1115 Demonstration Pilots**

| No. | Pilot Name and Description |
|---|---|
| 1 | **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD) Pilot**: This pilot authorized expenditures for otherwise covered services furnished to eligible individuals who were primarily receiving treatment and withdrawal management services for SUD and who were short-term residents in facilities that meet the definition of an institution for mental diseases (IMD). |
| 2 | **Clinically Managed Withdrawal Management Services Pilot:** This pilot authorized withdrawal management services such as intake, observation, medication services, and discharge services. A physician or licensed practitioner of the healing arts must recommend the services for delivery in accordance with an individualized plan of care. |

| No. | Pilot Name and Description |
|---|---|
| 3 | **SUD Case Management Pilot:** This pilot authorized SUD case management services to assist beneficiaries with accessing needed medical, social, educational, and other services. Case management services were individualized for beneficiaries in treatment, reflecting needs identified in the assessment process and those developed within the treatment plan. |
| 4 | **Peer Recovery Support Services Pilot**: This pilot authorized peer recovery support services delivered by individuals in recovery from an SUD (peer recovery coach) who is certified to provide counseling support to help prevent relapse and promote recovery. |
| 5 | **Crisis Intervention Services Pilot**: This pilot authorized crisis intervention services support stabilization, rapid recovery, and discharge of an individual experiencing psychiatric crisis. The services included crisis assessment and stabilization, treatment planning, counseling services, and discharge services. |
| 6 | **Evidence-Based Home Visiting Services Pilot**: This pilot authorized evidence-based home visiting services, including postpartum home visits and child home visits to postpartum mothers who gave birth to a baby born with withdrawal symptoms and Medicaid eligible children up to five years old who were born with withdrawal symptoms. |
| 7 | **Assistance in Community Integration Services Pilot**: This pilot authorized a set of home and community-based services (HCBS), including pre-tenancy supports and tenancy sustaining services. |
| 8 | **Supported Employment Services Pilot**: This pilot authorized supported employment services to be offered to eligible beneficiaries through a person-centered planning process when eligible services were identified in the individuals' plan of care. |
| 9 | **Intensive In-Home Services Pilot**: This pilot authorized intensive in-home services consisting of the following two services:<br>a. Intensive in-home clinical (IIH-C) services offered face-to-face, time-limited, focused intervention to support and stabilize children/youths in their home or home-like setting. IIH-C is a strengths-based, individualized, and therapeutic service driven by a clinical intervention plan focused on symptom reduction.<br>b. Intensive in-home support (IIH-S) services offered time-limited, focused intervention targeted to support and stabilize children/youths in their home or home-like setting. IIH-S is an adjunct service that can be provided only in conjunction with IIH-C services. |
| 10 | **Respite Services Pilot**: This pilot authorized time-limited respite care to families experiencing stressful situations, including avoiding a crisis or escalation within the home. Services were delivered in or outside of the home as long as they took place in community-based settings. The services were provided on a scheduled basis and had to be planned as part of a child's individualized care plan. These services also had to be culturally competent and aligned with the family's beliefs and preferences. |

The overall start-up and implementation of these demonstration pilots were delayed because of several circumstances and changes in Illinois' Medicaid behavioral health landscape. At the time of demonstration approval, HFS rebid most of the state's existing Medicaid managed care program contracts, consolidating multiple programs into a single streamlined program and expanded managed care statewide. This unprecedented procurement consolidated the Family Health Plans/ACA Adults (FHP/ACA), the Integrated Care Program (ICP) and the Managed Long-Term Services and Supports (MLTSS) program into a single contracting approach while reducing the number of contracted managed care organizations (MCOs) from 11 to six.

Implementation of the new contracts began in January 2018 for existing enrollees, with the full transition timeline for existing and new enrollees taking place by the end of 2018. Therefore, the state was still in the process of managing the transition to the new MCO contracts when the approval of the

Behavioral Health Transformation Section 1115 Demonstration was received in May 2018. This timing resulted in delays in the initial planning for implementation of the 10 section 1115 demonstration pilots.

The second key source of delay was the Illinois gubernatorial election in November 2018 and the subsequent change in administration. In 2019, the start-up and ongoing implementation of the demonstration was paused while program and policy decisions, along with staffing assignments related to the section 1115 demonstration were realigned in accordance with the administration.

On January 31, 2020, the Secretary of the US Department of Health and Human Services declared a public health emergency (PHE) for the United States. As a result, Illinois like the rest of the world, had to shift focus to address the needs of Illinois' healthcare community's response to COVID-19. The COVID-19 pandemic had an unprecedented impact on Medicaid in Illinois. First, many providers temporarily or permanently ceased operations during the pandemic. Workforce shortages contributed to the state's issues with addressing capacity throughout the state. The types of Medicaid services provided shifted from residential and inpatient treatment to increased outpatient and telehealth services. Fortunately, this impact was short-lived during the shutdown period; however, there were still lingering effects on Medicaid and efforts to implement the 10 Behavioral Health Transformation Section 1115 Demonstration pilots.

Illinois prioritized initial implementation of the four SUD pilots (i.e., pilots one through four as listed in Table 1). The goal of these SUD pilots was to facilitate the state's ability to maintain access to critical OUD and SUD services and continue delivery system improvements for these services to ensure more coordinated and comprehensive OUD/SUD treatment for Medicaid beneficiaries. The pilots enabled the provision of targeted OUD/SUD treatment services for Medicaid-eligible people in certain residential and inpatient treatment settings that otherwise would not qualify for federal funding. Through the combined implementation of these four pilots, Medicaid enrollees had access to the following services received:

- Treatment and withdrawal management services for SUD while receiving care at a short-term residential institution for mental diseases (IMD) to increase the likelihood of ongoing treatment and recovery
- Peer recovery supports counseling (or a peer recovery coach) to prevent relapse and promote recovery
- Case management services for individuals with an SUD who have requested diversion from the criminal justice system

Illinois identified six milestones for implementation as listed in Table 2. However, implementation was delayed because of the healthcare system changes in Illinois, along with the challenges resulting from the COVID-19 pandemic response. As such, the state has gathered limited, yet promising, information and found that some marked progress has been made toward achieving each of the six milestones. The milestone progress results are also summarized in Table 2.

**Table 2. Original 1115 Demonstration Milestones**

| SUD Pilot Milestones | Summary Progress and Outcomes |
|---|---|
| 1. Access to critical levels of care for OUD and other SUDs | Illinois experienced significant increases in medication-assisted treatment (MAT) from baseline to midpoint (52.7%) and outpatient services (71.1%). The early intervention program serves, on average, 73 beneficiaries per quarter. |

| SUD Pilot Milestones | Summary Progress and Outcomes |
|---|---|
| | Though decreases were seen intensive outpatient and partial hospitalization services (−7.2%), residential and inpatient services (−3.5%), and withdrawal management (−18%), HFS believes the declines are attributable to the substantial increases in MAT and outpatient treatment. In Illinois, telehealth was used more frequently than before the pandemic, which may also account for some of the decreases in service use for hospitalizations and withdrawal management. This finding is consistent with stakeholder interviews conducted in other states showing that residential services experienced significant financial strain and workforce turnover during the pandemic (Pagano et al., 2021). |
| 2. Use of evidence-based SUD-specific patient placement criteria | The average length of stay in IMDs remained consistent at less than 30 days. However, the number of Medicaid beneficiaries treated in an IMD for SUD decreased. Though the goal was to maintain consistency, COVID-19 likely affected this metric. As shown in Milestone 1, the number of inpatient services declined during the pandemic with a corresponding increase in outpatient treatment. Therefore, this milestone was affected by the pandemic, and use of evidence-based placement criteria will continue to increase over time. |
| 3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications and establish a provider review process that requires residential treatment providers to offer MAT onsite or facilitate access to MAT offsite | Providers were required to provide information about MAT and potential facilities that offer this service. However, because of Illinois' health system changes, this requirement was revised to require all providers to provide MAT directly. There was no further information to report. |
| 4. Sufficient provider capacity at each level of care, including MAT for OUD | SUD provider availability was expected to remain consistent, but 34% more were available at midpoint than baseline. SUD providers who offered MAT services also increased by 33.57%. The State of Illinois has made significant progress in improving the availability of MAT, as buprenorphine is now available in every county, but also has made several recommendations to further enhance MAT availability and sufficient provider capacity moving forward. |
| 5. Implementation of comprehensive treatment and prevention strategies to address OUD and an SUD Health IT Plan | The state collaborated with providers on policies to ensure access to Naloxone and adequate training for staff. However, despite these efforts and the successful decreases seen in use of opioids and emergency department visits, the overdose death rate still increased by 25%. It is worth noting that this increase is consistent with national trends; however, Illinois' overdose rate of 0.91 per 100,000 population is low relative to the national figure of 27.9 per 100,000, so the percentage change represents a small increase in the actual number of overdoses (Centers for Disease Control and Prevention, 2021). Thus, Illinois' efforts |

| SUD Pilot Milestones | Summary Progress and Outcomes |
|---|---|
| | may have offset an even greater increase in opioid-related mortality. |
| 6. Improved care coordination and transitions between levels of care | Readmissions for beneficiaries with SUD remained consistent along with treatment engagement and follow-up visits. Two metrics not achieved were initiation of treatment for alcohol use disorder and OUD; however, the total number of initiated treatments remained consistent. |

**Next Phase of Program Implementation**

**Demonstration Mission and Vision**
*Mission*: To advance equity and drive sustainable transformation
*Vision*: An equitable and sustainable healthcare delivery system

Illinois is seeking to expand the Behavioral Health Transformation Section 1115 Demonstration to transform the state's Medicaid program and incentivize a holistic system of healthcare that strengthens and coordinates physical health, behavioral health, and social services in communities where people experience the most significant health disparities. With this demonstration extension request, the state will expand its proposed set of initiatives, building on the foundation of the original demonstration program to address several causes of disparities identified throughout the state's healthcare system. Hence, Illinois is requesting to rename this section 1115 demonstration program from Illinois Behavioral Health Transformation Section 1115 Demonstration to the **Illinois Healthcare Transformation Section 1115 Demonstration** to better align with the state's overall goal and current efforts to create an equitable and sustainable healthcare system for Illinoisans.

**Demonstration Components Not Continuing from Initial Approval Period**

Due to the decision to use Medicaid state plan authority when available and the evolved focus of this demonstration on a more holistic person-centered approach, the state is not requesting to continue section 1115 authority for six of the 10 pilots originally approved under the demonstration. Those pilots are:

1. Clinically Managed Withdrawal Services: Despite low utilization experience under the demonstration. HFS will continue to collaborate with providers, MCOs, and other stakeholders to increase accountability around withdrawal monitoring and to identify innovative, evidence-based services to best meet the needs of Medicaid enrollees.
2. Peer Recovery Support Services: HFS plans to include these services in an upcoming state plan amendment.
3. Crisis Intervention Services: HFS plans to include these services in an upcoming state plan amendment.
4. Evidence-Based Home Visiting Services: HFS plans to include these services in an upcoming state plan amendment.
5. Intensive In-Home Services: These services have been incorporated into a state plan amendment through 1915(i) authority.
6. Respite Services: These services have been incorporated into a state plan amendment through 1915(i) authority.

# III. Demonstration Program Redesign; Goals and Objectives for Extension

**State Investments in Healthcare Transformation**

> **Definitions**
> *Healthcare Transformation*: A person-centered, integrated, equitable, and thorough or dramatic change in the delivery of healthcare at a community level.
> *Health equity*: Everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, gender identity, sexual orientation, socioeconomic status, geography, or any other social barrier/factor.

The Pritzker Administration has put forth a bold, significant *Healthcare Transformation* plan to achieve an *equity-driven* healthcare system that invests in underserved communities, increases access to community-based health services, and creates innovative collaborations aimed at bridging gaps in the delivery of care. Illinois' Medicaid population, like people in many other state healthcare systems across the nation, faces many challenges related to SDOH, such as limited access to nutritious food, affordable and accessible housing, convenient and affordable transportation, safe neighborhoods, and opportunities for meaningful employment. In response, Illinois has made several investments in its healthcare system. Examples include:

- Dispersed $140 million in Coronavirus Aid, Relief, and Economic Security (CARES) payments, $58.8 million of which was directed specifically to Medicaid providers in disproportionately affected areas.
- Provided an unprecedented response during first months of the COVID-19 pandemic to ensure access through eligibility maintenance and new access points, such as telehealth. MCO partners have distributed food and worked on multiple SDOH projects and done rate add-ons for behavioral health, with $75 million in stability payments to hospitals.
- Issued $250 million in new funding through the state fiscal year (FY) 2021 hospital assessment, with $85 million directed toward safety net hospitals.
- Issued significant funding for enhanced rates, including $150 million toward physician rate increases; minimum wage increases in several areas for frontline workers, primarily for those who provide long-term services and supports; and increases for behavioral health (mental health and SUD) services.
- Updated the Managed Care Resolution Portal to ensure fair resolution of disputes involving MCOs and providers using a secure electronic platform.
- Implemented a Five Pillar Quality Strategy to invest in priorities such as equity and behavioral health.
- Invested $66.2 million in minority- and women-owned businesses through MCOs, representing a 37 percent increase in expenditures with diverse businesses over state FY 2019.

To further drive Illinois' healthcare transformation toward a fully sustainable, person-centered, equitable healthcare system, in the spring of 2021, Illinois enacted the Health Care and Human Service Reform Act to aggressively pursue an equitable system of health and human services delivery and dismantle systemic racism throughout the state. The law was one of four comprehensive public policy pillars that the Illinois Legislative Black Caucus championed to address systemic racism, criminal justice, economic opportunity, education, and healthcare. With the passage of this legislation, Illinois created the Healthcare Transformation Collaboratives (HTC) Program to reorient the state's healthcare system around people and communities. As described in more detail below, the HTCs create partnerships and bring entities together to find innovative ways to bridge gaps in the healthcare delivery system and increase access to quality healthcare services in underserved communities across Illinois. The HTC

Program encourages healthcare providers to work together and leverage their shared resources to create stronger and more innovative strategies for improving access, quality, and equity in the healthcare landscape.

As of State FY 2021, HFS is making available $150 million annually to fund the HTC Program. Following are examples of the type of projects implemented under the HTC Program to address HRSN:

- With a focus on coordinating access to care and providing HRSNs, one program seeks to improve the health and well-being of individuals reentering the community after incarceration. This project uses a whole-health approach and emphasizes cross-system collaboration, with the goal of helping individuals achieve sustained recovery, upward economic mobility, and improved health outcomes.
- Prioritizing residents with serious mental illness (SMI), SUD, depression, adverse childhood experiences, hypertension, and diabetes, another program strives to increase access to culturally and linguistically responsive healthcare while supporting the socioeconomic needs of individuals and families. Some key features of this program will focus on improving communication and information sharing among providers, connecting individuals to HRSNs to alleviate barriers to care and treatment adherence, and building care teams that span the continuum of care by adding new members, such as community health workers (CHWs). The program aims to improve self-management, reduce avoidable use of costly services, increase appropriate use of preventive and primary care services, and reduce health inequities.
- With an emphasis on increasing access to needed healthcare services and enhancing community partnerships to address SDOH, a program is creating new locations for the delivery of healthcare and supportive services. This program, for example, addresses the lack of access in predominantly Black communities by establishing a behavioral health unit and urgent care facility, creating a diversion program, and providing supportive and transitional housing. Additional activities will include deployment of CHWs and establishing a workforce development and job training center. The program will track several outcome measures including infant mortality, uncontrolled diabetes, and hypertension rates, as well as performance measures such as cancer screening rates, seven-day follow-up rates for individuals with mental illness and SUD who have been discharged from the hospital, emergency department (ED) usage, ED visits for individuals with asthma, and prenatal care initiation in the first trimester.
- One program is implementing an evidence-based integrated care model that will leverage meaningful data sharing and interconnectivity between partners that will support care management, care coordination, discharge planning, referrals, and community placement. This program's target population includes individuals in rural counties with behavioral health, SUD, and physical health needs. Investments in wellness and prevention coaches, CHWs, and community engagement specialists will be key components of this model. As a result of implementing this model, the program anticipates increased access and follow-up rates for individuals in need of mental health services, increased access and referrals to primary care, fewer preventable and avoidable hospitalizations, improved opportunities to connect with SUD treatment for at-risk populations, and better access to preventive and wellness services.
- Through community engagement, employment of digital clinical care, and sophisticated technology and infrastructure, one program seeks to reduce healthcare disparities and improve health outcomes through person-centered design. Priority populations are adults with behavioral health needs, women with maternity and well-baby care needs, and individuals with chronic conditions such as hypertension and diabetes. Program goals include increased follow-

up rates for individuals hospitalized for mental illness or SUD, use of SDOH assessments, access to timely prenatal care, postpartum depression screening, well-baby visits in the first two weeks of life, hypertension control, and improved hemoglobin A1C scores for people with diabetes.

Early successes from community-driven collaborations like these demonstrate that equity-focused solutions are key to a sustainable, reimagined healthcare system in Illinois that truly meets the unique needs of individuals. This demonstration extension is intended to achieve this aim with a broad focus on new investments to decrease disparities across all levels of healthcare and foster sustainable and equitable access and quality care for individuals over time.

**Background and Need - Identified Gaps in Illinois Medicaid**

The Illinois Department of Healthcare and Family Services evaluated a broad range of research on health status and conditions throughout the state that quantify significant health disparities across racial, geographic, gender, socioeconomic, and other SDOH factors in the areas of housing, food, community violence, economic, and workforce underdevelopment. Key findings are summarized in Table 3 and informed the demonstration's expanded focus.

**Table 3. Identified Priority Populations**

| Priority Population | Findings |
|---|---|
| Individuals and Families who are Homeless or Housing Insecure | Lack of affordable housing and poor housing conditions are associated with a variety of preventable health conditions and may restrict access to healthcare providers. The 2019 Alliance for Health Equity (AHE) Community Health Needs Assessment for Chicago and Suburban Cook County classified households spending more than 35% of their monthly gross income on housing as cost burdened. The report identified several regions of Cook County where 40% of households are cost-burdened.[1]<br><br>A 2021 study conducted in the Chicago region showed use of data linkages between homeless systems and health systems to gain an understanding of the unique needs across homeless populations. The study also determined housing's impact on health system use and compared populations in stable housing with people identified as homeless on presentation for care at health systems. Among many significant findings about caring for different homeless populations, the study found that homeless patients experienced a higher burden of chronic conditions for nine of 10 conditions than individuals in stable housing. Further, people experiencing homelessness are less likely to receive treatment for behavioral conditions than individuals who are stably housed. In addition, three out of four homeless individuals had an ED visit, with 24% having multiple visits to the ED.[2] |
| Justice-Involved Individuals | According to the Illinois Department of Corrections prison population data set,[3] 29,507 individuals in were confined to Illinois prisons in December 2022, and Black |

[1] Alliance for Health Equity. Community Health Needs Assessment: For Chicago and Suburban Cook County, 2019. https://allhealthequity.org/wp-content/uploads/2019/06/FINAL_2019_CHNA-Report_Alliance-for-Health-Equity.pdf.

[2] Trick WE, Rachman F, Hinami K, et al. Variability in Comorbidities and Health Services Use Across Homeless Typologies: Multicenter Data Linkage Between Healthcare and Homeless Systems. *BMC Public Health*. 2021;21(1):917. https://doi.org/10.1186/s12889-021-10958-8.

[3] See https://idoc.illinois.gov/reportsandstatistics/prison-population-data-sets.html.

| Priority Population | Findings |
| --- | --- |
| | people are incarcerated at disproportionately high rates (nearly 54% of the prison population). Illinois' recidivism rate is nearly 40%.<br><br>Incarceration is a stressor according to stress process theory and can lead to poor physical or mental health and difficulty finding employment. A study published in 2020 found that better mental health, both in prison and post-release, is related to a decrease in the likelihood of recidivating.[4] |
| Pregnant Individuals | In 2021, the Illinois Department of Public Health (IDPH) reported that Illinois' severe maternal morbidity rate for 2016-2017 was 75.4 per 10,000 deliveries. Black women had the highest rate of severe maternal morbidity (at a rate of 132.4 per 10,000 deliveries; more than two times higher than the rate for White women), and women older than the age of 40 had the highest rate of severe maternal morbidity at a rate of 144.4 per 10,000 deliveries. Pregnancy-associated mortality ratios are higher among Black women (142 per 100,000 live births) and women with Medicaid coverage (77 per 100,000 live births), compared with the state's overall ratio in 2016−2017 of 58 per 100,000 live births.[5] |
| People who are Unemployed | The 2019 AHE Community Health Needs Assessment for Chicago and Suburban Cook County indicated unemployment rates for adults older than 16 years of age at 8% in Illinois but 10% in Cook County, significantly higher than the national average of 7% reported that year. Cook County has experienced a persistent, long-term lack of market investment, leading to declining property values, employment, and population. This disinvestment in Chicago and suburban Cook County created a lack of access to economic opportunity and generated a perpetual gap in job opportunities for residents. Unemployed or underemployed people were more likely to report depression, alcohol abuse, and poor physical health. Though unemployment rates have improved somewhat in Illinois and Cook County (February 2023 data reports rates at 4.5% and 4.2% respectively), these rates are still above the reported US rate of 3.9%.[6] |
| People with Food Insecurities | Access to healthy food is an important factor in achieving good health and preventing chronic disease. Food insecurity and lack of access to nutritious food is associated with diabetes, obesity, heart disease, mental health disorders, and other chronic conditions.[7]<br><br>The USDA Food Access Research Atlas map highlights low-income and low food access areas in Illinois.[8] This map shows a number of low-income census tracts in |

[4] Wallace D, Wang X. Does In-prison Physical and Mental Health Impact Recidivism? SSM - population health, 11, 100569. https://doi.org/10.1016/j.ssmph.2020.100569.

[5] Illinois Department of Public Health. Illinois Maternal Morbidity and Mortality Report, 2016-2017. Accessed: https://dph.illinois.gov/content/dam/soi/en/web/idph/files/maternalmorbiditymortalityreport0421.pdf.

[6] See: https://ides.illinois.gov/resources/labor-market-information/laus/current-monthly-unemployment-rates.html.

[7] See https://www.nimhd.nih.gov/resources/understanding-health-disparities/food-accessibility-insecurity-and-health-outcomes.html.

[8] USDA Economic Research Service. US Department of Agriculture. Food Access Research Atlas, 2019. Accessed: https://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas/.

| Priority Population | Findings |
|---|---|
| | Illinois that are one mile (urban) or 10 miles (rural) from the nearest supermarket. People without access to a vehicle are further affected.<br>According to Feeding America, 1 in 12 people, and 1 in 9 children in Illinois are facing hunger.[9] |
| Individuals and Families Exposed to or At-Risk of Violence | The prevalence of violence has negatively affected the economic vitality of many communities and contributed to an increased need for mental health services. According to IDPH's 2016 Division of Vital Records for 2012–2016, the overall homicide mortality rate for Chicago was 26.6 per 100,000. The homicide rate among Chicago's Black populations was 65.6 per 100,000, with the highest concentration in areas of the city with the highest social vulnerability index. Responding to these high violence rates, Community Health Needs Assessments (CHNAs) identified a focus on violence prevention as one of the highest health priorities.<br><br>The Chicago Police Department reports that homicides did decline in 2022 (695) from 804 in 2021 and 776 in 2020 but are still higher than 2019 and 2018 numbers (500 and 579 respectively).[10]<br><br>Many forms of violence (many forms) affect the brain, neuroendocrine system, and immune response and can cause depression, anxiety, posttraumatic stress disorder, suicide, increased risk of cardiovascular disease, and premature death.[11] |
| People with Behavioral Health Needs | The lack of affordable housing options, high violence rates, and other social, economic, and environmental factors in certain communities further exacerbates the impact of healthcare provider shortages that exist within those same communities, particularly the shortage of mental health providers.[12] When comparing areas designated as mental health shortage areas in Cook County with regions that have higher concentrations of opioid deaths, behavioral health hospitalizations, and adults experiencing serious psychological distress in the past month,[13] the correlation becomes clear. |

**Demonstration Redesign and Associated Goals and Objectives**

The redesigned **Illinois Healthcare Transformation Section 1115 Demonstration** will continue the implementation of certain pilot initiatives targeted at addressing behavioral health (OUD/SUD) needs; and will expand to address structural inequities including housing insecurity, food insecurity, community violence, and economic and workforce underdevelopment to improve health outcomes. As the above research suggests, it is well documented that SDOH are major considerations in addressing avoidable

[9] See https://www.feedingamerica.org/hunger-in-america/illinois.

[10] See https://home.chicagopolice.org/statistics-data/crime-statistics/.

[11] Rivera F, Adhia A, Lyons V, et. al. The Effects of Violence on Health. Health Affairs, 2019. Accessed: https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00480#:~:text=Consequences%20include%20increased%20incidences%20of,as%20the%20form%20of%20violence.

[12] Health Resources and Services Administration. Map Tool. Mental Health Shortage Areas, Illinois. Available at: https://data.hrsa.gov/maps/map-tool/.

[13] Healthy Chicago. Chicago Department of Health. October 2019. Healthy Chicago 2025 Data Compendium. Available at: https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy_Chicago_2025_Data-Compendium_10222019.pdf.

complications from undetected and undertreated chronic diseases, which lead to poor health outcomes and higher medical costs. Section 1115 demonstration authority is the best pathway to achieve the goals of improving the health and safety of underserved people in Illinois because the standard payment and programmatic constraints of the Medicaid statute do not fully provide the levers necessary to address the comprehensive set of goals of the state for its healthcare system. Aligning to CMS's five health equity priority areas, the goals of the revamped demonstration are to:

1. Identify and assess causes of disparities, including the identification and revision of policies and operations that perpetuate healthcare inequities in order to effectively close gaps and improve healthcare access, quality, and outcomes.
2. Implement effective technologies and solutions that expand data collection, reporting, and analysis in order to make data-informed and person-centered decisions that will lead to better access to equitable care and coverage.
3. Create and sustain capacity within healthcare organizations with a workforce skilled at meeting the unique needs of the communities of Illinois.
4. Offer culturally and linguistically responsive care, providing communities with improved health care, patient safety, and experiences.
5. Tailor programs to individuals and communities, resulting in improved access to care and services.

The Illinois Healthcare Transformation Section 1115 Demonstration will leverage section 1115 demonstration authority to provide HRSN benefits in Medicaid. The demonstration will build on Illinois' ongoing health equity efforts with proposed new initiatives and administrative infrastructure to obtain community-wide, multidisciplinary collaboration on focused transformation and innovative efforts to radically change health outcomes at the community-level. The demonstration extension will enhance Illinois' transformation efforts by enabling HFS to maximize the state's investments in SDOH-related activities through the availability of new Medicaid expenditure authority for HRSN services and infrastructure support. Thereby enabling the state to standup more robust and sustainable SDOH initiatives to address the gaps identified in Illinois Medicaid. Further, these efforts support HFS' quality pillars for improvement: Maternal and Child Health, Adult Behavioral Health, Child Behavioral Health, Equity, and Community-Based Services and Supports.

Through the implementation of nine pilot initiatives (six new, three currently approved), this demonstration extension will provide or facilitate the provision of HRSN services prioritizing geographic areas with the highest rates of social vulnerability. The following diagram outlines the proposed design framework for the demonstration extension to provide enhanced benefits through an infrastructure that immediately reinvests directly back into the community to stimulate further investment into community-based health and health-related needs. Each of the key program components in Figure 1 are described in further detail in Section VI of this document.

**Figure 1. Proposed 1115 Demonstration Framework for HRSN**

<table>
<tr><th colspan="7">DEMONSTRATION BENEFITS</th></tr>
<tr><td>Justice-Involved Community Reintegration – Transitioning from Incarceration</td><td>Non-medical Transportation</td><td colspan="2">Food and Nutrition Services</td><td>Employment Assistance</td><td>Medical Respite</td><td>Violence Prevention and Intervention Services</td></tr>
<tr><td>SUD Services in IMDs</td><td colspan="3">SUD Case Management</td><td>Housing Support Services</td><td colspan="2">Community Reintegration – Transitioning from Institutions</td></tr>
<tr><th colspan="7">HRSN DELIVERY SUPPORT – Key Components to Support Healthcare Transformation</th></tr>
<tr><td>Justice-Involved Reentry Pilot</td><td>Outreach and Engagement Pilot</td><td colspan="2">Community Health Worker (CHW) Training Pilot</td><td>Healthcare Transformation Collaboratives</td><td colspan="2">Safety Net Hospital Health Equity and Access Leadership (HEAL) Grant Program</td></tr>
<tr><td>Cook County DSH/Community Reinvestment Pool</td><td colspan="2">Housing Support Services Pilot</td><td colspan="2">Treatment for Individuals with Substance Use Disorder (SUD) Pilot</td><td colspan="2">Supported Employment Services Pilot</td></tr>
<tr><td colspan="3">Violence Prevention and Intervention Pilot</td><td colspan="2">HRSN Hypothetical Infrastructure Cap</td><td colspan="2">HRSN Hypothetical Expenditure Cap</td></tr>
</table>

# IV. Demonstration Eligibility and Benefits

**Demonstration Eligibility and Impact**

All Medicaid state plan populations enrolled in full-scope Medicaid coverage will be eligible for this demonstration. Individuals eligible only for limited benefit Medicaid plans are not eligible for the demonstration. The proposed demonstration extension does not propose any changes to Medicaid eligibility. Standards for eligibility remain as set forth under the state plan. All individuals will continue to derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable. This demonstration extension is, therefore, not expected to impact Medicaid program eligibility or enrollment trends. All full-scope Medicaid state plan populations with an identified need for a SUD or HRSN benefit, who meet the state's eligibility needs criteria as defined in Table 4, will receive 1115 services as described. HFS estimates this number to be approximately 400,000 Medicaid eligibles in each year of the proposed five-year demonstration extension period.

**Demonstration Benefits**

The proposed demonstration benefits will be additional services not yet covered under the state's Medicaid program or Children's Health Insurance Program (CHIP). Medicaid beneficiaries eligible under the Medicaid state plan or under a 1915(c) HCBS waiver will continue to receive services under those

authorities and will receive additional services to be authorized through this section 1115 demonstration extension in accordance with the eligibility criteria defined in Table 4.

**Table 4. Medicaid Eligible Populations by Proposed 1115 Benefit Category**

| 1115 Benefit | Eligible Medicaid Population(s) | Eligibility Needs Criteria | Benefit Description |
|---|---|---|---|
| Housing Support | Individuals enrolled in Medicaid managed care who meet the needs criteria | Are experiencing homelessness, at risk for homelessness or institutional placement, including individuals fleeing violence, assault, or other dangerous, unsafe, life-threatening circumstances related to violence, and meet one of the following criteria:<br>• Have received care in EDs, hospitals, or crisis centers on multiple occasions (twice in six months or four times in 12 months)<br>• Have been determined to be high-risk or high cost based on service utilization or healthcare history<br>• Have complex physical health needs (persistent, disabling, or progressively life-threatening physical health conditions that require improvement or stabilization to prevent deteriorated functioning)<br>• Have a behavioral or mental health need requiring improvement or stabilization to prevent deteriorated functioning<br>• Are experiencing a high-risk pregnancy or complications associated with pregnancy, or are infants (up to one year old) born of such pregnancies<br>• Is a young adult, ages 18–26 who has aged out of foster care<br>• Are transitioning from institutions or carceral settings | <u>Pre-tenancy supports</u><br>• Intensive case management/care coordination to support housing stability, including access to Supplemental Security Income (SSI)/ Social Security Disability Insurance (SSDI) benefits using models such as SOAR (SSI/SSDI Outreach, Access, and Recovery) to provide application assistance and support through determination<br>• Housing navigation, including location assistance<br>• Inspection fees for housing safety and quality<br>• Application fees and fees to secure needed identification<br>• Home accessibility and safety modifications, including medically necessary air conditioners, heaters, humidifiers, air filtration devices and ventilation improvements/repairs or mold/pest remediation, generators, refrigeration units, as well as accessibility ramps, handrails, and grab bars<br>• Security deposit and rent/temporary housing up to six months (including arrears)<br>• Utility deposits, activation fees, and back payments<br>• Other one-time transition and moving costs, including movers and essential home furnishings<br><br><u>Tenancy sustaining supports</u><br>• Intensive case management/care coordination to support housing stability, including tenant rights education and eviction prevention |

| 1115 Benefit | Eligible Medicaid Population(s) | Eligibility Needs Criteria | Benefit Description |
|---|---|---|---|
| | | | • Early identification of at-risk behaviors<br>• Education and connection to resources |
| Medical Respite | Individuals enrolled in Medicaid managed care who meet the needs criteria | Are experiencing homelessness or are at risk for homelessness and meet one of the following criteria:<br>• Are at risk of ED/hospitalization or institutional care<br>• In the ED or hospitalized<br>• In institutional care | Recuperative care may be offered for up to six months and includes:<br>• Specialized onsite case management<br>• Connections to other health related services<br>• Transition support<br>• Limited support for activities of daily living and/or instrumental activities of daily living<br>• Monitoring of the individual's ongoing medical or behavioral health condition(s) (e.g., monitoring of vital signs, assessments, wound care, medication monitoring) |
| Food and Nutrition Services | Individuals enrolled in Medicaid managed care who meet the needs criteria | Identified as being food insecure, and meet one of the following:<br>• Have a chronic condition, such as diabetes or cancer<br>• Have a behavioral or mental health condition<br>• Are pregnant or up to 60 days postpartum | • Up to six months of:<br>  ○ Case management<br>  ○ Nutrition education, coaching, and skill development<br>  ○ Group nutrition classes<br>• Assistance in identifying healthy foods and permanent food sources<br>• Application assistance for SNAP and other available resources<br>• Stocked refrigerator and pantry when transitioning out of institutional settings or prolonged hospitalization<br>• Medically tailored, home-delivered (or for pick-up) meals (up to three meals a day for up to six months)<br>• Cooking supplies for meal prep and nutritional welfare such as pots, pans, and utensils |
| Employment Assistance | Adults ages 18 and older who are enrolled in Medicaid | Identified as needing employment assistance and who meet one of the following criteria: | • Pre-vocational/job-related discovery or assessment<br>• Person-centered employment planning |

| 1115 Benefit | Eligible Medicaid Population(s) | Eligibility Needs Criteria | Benefit Description |
|---|---|---|---|
| | managed care and meet the needs criteria | • Have a physical, intellectual, or developmental disability<br>• Have a behavioral or mental health condition<br>• Are very low income (e.g., recipients of Temporary Assistance for Needy Families) | • Job development and placement assistance, including job carving and vocational analysis<br>• Benefits education and planning<br>• Assessing and developing natural supports<br>• Job training and coaching<br>• Career advancement services<br>• Employee/employer negotiations<br>• Asset development<br>• Follow-along supports |
| Violence Prevention and Intervention | Individuals enrolled in Medicaid managed care who are identified as needing this service | Survivors of violence, people currently experiencing violence, and individuals at risk of experiencing violence | • Injury, prevention, and violence case management services<br>• Violence intervention services<br>• Evidence-based parenting curriculum<br>• Home visitation services<br>• Dyadic therapy |
| Non-medical Transportation | Individuals enrolled in Medicaid managed care who are identified as needing this service | Are identified as needing transportation to needed, non-medically related services, supports, or locations | • Grocery store or food pantry trips<br>• Pharmacy trips<br>• Trips to social services agencies for application assistance/support<br>• Trips to support groups or similar meetings<br>• Trips to other HRSN services, such as violence intervention services, housing support, or employment support (including to and from job interviews) |
| Justice-Involved Community Reintegration: Transitioning from Incarceration | Individuals enrolled in Medicaid managed care and involved with the justice system | Individuals transitioning from incarceration | • Up to 90 days before release,<br>  • Reentry case management services, including:<br>    ▪ Obtaining identification<br>    ▪ Connecting to the HRSN employment assistance services if needed, as well as addressing the additional preparation needed to navigate employment for |

| 1115 Benefit | Eligible Medicaid Population(s) | Eligibility Needs Criteria | Benefit Description |
|---|---|---|---|
| | | | post-incarcerated individuals<br>▪ Connecting to the HRSN housing support services if needed, as well as addressing the additional housing barriers for post-incarcerated individuals<br>• Physical and behavioral health clinical consultation services provided in-person or via telehealth<br>• Laboratory and radiology services<br>• Medications and medication administration<br>• MAT for all types of SUD with accompanying counseling<br>• Services of CHWs and community navigators with lived experiences<br>• Upon exit, a minimum 30-day supply, as clinically appropriate and consistent with the approved Medicaid state plan, of covered outpatient prescribed medications and over-the-counter drugs and durable medical equipment |
| Community Reintegration: Transitioning from Institutions | Individuals enrolled in Medicaid managed care who are transitioning out of institutional settings, including, but not limited to, Class Members of the Williams and | Individuals transitioning from institutional settings | • Linkages to various HRSN services including housing support, food and nutrition, employment assistance, and non-medical transportation<br>• Transition assistance and coaching, including peer-based outreach, engagement, and support pre- and post-transition<br>• Individualized plan to address social isolation using person-centered goals<br>• Linkages to social supports and recreation to mitigate impact or |

| 1115 Benefit | Eligible Medicaid Population(s) | Eligibility Needs Criteria | Benefit Description |
|---|---|---|---|
| | Colbert Consent Decrees | | risk of health effects related to social isolation, including transportation to community and senior centers, places of worship, park districts, libraries, etc. |
| SUD Case Management | Individuals enrolled in Medicaid managed care or Medicaid fee-for-service with an OUD/SUD diagnosis | Individuals with an OUD/SUD diagnosis who qualify for diversion from the criminal justice system into treatment | • Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services<br>• Transition to a higher or lower level of SUD care<br>• Development and periodic revision of a client plan that includes service activities<br>• Communication, coordination, referral, and related activities including connections to deflection and diversion programs and HRSN services<br>• Monitoring service delivery to ensure beneficiary access to services and the service delivery system<br>• Monitoring the individual's progress<br>• Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services |
| SUD Services in IMDs | Individuals enrolled in Medicaid managed care or Medicaid fee-for-service with an OUD/SUD diagnosis | Individuals with an OUD/SUD diagnosis who are primarily receiving treatment and withdrawal management services as a short-term resident in a facility that meets the definition of an IMD | • Clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an IMD |

# V. Demonstration Cost-Sharing and HRSN Delivery System

**Demonstration Cost-Sharing**

No cost-sharing requirements will be associated with this section 1115 demonstration extension.

**Demonstration Delivery System and Geographic Scope**

The proposed HRSN benefits will be administered through the statewide Medicaid managed care program. In 2018, HFS expanded their Medicaid and CHIP managed care program to cover all counties in Illinois. This program is a member-focused program called HealthChoice Illinois. HealthChoice Illinois combines the Family Health Program, Integrated Care Program and Managed Long-Term Supports and Services and is mandatory in all counties. In 2021, HFS expanded its managed care program for full benefit dually eligible individuals, the Medicare-Medicaid Alignment Initiative (MMAI) program, to cover all counties.

Illinois Medicaid managed care enrollment is mandatory for all eligible state plan populations, except the following:

- Medicaid managed care is voluntary for American Indians and/or Natives of Alaska and full benefit dual-eligible adults (MMAI) who are not accessing long-term services and supports (LTSS).
- Children enrolled in the Medically Fragile Technology Dependent (MFTD) Waiver
- Individuals not eligible for full Medicaid coverage under the state plan but eligible for certain limited program benefits or are subject to Medicaid spend-down requirements to become eligible for coverage. These populations include:
    - Individuals in a spend-down program
    - Individuals receiving temporary medical benefits
    - Individuals receiving care through the Illinois Breast and Cervical Cancer Program
    - Individuals with private insurance that pays for hospital and physician visits
    - Individuals receiving care through the Medicaid Family Planning Program

**1115 Services Rollout**

The proposed 1115 benefits will be implemented statewide through managed care, and HFS is engaging its provider community and MCOs in appropriate phases for rolling out the provision of HRSN services. SUD case management services and SUD services provided to enrollees while in a short-term IMD stay will be provided under either managed care or fee-for-service. All other 1115 benefits will be provided exclusively through an MCO. The rollout of certain HRSN services may be prioritized based on level of need, such as medical respite and housing supports.

Individuals who qualify for voluntary enrollment in Medicaid managed care will be eligible to receive clinically appropriate HRSN services upon enrollment in a plan.

**Choice and Access**

Individuals will be able to maintain their enrollment in their MCO, and the proposed HRSN services will be available as a supplemental benefit. The only exception will be for individuals auto enrolled into the CountyCare Health Plan because of incarceration status as described in more detail in Section VI.

**Managed Care Provider Selection/Procurement**

The HRSN services will be added through contract amendments with the MCOs.

**Participant Notification and Enrollment**

Participation in the 1115 services provided through the demonstration initiatives are voluntary and special enrollment is unnecessary

# VI. Pilot Initiatives and HRSN Framework for Demonstration Extension

Through the implementation of the nine pilot initiatives, this demonstration extension will direct community-based investments to provide or facilitate the provision of HRSN services in geographic areas with the highest rates of social vulnerability and a presence of significant economic, environmental, and socio-cultural healthcare access barriers to achieving and maintaining good health. Illinois' proposed infrastructure framework for the extension uses the following multi-pronged approach that will directly support and enhance the provision of HRSN benefits to program eligibles:

A. HRSN expenditure authority cap
B. Nine pilot initiatives
C. Cook County DSH/Community Reinvestment Pool

## A. HRSN EXPENDITURE AUTHORITY CAP

In alignment with other CMS 1115 approvals that include HRSN, Illinois is requesting expenditure authority for hypothetical HRSN expenditures equal to 3 percent of the state's total Medicaid spending, including HRSN infrastructure expenditures capped at 15 percent of the total 3 percent HRSN expenditure authority. The HRSN expenditure cap will support the provision of the enhanced HRSN benefits that are being driven by the implementation work across the nine pilot initiatives aimed at addressing Illinois' identified healthcare gaps comprehensively at the community, provider, and state levels. The proposed HRSN cap will include certain HRSN-specific infrastructure expenditures for technology, development of business or operational practices, workforce development, and outreach, education, and stakeholder convening. As part of implementation planning, Illinois will identify data systems and workflows that need updates to connect Medicaid enrollees effectively and efficiently to HRSN services. This process will include enhancing collaboration and coordination efforts with key partners, such as those in the housing and justice systems, as well as with the University of Illinois Office of Medicaid Innovation (OMI), IDHS, Division of Substance Use Prevention and Recovery (SUPR), and the University of Illinois Medicaid Technical Assistance Center (MTAC).

## B. DEMONSTRATION PILOT INITIATIVES

As summarized in Section V, Illinois will provide HRSN services specifically through the implementation of nine initiatives summarized and described in Table 5. Pilots will support the direct provision of the HRSN benefit to program eligibles and/or will implement supporting infrastructure activities, such as CHW training, to address related HRSN needs. Where applicable, related to the requested HRSN service, HFS will collaborate with and leverage the partnerships and agencies that provide programs to support existing housing and food-related initiatives, thereby maximizing impact for Medicaid beneficiaries and ensuring appropriate utilization.

**Table 5. Illinois 1115 Demonstration Pilots**

| No. | Pilot Initiative | Status within this Extension Request | Medicaid Program Goal(s) | Supports the Primary 1115 Goal/Objective(s) |
|---|---|---|---|---|
| 1 | **Healthcare Transformation Collaboratives** that drive local, innovative approaches to | New | Reorient the healthcare delivery system in Illinois | Identify and assess causes of disparities, including the |

| No. | Pilot Initiative | Status within this Extension Request | Medicaid Program Goal(s) | Supports the Primary 1115 Goal/Objective(s) |
|---|---|---|---|---|
| | deliver high-quality healthcare, with an intentional focus on addressing HRSN | | around people and communities | identification and revision of policies and operations that perpetuate healthcare disparities, to effectively close gaps and improve healthcare access, quality, and outcomes. |
| **2** | Supports for **justice-involved populations** to assist in successful community reintegration and improved health and well-being | New | Improve and customize the coordination of care and supports available before and during transitions | Identify and assess causes of disparities, including the identification and revision of policies and operations that perpetuate healthcare disparities, to effectively close gaps and improve healthcare access, quality, and outcomes. |
| **3** | **Violence prevention and intervention** community-led initiatives, in partnership with local and state agencies, along with person-centered and trauma-informed case management and other services, to prevent and reduce the health impact of violence in communities and homes | New | Prevent violence, including gun violence, as well as reduce the impact of prolonged, chronic stress and trauma resulting from it | Identify and assess causes of disparities, including the identification and revision of policies and operations that perpetuate healthcare disparities, to effectively close gaps and improve healthcare access, quality, and outcomes. |
| **4** | **Outreach and Engagement** to promote health and well-being, with a focus on preventive health in underserved communities through culturally responsive, enhanced care management services | New | Improve the health and well-being of individuals in underserved communities | Offer culturally and linguistically responsive care, providing communities with improved health care, patient safety, and experiences. |
| **5** | **Community Health Worker (CHW) Training** that will create a workforce of providers who serve people of the communities in which they live | New | Identify, recruit, train, and certify a workforce of CHWs who serve the communities in which they live | Create and sustain capacity within healthcare organizations with a workforce skilled at meeting the unique |

| No. | Pilot Initiative | Status within this Extension Request | Medicaid Program Goal(s) | Supports the Primary 1115 Goal/Objective(s) |
|---|---|---|---|---|
| | | | | needs of the communities of Illinois. |
| 6 | **Safety Net Hospital Health Equity and Access Leadership (HEAL) Grant Program** to support projects that reduce health disparities, advance health equity, and improve access to quality healthcare services | New | Ensure that vulnerable people and communities have access to quality healthcare | Implement effective technologies and solutions that expand data collection, reporting, and analysis to make data-informed and person-centered decisions that will lead to better access to equitable care and coverage. |
| 7 | **Treatment for Individuals with Substance Use Disorder (SUD) Pilot** that will continue to authorize expenditures for primary SUD treatment services for short-term residents of facilities that meet the definition of an IMD, including providing SUD case management services to assist beneficiaries in accessing needed medical, social, educational, and other services | Current and continuing without changes | Maintain critical access to OUD and SUD services and continue delivery system improvements for these services to provide more coordinated and comprehensive OUD/SUD treatment for Medicaid beneficiaries | Tailor programs to individuals and communities, resulting in improved access to care and services.<br><br>Case management services are individualized for beneficiaries in treatment, reflecting needs identified in the assessment process, and those developed within the treatment plan. |
| 8 | **Housing Support Services Pilot** that will authorize pre-tenancy supports and tenancy sustaining services | Current and continuing with proposed changes | Provide care coordination and other proven strategies to help people experiencing homelessness, or at risk of becoming homeless, to stay in stable and secure housing situations | Identify and assess causes of disparities, including the identification and revision of policies and operations that perpetuate healthcare disparities, to effectively close gaps in health and improve healthcare access, quality, and outcomes. |
| 9 | **Supported Employment Services Pilot** that will | Current and continuing | Promote an Illinois workforce that is | Create and sustain capacity within |

| No. | Pilot Initiative | Status within this Extension Request | Medicaid Program Goal(s) | Supports the Primary 1115 Goal/Objective(s) |
|---|---|---|---|---|
| | authorize supported employment services to eligible beneficiaries through a person-centered planning process when eligible services are identified in the individuals' plan of care | with proposed changes | sufficiently sized, diversified, culturally competent and trained | healthcare organizations with a workforce skilled at meeting the unique needs of the communities of Illinois. |

The aim of these nine transformation pilot initiatives is to produce person-centered, integrated, and equitable change in the delivery of healthcare services. Illinois' proposed approach to healthcare transformation through these initiatives will assist in achieving the state's mission to identify and address healthcare disparities. Healthcare transformation through these innovative pilots is a critical step toward realizing the state's mission of bringing high-quality healthcare to Illinoisans to advance their physical, mental, and financial well-being.

1. **Pilot Initiative No. 1: Healthcare Transformation Collaboratives (HTC) Program** (supports direct HRSN service provision and infrastructure)

As mentioned in Section III, the Illinois legislature authorized the HTC Program in 2021 through Public Act 101-0650[14] and Public Act 101-655.[15] The HTCs create partnerships and bring entities together to find innovative ways to bridge gaps in the healthcare delivery system and increase access to quality healthcare services in underserved communities across Illinois. The HTC Program makes available approximately $150 million per fiscal year to support collaborations between care providers, including preventive care, primary care, specialty care, hospital services, mental health and substance use disorder services, and community-based entities that address SDOH. Illinois is seeking expenditure authority for payments to HTCs for program activities not traditionally included as Medicaid state plan services to advance health equity and build capacity in underserved areas.

The HTCs will operate under the demonstration in the same manner as authorized by the Illinois legislature. The state's annual funding appropriation will continue to be made available to foster "on the ground" local collaborations between care providers, including preventive care, primary care specialty care, hospital services, mental health and substance use disorder services, and community-based entities that address SDOH. Collaborations must include at least one Medicaid provider that is eligible to bill Illinois' Medicaid program. Priority will be given to collaborations that include safety net hospitals or critical access hospitals, as well as minority-controlled or led organizations.

The HTCs will operate in regions identified through the state defined application process. HTCs will operate in additional Illinois counties and regions based on local needs and will continue to be intentionally established in areas of the state that are experiencing health inequities through the established application process.

[14] See: https://www.ilga.gov/legislation/publicacts/101/101-0650.htm
[15] See: https://ilga.gov/legislation/publicacts/101/PDF/101-0655.pdf

*Pilot Design*

Collaboratives selected for funding under this pilot initiative are expected to meet the following proposed criteria:

a. Ensure that multiple healthcare provider organizations, community service providers, and community-based stakeholders work together to address targeted community health needs and desires as determined via direct community input, incorporating health equity into all proposed interventions.
b. Address at least two HFS Quality Strategy Goals
    1. Improve population health
    2. Improve access to care
    3. Increase effective coordination of care
    4. Improve participation in preventive care and screenings
    5. Promote integration of behavioral and physical healthcare
    6. Create a person-centric healthcare delivery system
    7. Identify and prioritize reducing health disparities
    8. Implement evidence-based interventions to reduce disparities
    9. Invest in the development and use of health equity performance measures
    10. Incentivize the reduction of health disparities and achievement of health equity
c. Bring together at least two healthcare providers and at least one community-based organization (CBO), business enterprise program (BEP),[16] or group that addresses SDOH to better address the health and social needs of the community's Medicaid population.
d. Address social barriers to care and treatment that exacerbate chronic health conditions.
e. Address access to care both by increasing services available in the community and engaging in outreach and other interventions to increase use of services already in the community (e.g., maternal health with a focus on addressing Black maternal health disparities, specialty care for chronic conditions)
f. Understand each individual's physical health, behavioral health, and social needs and deliver services in a well-coordinated manner in the communities where they live and work
g. Provide data that supports the need for the activities that the Collaborative funds, including information shared with local public health departments
h. Track clinical quality and performance measures affected by the Collaborative's activities
i. Demonstrate how pilots funded by the state through this program will achieve financial sustainability in the future without subsidization by Transformation funds

Collaboratives will identify and employ the technology solutions and data analytics needed to support and coordinate the pilot demonstrations and effectively integrate physical, behavioral, and HRSN services in a person-centered, holistic way. By using data-informed approaches, Collaboratives will mitigate the impact of structural racism on health equity, access, and total cost of care. Workforce development will be a critical focus area for these Collaboratives and is further described below in the CHW initiative.

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[16] State of Illinois Commission on Equity and Inclusion. Welcome to the Business Enterprise Program. Available at: https://cei.illinois.gov/business-enterprise-program.html.

2. **Pilot Initiative No. 2: Justice-Involved Reentry Pilot** (supports direct HRSN service provision)

The justice-involved population has a high prevalence of untreated, chronic conditions, as well as a high incidence of SUD and mental illness. Through collaborative and coordinated efforts, these individuals can be connected with Medicaid to facilitate a comprehensive and supportive plan to successfully reintegrate them into the community. This process will ensure that their physical and mental health are addressed, including any HRSN that may create barriers to receiving necessary healthcare services.

Cook County is testing innovative approaches to improve healthcare for the adult justice-involved population and seeing promising results. Through this initiative, adults who are incarcerated at Cook County Jail receive assistance with completing and filing Medicaid applications. If they meet Medicaid eligibility requirements, they are automatically enrolled in the CountyCare Health Plan when they reenter the community (note that enrollees have the option to "opt out" into another MCO if desired in accordance with traditional managed care). CountyCare Health Plan is affiliated with Cook County Health, and through this auto-enrollment feature, HFS is facilitating seamless transitions to a medical home upon an individual's release. Cook County Health is already the provider of healthcare while individuals are incarcerated in Cook County Jail and, therefore, has the most recent medical records for these individuals. As a result of this pilot, Medicaid received more than 1,500 applications in 2021 and nearly 1,500 applications in 2022. These efforts are helping ensure continuity of care for these individuals once their incarceration ends.

Illinois is requesting expenditure authority to provide "community reintegration (i.e., reentry) services" up to 90 days before an individuals' release from incarceration. This pathway to Medicaid coverage for incarcerated people, coupled with specialized reintegration services up to 90 days before release, will ensure these individuals receive better care coordination and critical services that assist them in receiving adequate supports, which can lead to successful treatment of common conditions such as SUD, close other gaps in care, and reduce recidivism.

*Pilot Design*

For up to 90 days before release, the state will:

- Auto enroll Medicaid-eligible individuals incarcerated at Cook County Jail into CountyCare Health Plan.
- Share data across the justice system(s) and Medicaid managed care.
- Implement and provide targeted community reintegration services through Medicaid managed care that will include person-centered, tailored reentry case management and transition planning up to 90 days before an individual's release. These services can help eligible individuals obtain identification, prepare for employment, and access additional HRSN services as needed, such as housing and employment support. Additional services may include physical and behavioral health clinical consultation services provided in-person or via telehealth, laboratory and radiology services, medications and medication administration, medication-assisted treatment (MAT) for all types of SUDs with accompanying counseling, and services of CHWs and community navigators with lived experiences. Upon exit, a minimum 30-day supply, as clinically appropriate and consistent with the approved Medicaid state plan, of covered outpatient prescribed medications and over-the-counter drugs and durable medical equipment will also be provided as needed.

The Cook County Department of Corrections (CCDOC), as operator of one of the largest single-site jails in the country as well as the largest carceral setting within the state, will be the first to focus on providing reintegration (i.e., "reentry" services) to justice-involved populations.

Estimates indicate approximately 70 percent of individuals leaving Illinois Department of Corrections (IDOC) custody take up residence in Cook County. Accordingly, Illinois will initially develop this program specifically for individuals in Cook County Jail (as well as those leaving IDOC custody and returning to Cook County) and will design an evaluation plan that will help identify best practices that can be replicated and scaled to meet the needs of other communities and populations in the state. Expansion to other counties and regions of Illinois will occur once the evidence base is established in Cook County, allowing for easy replication and adaptation in other parts of the state based on the availability of MCOs with proven expertise in working with and assisting this population. When Illinois is ready to expand this pilot throughout the state, it will expand to include all eligible individuals leaving IDOC custody and youth involved in the juvenile justice system.

3. **Pilot Initiative No. 3: Violence Prevention and Intervention** (supports HRSN service provision)

One way Illinois is addressing violence head-on is through the Reimagine Public Safety Act (RPSA). This legislation creates a comprehensive approach to ending Illinois firearm violence through targeted, integrated behavioral health services and economic opportunities. Through this initiative, Illinois is supporting programs, training and technical assistance, and community convenor efforts in 22 Chicago communities and 15 areas across Illinois. These programs focus on Violence Prevention, Youth Development, and High-Risk Youth Interventions.

Violence Prevention Community Support Teams are part of this large safety initiative and will provide culturally responsive, trauma-informed therapeutic interventions and supports focused on reducing traumatic stress symptoms and improving community functioning for individuals who have experienced chronic exposure to firearm violence.

To support and expand the violence prevention work under way in Illinois, the state is requesting expenditure authority to help these support teams bring additional activities to local communities. Activities such as evidence-based coaching programs will assist youth and young adults in identifying job and career options and provide them with resiliency training. The state also is requesting expenditure authority to provide person-centered, trauma-informed services to Medicaid eligible people who need it by implementing and providing violence prevention and intervention services through MCOs that will address the health effects associated with violence.

4. **Pilot Initiative No. 4: Outreach and Engagement** (supports HRSN service provision)

Illinois proposes to implement an outreach and engagement pilot program, such as authorized by the General Assembly via 305 ILCS 5/12-4.56 [17] to provide specialized patient navigators to connect people in communities with high healthcare disparities and structural barriers to preventive and primary care providers. The state is requesting expenditure authority to implement this pilot that will provide highly specialized and culturally responsive enhanced care management services in communities not currently served by the Healthcare Transformation Collaboratives and incorporate targeted outreach and engagement services for underserved communities. The state will accomplish this by:

[17] See https://www.ilga.gov/legislation/ilcs/documents/030500050K12-4.56.htm.

- Providing targeted outreach to Medicaid enrolled individuals in underserved communities, with a goal of increasing the use of preventive care
- Providing patient-centered, prevention-focused services and enhanced care management, which may include:
    - Patient navigators to manage patient care
    - Patient-tailored preventive health care plans
    - Administrative personal health care consultants or community health workers for home health maintenance between office visits
    - Clinical personal healthcare consultants for telehealth (health information and advice) and wellness initiatives
    - A patient portal
    - An online virtual health hub that provides patents with access to wellness, self-guided education, health seminars, a video library, and additional health and wellness resources
    - Community health and human services centers to engage, educate, and empower patients to get involved in their own self-care
    - Mobile preventive health stations and kiosks to bring services to underserved communities that are health or medical deserts
    - Call centers to interact with medical homes and facilitate service offerings

This initiative will use convenient and accessible approaches that can help bring culturally responsive and linguistically appropriate health information to individuals who need it, which, in turn, will increase their health literacy and promote access to healthcare and related services. This initiative will leverage existing patient navigator models in Illinois, including those that are part of health systems, MCOs, and CHW networks. Upon implementation, Illinois will ensure that healthcare entities have clear roles and expectations to avoid any duplicative efforts and, rather, promote collaborative engagement so that eligible individuals can receive customized interventions and health-related supports from trusted and preferred providers.

This Outreach and Engagement pilot will complement the Healthcare Transformation Collaboratives by operating in counties and regions selected by the state that do not overlap and have been identified as communities that will benefit from services and enhanced care management designed to promote prevention and improve health outcomes.

5. **Pilot Initiative No. 5: Community Health Worker Training** (infrastructure support)

The Illinois Department of Public Health (IDPH) is spearheading statewide efforts to develop a training and certification process for Illinois. Such efforts will be based on strong, existing community health worker programs in the state and will build on nationally available, evidence-based programs. The state is seeking expenditure authority to support recruitment, training, and certification of CHWs, as they would contribute two-fold to the goals of this demonstration by providing high-quality, culturally and linguistically competent, community-based healthcare services to Illinois Medicaid recipients and promoting the meaningful employment of individuals in search of local career paths that contribute to a community's well-being. Support of this initiative will also assist Illinois Medicaid in sustaining coverage for services that CHWs provide, as state law requires that these providers be certified before providing Medicaid services. To operationalize this pilot, the state will:

- Collaborate with and support IDPH in developing and implementing a CHW training curriculum and certification guidelines
- Cover expenses for Healthcare Transformation Collaboratives initiatives and possibly other organizations to recruit, train, and certify individuals from the community, inclusive of providing stipends for any travel associated with obtaining and maintaining certification
- Collaborate with MCOs to integrate systems and implement a seamless process for members to access physical, behavioral, and HRSN services

By providing staff with training and certification as a benefit of employment, this strategy not only will bring quality healthcare workers into the Healthcare Transformation Collaboratives, it also will create a personal career path that will bring health and well-being opportunities directly to members of the communities that the Collaboratives serve.

Through this initiative, the state will encourage Medicaid MCOs to recognize and value the contributions that CHWs bring to care teams and the tremendous amount of work they do to assist people in reaching their personal health goals through person-centered and strengths-based approaches. Illinois will evaluate the effectiveness of this effort and may expand it to organizations in additional areas of Illinois that use CHWs to provide services to Medicaid-eligible populations. This initiative also may inform opportunities for additional traditional healthcare workers in the future, including peer support specialists or other behavioral health counselors, certified nursing assistants and medical assistants, hospital-based navigators and peer navigators, and others as identified through needs assessments.

6. **Pilot Initiative No. 6: Illinois' Safety Net Hospital Health Equity Transformation Program** (supports direct HRSN service provision and infrastructure)

Authorized by the General Assembly, the Safety Net Hospital Health Equity and Access Leadership (HEAL) Grant Program was enacted to address the significant healthcare disparities Illinois was experiencing, which the COVID-19 pandemic exacerbated.[18] Safety net hospitals, as defined under the Illinois Public Aid Code, serve as the anchors of the healthcare system for many of the communities experiencing the negative impacts of SDOH and a lack of sufficient access to high quality healthcare resources, particularly community-based services, preventive care, obstetric care, chronic disease management, and specialty care. Safety net hospitals serve a significant number of Medicare, Medicaid, and uninsured patients, and therefore, are heavily burdened by uncompensated care. At the same time, the overall cost of providing care has increased substantially in recent years, driven by increasing costs for staffing, prescription drugs, technology, and infrastructure. This pilot 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.

This pilot initiative will support Illinois safety net hospitals' key role as the anchors of the healthcare system for many of the communities experiencing high disparities. Safety net hospitals not only care for their patients, they also are rooted in their communities by providing jobs and partnering with local organizations to help address SDOH by providing connections to HRSN, such as food, housing, and transportation needs. To implement this pilot, the state will:

[18] See Illinois Compiled Statutes - https://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=002023100K2310-710.

- Create criteria for eligible safety net hospitals. Eligibility could be based on such factors as participation in Medicaid MCO networks; location in a medically underserved area; Medicaid and Medicare utilization rates; percentage of uncompensated care; role in providing access to services, reducing health disparities, advancing health equity, and improving access to or the quality of healthcare services; and quality indicators.
- Support projects that reduce health disparities, advance health equity, and improve access to or the quality of healthcare services.

This Safety Net Hospital Health Equity Transformation Program pilot will operate throughout the state, especially at safety net hospitals in medically underserved areas as determined by the state. This grant program will be another key initiative in furthering the state's vision for an equitable and sustainable healthcare system.

7. **Pilot Initiative No. 7: Treatment for Individuals with Substance Use Disorder (SUD) Pilot** (supports HRSN service provision)

According to the IDPH, more than 3,000 people in Illinois died of drug overdoses in 2021.[19] In 2022, the state launched the Statewide Overdose Action Plan,[20] emphasizing a framework that includes strategies around social equity, prevention, treatment and recovery, harm reduction, and justice-involved populations and public safety. This action plan highlights the critical need for continued and heightened efforts around transformational changes to the healthcare delivery system in Illinois to achieve equitable and improved behavioral health and mental health outcomes.

As a partner in this work, HFS is requesting to continue the OUD/SUD pilot as originally approved for this demonstration, given that the recent Illinois overdose statistics indicate a critical need remains for high-quality, evidence-based OUD/SUD treatment services. The state is requesting to continue the OUD/SUD 1115 expenditure authorities that permits the provision of evidence-based OUD/SUD treatment services to Medicaid-eligible people through the demonstration. Those service authorities are:

- Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD), which are not otherwise matchable expenditures under section 1903 of the Social Security Act.
- SUD case management services that assist individuals with accessing needed medical, social, educational, and other services. SUD case management services will assist persons with an OUD/SUD diagnosis that qualifies for diversion from the criminal justice system into treatment. Services are individualized for persons in treatment, reflecting needs identified in the assessment process, and those developed within the treatment plan. SUD case management services include:
    - Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services
    - Transition to a higher or lower level of SUD care
    - Development and periodic revision of a client plan that includes service activities

[19] See https://dph.illinois.gov/topics-services/opioids/il-opioid-action-plan.html.
[20] See https://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/SUPR/State-of-Illinois-Overdose-Action-Plan-March-2022.pdf.

- Communication, coordination, referral, and related activities, including connections to deflection and diversion programs and HRSN services
- Monitoring service delivery to ensure beneficiary access to services and the service delivery system
- Monitoring the beneficiary's progress
- Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services

The services in this pilot will continue to be available to Medicaid enrollees in both managed care and fee-for-service as applicable.

**8. Pilot Initiative No. 8 – Housing Support Services Pilot** (supports HRSN service provision)

Addressing housing insecurity is a critical priority for the state. The Chicago Coalition for the Homeless[21] published a report in 2022, highlighting this critical need. The organization reports that in 2020, an estimated 10,431 people experienced street and shelter homelessness in Illinois on any given day, 39,421 Illinois public school students experienced homelessness, and 109,842 people experienced homelessness by doubling up. Racial disparities were found to exist and are largest in urban areas including Chicago, Springfield, and Champaign, where Black Illinoisans constitute 74 percent of the homeless population. Further, dependent children and infants ages 0-18 make up 21 percent of the Illinois homeless population. In September 2021, Governor Pritzker signed the Executive Order to Fight Homelessness in Illinois.[22] This order established the Illinois Interagency Task Force on Homelessness, the Community Advisory Council on Homelessness, and a State Homelessness Chief—all working together to decrease homelessness and unnecessary institutionalization, improve health and human services outcomes for people who experience homelessness, and strengthen the safety nets that contribute to housing stability. Subsequently, Illinois' Plan to Prevent and End Homelessness[23] was released, outlining key action steps for Illinois to reach functional zero and unnecessary institutionalization. In implementing this action plan, Illinois has invested more than $1.5 billion to date in housing relief and has seen reported decreases in certain homelessness data statistics; however, more robust efforts are needed to effectuate a sustainable strategy that: 1) builds affordable and permanent supportive housing; 2) builds a sound safety net for households at risk of homelessness; and 3) supports an individual with securing financial (employment) stability, which is the most common cause of housing insecurity.

To address this critical need for housing stability and to achieve the goals outlined in this application, HFS is seeking expenditure authority to provide housing support services. Illinois anticipates that this benefit will not only create opportunities for stable housing, but also will improve health outcomes among Medicaid enrolled individuals and their families, reducing the burden of chronic health conditions, as well as reducing costs related to emergency departments (ED)/, hospital, and institutional care.

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[21] See https://www.chicagohomeless.org/estimate-of-homeless-people-in-chicago/.
[22] See https://www.illinois.gov/government/executive-orders/executive-order.executive-order-number-21.2021.html.
[23] See https://www.dhs.state.il.us/OneNetLibrary/27897/documents/Homelessness/HomeIllinoisPlantoPreventandEndHomelessnesA11Y.pdf.

Housing support services will address persons experiencing or at risk of homelessness or institutional placement, including individuals fleeing violence, assault, or other dangerous, unsafe, life-threatening circumstances related to violence. The housing support pilot will include housing deposits, rent and application assistance, home modifications, and intensive case management to support housing stability. Housing support services are for individuals who are enrolled in Medicaid managed care, who are experiencing homelessness or at risk of homelessness, and who are facing at least one or more of the following conditions or circumstances:

(a) Have received care in EDs, hospitals, or crisis centers on multiple occasions (twice in six months or four times in 12 months)
(b) Have been determined to be high-risk or high cost based on service utilization or healthcare history
(c) Have complex physical health needs (persistent, disabling, or progressively life-threatening physical health conditions that require improvement or stabilization to prevent deteriorated functioning)
(d) Have a behavioral or mental health need requiring improvement or stabilization to prevent deteriorated functioning
(e) Are experiencing a high-risk pregnancy or complications associated with pregnancy, or are infants (up to one year old) born of such pregnancies
(f) Are young adults, ages 18 through −26, who have aged out of foster care
(g) Are transitioning from institutions or carceral settings

The supported housing services benefit will consist of:

Pre-Tenancy Supports

(a) Intensive case management/care coordination to support housing stability, including access to SSI/SSDI benefits using models such as SOAR (SSI/SSDI Outreach, Access, and Recovery) to provide application assistance and support through determination
(b) Housing navigation, including location assistance
(c) Inspection fees for housing safety and quality
(d) Application fees and fees to secure needed identification
(e) Home accessibility and safety modifications, including medically necessary air conditioners, heaters, humidifiers, air filtration devices and ventilation improvements/repairs or mold/pest remediation, generators, refrigeration units, as well as accessibility ramps, handrails, and grab bars
(f) Security deposit and rent/temporary housing up to six months (including arrears)
(g) Utility deposits, activation fees, and back payments
(h) Other one-time transition and moving costs, including movers, and essential home furnishings

Tenancy Sustaining Supports

(a) Intensive case management/care coordination to support housing stability, including tenant rights education and eviction prevention
(b) Early identification of at-risk behaviors
(c) Education and connection to resources

9. **Pilot Initiative No. 9: Supported Employment Services Pilot** (supports HRSN service provision)

According to the US Department of Labor, Disability Statistics, the labor force participation for people with disabilities in 2021 was 21.3 percent, whereas it was 67.1 percent for people without disabilities. Similarly, there are disparities in unemployment rates between these populations (10.1% for people with disabilities, and 5.1% for people without disabilities). Further, the National Alliance on Mental Illness reports that the unemployment rate for individuals receiving public mental health services is approximately 80 percent. To address these inequities and the overarching employment-related needs identified in the 2019 AHE Community Health Needs Assessment for Chicago and Suburban Cook County previously highlighted in Table 3, HFS is seeking continued expenditure authority for the Supported Employment Services HRSN benefit with enhanced eligibility criteria. Through this critical HRSN benefit and using the Individual Placement and Support (IPS) approach, we anticipate that individuals will be able to obtain and maintain meaningful employment and also improve quality of life, mental health, and global functioning.

The supported employment services will address persons needing employment assistance and have a physical, intellectual, or developmental disability, behavioral or mental health condition, or very low-income. The Supported Employment Services Pilot will include pre-vocational and vocation sustaining services.

Employment assistance services are for individuals enrolled in Medicaid managed care, ages 18 and older, who are identified as needing employment assistance and who have at least one or more of the following conditions or circumstances:

(a) A physical, intellectual, or developmental disability
(b) A behavioral or mental health condition
(c) Are very low income

The supported employment services benefit is individualized and may include any combination of the following services:

(a) Pre-vocational/job-related discovery or assessment
(b) Person-centered employment planning
(c) Job development and placement assistance, including job carving and vocational analysis
(d) Benefits education and planning
(e) Assessing and developing natural supports
(f) Job training and coaching
(g) Career advancement services
(h) Employee/employer negotiations
(i) Asset development
(j) Follow-along supports

## C. COOK COUNTY DSH/COMMUNITY REINVESTMENT POOL

Illinois requests expenditure authority to repurpose a portion or all of Cook County's annual disproportionate share hospital (DSH) allotment (up to approximately $331 million) to be spent on implementing HRSN initiatives in underserved communities as another tool for advancing goals around equity. In 2019, Health & Medicine Policy Research Group (HMPRG), a Chicago based non-profit working to improve the health of all people in Illinois by promoting health equity, initiated a

research project to explore the impacts, unintended consequences, and unfinished work of health reform (broadly defined) on Cook County's healthcare safety net.[24] HMPRG identified certain themes in system complexity and inequities across and within the safety net despite certain strengths realized in the Cook County safety net.

Cook County safety net patients and families experience significant system complexity and inequities that affect both their health and ability to access healthcare. Unmet healthcare and social needs persist and are rooted in long-term systemic oppression across the lived experience. Significant portions of the population served by the safety net remained uninsured or underinsured. Along with barriers to healthcare access, safety net patients endure the effects of the inequitable impacts of SDOH, including housing, food, transportation, jobs and economic security, safety, and freedom from violence. An important part of HFS' strategy is to ensure payment methodologies support quality and equity goals. DSH payments based on uncompensated care only serve to shore up and sustain inequities in local systems and in many cases do nothing to drive quality of care or health equity.

The repurposed Cook County DSH allotment will create a Community Reinvestment Pool to finance strategies that tie directly to improving health and health equity in underserved communities. The interventions would be subject to regular measurement and reporting on metrics that will be specified in the Special Terms and Conditions (STCs) for the demonstration extension, thus providing a laboratory for discerning which strategies should be replicated throughout underserved areas in the state. This "pool" approach is expected to complement the approaches the various collaboratives are developing under the Healthcare Transformation Collaboratives Pilot, which are good starting points but may not necessarily represent the full universe of equity approaches that could be supported through a pool payment methodology. By tying these payments to strict criteria around outcomes, the state will be able to replicate effective programs rather than just paying for uncompensated care that is often delivered in the costliest settings.

All other aspects of the annual DSH allotment and hospital specific DSH payments made to qualifying Illinois hospitals will remain the same.

# VII. Other Program Features to be Modified by Demonstration

A. **Continuum of Care Facility Licensure:** The Illinois General Assembly enacted the Continuum of Care Services for the Developmentally Disabled Act[25] to authorize a new type of license for organizations that provide services to individuals with developmental disabilities, to be known as a continuum of care license. This new licensing category will create an umbrella license for organizations that provide a continuum of services to people with intellectual or developmental disabilities (I/DD). The basis for the enactment of a continuum of care license is to protect the welfare, safety, and rights of individuals with disabilities; provide additional options for care and services for individuals with developmental disabilities; and provide a model of care that can transition individuals with developmental disabilities in a seamless and timely manner across the

[24] Health & Medicine Policy Research Group. A Checkup for Cook County's Safety Net: A Qualitative Review of Health Reform. Published December 2019. Available at: https://www.hmprg.org/wp-content/uploads/2019/12/A-Checkup-for-Cook-Countys-Safety-Net-Dec-2019.Update.pdf.
[25] See Illinois Compiled Statutes at https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=3741&ChapterID=21

continuum of residential care settings and supportive services to maximize enrollee choice and satisfaction.

The legislation directs HFS to request from the government a "waiver pursuant to the federal Social Security Act" to define the requirements for a continuum of care facility licensure, to establish a process for receiving and maintaining such a license and to establish an alternative budget-neutral reimbursement approach for adopting continuum of care facility licensure. The new license will be implemented in compliance with the CMS home and community-based settings criteria.

In partnership with Misericordia Heart of Mercy[26] and in collaboration with the IDPH, Illinois is requesting expenditure authority to implement the continuum of care licensure as directed by the Continuum of Care Services for the Developmentally Disabled Act. This proposed model would promote disability inclusion and integration, address SDOH by providing HRSN (such as training, education, and employment opportunities) to increase the health and well-being and facilitate transitions of care, thus decreasing the administrative burden on residents and their families when significant changes occur in the residents' condition. Licensees would be expected to follow these stipulations:

- Organizations would remain individually licensed or certified as appropriate to the level of care they provide (e.g., skilled nursing facility, intermediate care facility services, supportive living facility services).
- Each licensee would still be expected to adhere to all federal, state, and local regulations (including the CMS home and community-based settings criteria).

Licensure Standards and Other Guidelines
The state will establish a system to receive umbrella licensure, and facilities may add new elements if they show need. Licensing standards for a continuum of care facility might include:

- Meeting the definition of a continuum of care facility and providing all services required
- Submitting and maintaining adherence to the continuum of care plan
- Meeting all applicable regulatory requirements for long-term care, including those for abuse and neglect
- Meeting any requirements that the Secretary of the Illinois Department of Human Services deems appropriate

Such facilities would be expected to create a continuum of care plan that:
- Undertakes a comprehensive approach to placing residents in the most appropriate level of care based on the individual's desires and needs
- Maximizes employment and training opportunities
- Provides programs and services to address the demand for a growing, aging population with I/DD
- Commits to providing choice
- Uses an evidence-based assessment tool approved by the departments

[26] Misericordia Heart of Mercy offers a community of care that maximizes potential for people with mild to profound developmental disabilities with the mission of providing a quality of life for Illinoisans. See https://www.misericordia.com/.

To be fully operational as a continuum of care facility, the facility's model would need to include:

- Community-integrated living arrangements
- On- and off-campus employment opportunities
- Developmental training programs and services
- Community living opportunities
- Campus group homes

In the event a continuum of care facility loses its license, any constituent elements that meet the established criteria will maintain their licensure. Residents of these facilities will continue to have all rights and benefits of I/DD care. Misericordia will serve as the pilot site. Once operationalized at this large campus-based setting, further planning will take place to determine operationalization in additional counties and regions of Illinois.

Budget Neutrality for Continuum of Care Facility Licensure
As directed by the authorizing legislation, HFS is proposing an alternative budget-neutral reimbursement approach for adopting the continuum of care facility licensure by deriving a "without waiver" baseline of expenditures across the separate state-operated facilities that would otherwise serve this population of individuals with developmental disabilities. With this "without waiver" baseline representing all state plan and 1915 waiver services, HFS is proposing hypothetical expenditure authority to use this same cost baseline as a pass-through for "with waiver" expenditure authority to reimburse newly formed continuum of care facilities for providing comprehensive state plan and expanded 1115 services. See the proposed without waiver hypothetical expenditure limits to implement this initiative described under application Section XII and in Attachment A for budget neutrality.

B. Provider Rate Increase Requirements – In accordance with other CMS 1115 approvals with HRSN related authorities, HFS expects that as a condition of CMS' approval of this extension request, HFS will be required to increase and sustain Medicaid fee-for-service (currently only SUD services) provider base payment rates and managed care payment rates in primary care, behavioral health, or obstetrics care should the state's Medicaid to Medicare provider rate ratio be below 80 percent in one of these categories. HFS will work with CMS to implement this program change upon approval to the extent applicable.

# VIII. Quality Assurance

As discussed in application Section V, HFS operates under statewide Medicaid managed care and services authorized under the 1115 demonstration will be delivered through managed care, except for SUD case management services and SUD IMD services, which are eligible for reimbursement under both managed care and fee-for-service. Because the SUD services are provided in the same manner under Medicaid managed care and fee-for-service, managed care quality assurance findings are used to inform any quality issues pertaining to the provision of SUD services provided to enrollees. HFS uses its MCO quality oversight program managed by an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG), to ensure the quality of and access to care provided under the demonstration. HSAG performs external oversight, monitoring, and evaluation of the quality assurance component of managed care. In accordance with 42 CFR §438.356, the EQRO conducts the mandatory

and optional external quality review activities as set forth in 42 CFR §438.358. The quality assurance process described here similarly will be used for the proposed demonstration extension.

HFS administers and monitors the state's managed care/care coordination programs and is charged to improve healthcare quality for Medicaid enrollees. Initiatives and programs are administered by HFS to help individuals improve their health status by ensuring the highest-quality, most cost-effective services possible, including disease management, hospital quality and utilization management, interfaces between primary care and behavioral health, as well as ongoing assessment and analysis of potential opportunities for healthcare coordination and improvement.

HFS is responsible for developing an overarching agency quality improvement strategy, coordinating agency-wide initiatives and overseeing the development of outcome measurements, and implementing quality improvement projects (QIPs) for providers and managed care/care coordination programs. They evaluate the quality and effectiveness of Medicaid funded programs by systematically monitoring and evaluating the quality of care and services; overseeing the design, implementation, monitoring, and evaluation of statewide quality management activities; and developing and implementing a quality management workplan that identifies specific activities, measures, indicators, and health equity.

HFS is also responsible for the oversight, monitoring, and evaluation of quality assurance to ensure health plans comply with state standards, federal regulations, and contract requirements. HFS monitors each health plan's compliance with the goals and objectives identified in the HFS Comprehensive Medical Programs Quality Strategy (adopted in accordance with federal regulations at 42 CFR 438.340) via its internal quality management program and onsite reviews. The pillars of this Quality Strategy are outlined in the table below.

**Table 6. HFS Quality Pillars of Improvement and Associated Goals**

| Pillar | Goals |
|---|---|
| Maternal and Child Health | Improve Maternal and Infant Health Outcomes<br>• Reduce pre-term birth rate and infant mortality<br>• Improve the rate and quality of postpartum visits<br>• Improve well-child visit rates for infants and children<br>• Increase immunization rates for infants and children |
| Adult Behavioral Health | Improve Behavioral Health Services and Supports for Adults with Mental Illness<br>• Improve integration of physical and behavioral health<br>• Improve transitions of care from inpatient to community-based services<br>• Improve care coordination and access to care for individuals with alcohol and/or SUD |
| Child Behavioral Health | Improve Behavioral Health Services and Supports for Children with Mental Illness<br>• Improve integration of physical and behavioral health<br>• Improve transitions of care from inpatient to community-based services<br>• Reduce avoidable psychiatric hospitalizations through improved access to community-based services<br>• Reduce avoidable ED visits by leveraging mobile crisis response |
| Equity | Increase Preventive Care Screenings – Use Data to Identify Target Areas, in Priority Regions, Where Disparities in Optimal Outcomes are the highest<br>• Focus on health equity |
| Community-Based Services and Supports | Serve More People in the Settings of their Choice |

| Pillar | Goals |
| --- | --- |
| | • Increase the percentage of older adults and people receiving institutional care to community or home-based programs to maximize the health and independence of the individual |

HFS' EQRO, Health Services Advisory Group, Inc., conducts compliance reviews at least once every three years. The purpose of the reviews is to determine a health plan's understanding and application of federal regulations and contractually required standards from a review of documents, observations, and interviews with key health plan staff, as well as file reviews conducted during an onsite evaluation. The reviews include an assessment of each plan's quality improvement structure. This structure is necessary in facilitating quality improvement of performance measures and performance improvement projects (PIPs), which measure each health plan's performance in achieving quality goals and objectives identified in HFS' Quality Strategy. The report enables health plans to implement improvement interventions to correct any areas of deficiency. The report also helps HFS determine each health plan's compliance with the contract and identify contractual areas that need to be modified or strengthened to ensure that a health plan complies with the standards and can achieve the goals and objectives identified in the Quality Strategy.

HFS hosts monthly conference calls and quarterly business review meetings with health plans to provide a forum for discussing quality of care and outcomes for Illinois Medicaid customers. During these meetings, HFS and health plan staff review and discuss performance measure results, PIP results, and whether the quality improvement outcomes align with the Quality Strategy goals and objectives. The meetings include representatives from the Managed Care Organization Quality Team, the Quality Management Team, the Managed Care Team, and other units with a vested interest in the topic being discussed. The representatives discuss quality objectives and policies and procedures, as well as provide resources and guest speakers to discuss outcomes and evidence-based interventions.

Quarterly Monitoring Reports are submitted to HFS for review and discussion during the Quarterly Quality Meeting. These reports include data relative to the quality measures identified, member and provider outreach, and any new initiatives related to the quality measures. In an effort to align health plan reporting, HFS created a template identifying general and specific reporting instructions to provide essential guidance for effectively comparing performance. Further, the health plans are required to present information on quality improvement results, barrier analyses, and planned quality improvement activities to be implemented to overcome obstacles that impede performance. Each plan is asked to provide HFS with a presentation on its recent activities and developments. This time also provides the opportunity for the health plans to ask any operational questions or receive assistance from HFS.

In addition, the Medicaid Advisory Committee (MAC) advises HFS with respect to policy and planning related to the health and medical services provided under HFS' medical programs pursuant to federal Medicaid requirements established in 42 CFR 431.12. The MAC consists of up to 15 members, at least five of whom must be consumers or advocates. The MAC meets six times a year and has five subcommittees: Quality Care, Public Education, Pharmacy, Health Equity, and Telemedicine. The subcommittees are supported by work groups.

**Summary of Recent Quality Assurance Findings**:
HSAG derived the below findings and conclusions after completing analyses and evaluations of external quality review activity findings from state FY 2021 to comprehensively assess the health plans' performance in providing quality, timely, and accessible healthcare services to Medicaid and CHIP

members. For each health plan reviewed, HSAG completes a summary of its overall key findings, conclusions, and recommendations based on the health plan's performance. The overall findings and conclusions for all health plans were also compared and analyzed to develop the following key findings relevant to the overarching goals and objectives of this demonstration extension:

Positive Relevant Outcomes:

- Overall, health plans have effective systems and processes to identify, report, address, and seek to prevent critical incidents (CIs) as determined by quarterly reviews of CI records.
- The HealthChoice Illinois statewide average of 95 percent and MMAI Statewide average of 90 percent for compliance review performance indicated that health plans' policies and procedures (P&Ps) are generally compliant with federal standards and the State contract requirements.
- Health plans demonstrated increased compliance with case management staffing and training requirements, including qualifications and related experience, caseload assignments, and training.
- All HealthChoice Illinois health plans were fully compliant with all HEDIS Information System (IS) standards, all data supported the elements necessary for HEDIS reporting, all measure calculations resulted in rates that were not significantly biased, and all performance measures under the scope of the audit received a Reportable designation.
- All but one health plan in both HealthChoice Illinois and MMAI performed at or above 90 percent in demonstrating compliance to CMS HCBS performance measures, as identified via the quarterly HCBS record reviews.
- Experience survey (CAHPS) results showed a statistically significant improvement from last year for Getting Needed Care, which indicates that adult members perceived they had a greater overall experience with access to the care they needed in 2020−2021.
- HealthChoice Illinois, including MLTSS and MMAI health, contracted with a sufficient range of required provider types within each service region as verified by the analysis and monitoring of the provider networks.

Opportunities to Improve:

- Adult members are not obtaining preventive or ambulatory visits, indicating that acute issues are not being addressed or chronic conditions are not being managed.
- Members who were hospitalized for mental illness are not accessing or receiving timely follow-up care as indicated by overall low rates across all age groups for the Follow-Up After Hospitalization for Mental Illness (FUH) measure and levels of low confidence validation results across all health plans' FUH PIPs.
- The time/distance study identified regional gaps in access to oral surgery providers and pharmacies.
- Adult consumer experience survey results were below the 50th percentile for every measure except one, which indicates that members perceive a lack of access to timely care, as well as an overall inadequate quality of care.

Illinois will continue to use its quality framework and HSAG-derived data to implement recommendations of improvement around the quality, timeliness, and accessibility of care of services provided to Medicaid enrollees through the demonstration.

The full external quality review annual report for state FY 2020−2021 (July 1, 2020 − June 30, 2021), as well as past EQRO and other quality assurance technical reports, can be accessed at: https://www2.illinois.gov/hfs/info/reports/Pages/default.aspx.

# IX. Interim Evaluation Report Summary – Initial Demonstration Period

As discussed in Section II, the start of the 1115 demonstration program experienced several delays as a result of comprehensive managed care changes, a change in administration following the 2018 election cycle, and the worldwide COVID-19 pandemic and related shutdowns. Several staffing changes and shortages throughout administrative and provider agencies also led to transitions in processes between the Department of Human Services – Substance Use Prevention and Recovery (SUPR) and HFS. By the end of demonstration year one, four pilots had begun. Over the course of the demonstration, two pilots were moved to 1915(i) waiver authority and are now part of the Pathways to Success Program, and three pilots are in the process of transitioning to a state plan amendment. Four pilots are planned for incorporation in this demonstration extension.

The interim evaluation report, conducted by independent evaluator, the Center for Prevention Research and Development (CPRD) at the University of Illinois at Chicago, describes progress and challenges experienced through demonstration year three. The evaluation compares data from the year prior to the start of the demonstration (2017) until just over halfway through current demonstration year five (2022). Approved by CMS, the evaluation design for the initial five-year demonstration period chose 18 metrics to address evaluation questions based on the six original 1115 demonstration milestones identified in Table 2 under application Section II. These metrics were evaluated using Medicaid claims data provided by Office of Medicaid Innovation (OMI) at the University of Illinois. Despite various challenges with the data, CPRD was able to analyze changes over time and conduct significance testing to measure progress on each of the metrics.

The analysis found that seven of the 18 (39%) metrics are trending in the expected direction, ten (56%) have remained consistent, and one (5%) is moving in the opposite direction. The progress shown was statistically significant when analyzed with Pearson's Chi-Square. Looking across the data, the metrics that are preventive of consequences are showing change (i.e., fewer beneficiaries are using a high dosage of opioids or taking benzodiazepines and opioids at the same time), while consequences (emergency room visits and overdose deaths) are remaining steady.

Based on the data presented, it is likely that more time is needed to see progress on the metrics used in the evaluation. The COVID-19 pandemic prevented the full implementation of several pilot programs and delayed care across the healthcare spectrum. Furthermore, unexpected changes in care occurred because of the pandemic, including higher usage of telehealth services, increased ED visits due to the closure of some services, and potential delays in care post-shutdown as a result of closures and staffing shortages.

Nonetheless, 39 percent of the metrics are progressing as expected. Of the 10 metrics that have remained consistent, a few are beginning to stabilize and have the potential to show change in the final two years of the five-year waiver period. The metric that is moving in the opposite direction could also be due to the delays in services post-pandemic. Postpartum care is an ongoing service that may not have had time to recover because of the closure of certain services and known staffing shortages.

DHS has learned several lessons from the initial demonstration period, despite limited implementation. The largest barrier to the demonstration involved multiple delays because of administrative changes and the pandemic, which have had a lasting impact on the ability of provider agencies throughout the state to staff and administer treatments and programs to Medicaid beneficiaries diagnosed with an SUD. Like other states, Illinois had to pivot its focus during the pandemic and has only recently been able to pass policies and begin new programs. However, the data overall are showing that Illinois is on the right path and, given more time with policies and programs in place, we believe that the impact of the demonstration on Medicaid beneficiaries will be resoundingly positive.

CPRD has offered three recommended actions for the demonstration extension: 1) address workforce challenges, 2) address structural factors that may drive differences in access and quality for specific racial and ethnic groups, and 3) better define recovery capital. First, as workforce shortages have plagued the service delivery system since the pandemic, CPRD recommends estimating the number of additional providers required to serve the Medicaid population and invest in additional workforce development initiatives as appropriate. Regarding structural factors that are driving race/ethnicity differences in access and quality of care, one potential solution to dismissal issues or cultural humility issues in contracted providers may be to a) require all providers to report their length of stay/engagement metrics by racial/ethnicity, and b) offer enhanced rates to providers that have a very low racial/ethnic disparities rates in such metrics. Additionally, technical assistance to agencies that have high disparities could be offered or beneficiary studies of experiences of racial/ethnic microaggressions during care could be conducted.

The full draft Preliminary Interim Evaluation Report for the initial demonstration approval period is provided in Attachment B. The CMS approved evaluation design for the initial five-year demonstration period also can be accessed at: [https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/il-behave-health-transform-appvd-eval-des-08132021](https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/il-behave-health-transform-appvd-eval-des-08132021).

# X. Evaluation Design Framework for the Demonstration Extension

In alignment with the new focus of the **Illinois Healthcare Transformation Section 1115 Demonstration** and the recommendations posed by the interim evaluation findings, Table 7 outlines the proposed preliminary evaluation plan design framework for the demonstration extension, including the goals, hypotheses, and possible measures for each proposed pilot. The evaluation design will consider and incorporate additional HEDIS, CAHPS, or other health outcome measures that data can track.

**Table 7. Proposed Preliminary Evaluation Plan**

| Initiative | Initiative-Specific Goals | Hypotheses | Possible Measures |
|---|---|---|---|
| *Overarching health equity goals (aligned with CMS's health equity priority areas):*<br>*1. Identify and assess causes of disparities, including the identification and revision of policies and operations that perpetuate health inequities in order to effectively close gaps in health and improve healthcare access, quality, and outcomes*<br>*2. Implement effective technologies and solutions that expand data collection, reporting, and analysis in order to make data-informed and person-centered decisions that will lead to better access to equitable care and coverage*<br>*3. Create and sustain capacity within healthcare organizations with a workforce skilled at meeting the unique needs of the communities of Illinois*<br>*4. Offer culturally and linguistically responsive care, providing communities with improved health care, patient safety, and experiences* | | | |

| Initiative | Initiative-Specific Goals | Hypotheses | Possible Measures |
|---|---|---|---|
| *5. Tailor programs to individuals and communities, resulting in improved access to care and services* | | | |
| Treatment for individuals with (SUD) | Increased rates of identification, initiation, and engagement in treatment.<br><br>Increased adherence to and retention in treatment.<br><br>Reductions in overdose deaths, particularly those related to opioid use.<br><br>Reduced use of EDs and inpatient hospital settings for treatment in cases where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.<br><br>Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.<br><br>Improved access to care for physical health and behavioral health conditions among beneficiaries. | The demonstration will increase the percent of members referred to and engaging in SUD treatment.<br><br>The demonstration will increase the percent of members adhering to SUD treatment.<br><br>The demonstration will result in decreased opioid-related overdose deaths.<br><br>The demonstration will result in fewer ED visits for SUD in the member population.<br><br>The demonstration will reduce readmissions to the same or higher levels of SUD care.<br><br>The demonstration will increase the percentage of members with SUD who access care for physical health conditions. | Process:<br>• Initiation and engagement in SUD treatment<br>• Initiation and engagement of SUD treatment<br>• Access to preventive and ambulatory health services for adult Medicaid beneficiaries with SUD<br>• Tobacco use screening and follow-up for people with alcohol or other drug dependence<br>• Annual dental visits (SUD diagnosis)<br>• Adolescent well-care visits (SUD diagnosis)<br>• Prenatal and postpartum care timeliness (SUD diagnosis)<br>• Prenatal and postpartum care (SUD diagnosis)<br>Outcome (stratified by race/ethnicity):<br>• Percentage of beneficiaries with an OUD/SUD diagnosis who used SUD services per month<br>• Continuity of pharmacotherapy for OUD<br>• Continuity of care after inpatient or residential treatment for SUD<br>• Continuity of care after medically |

| Initiative | Initiative-Specific Goals | Hypotheses | Possible Measures |
|---|---|---|---|
| | | | managed withdrawal from alcohol and/or drugs<br>• Opioid overdose deaths<br>• Use of opioids at high dosage in people without cancer per 1,000 Medicaid beneficiaries<br>• Concurrent use of opioids and benzodiazepines per 1,000 Medicaid beneficiaries<br>• ED utilization for SUD per 1,000 Medicaid beneficiaries<br>• ED utilization for OUD per 1,000 Medicaid beneficiaries<br>• Inpatient stays for SUD per 1,000 Medicaid beneficiaries<br>• Inpatient stays for OUD per 1,000 Medicaid beneficiaries<br>• 30-day readmission for SUD treatment |
| Healthcare Transformation Collaboratives | Reorient the healthcare delivery system in Illinois around people and communities.<br><br>Address SDOH, improve care delivery at the local level and address racist structures that create disparate health outcomes. | Healthcare Transformation Collaboratives will increase access to services, decrease avoidable ED use and hospitalizations, improve maternal and infant health outcomes, and improve health and quality of life. | Process:<br>• Completed SDOH assessments<br>• HRSN service use<br>• CHW workforce trained and hired<br>Outcome (stratified by race/ethnicity):<br>• ED utilization<br>• Hospital utilization and length of stay<br>• HEDIS measures such as: use of preventive services (e.g., PCP visits) |

| Initiative | Initiative-Specific Goals | Hypotheses | Possible Measures |
|---|---|---|---|
| | | | and use of SUD and/or BH services<br>Health Outcomes (stratified by race/ethnicity):<br>• Control and prevalence of chronic conditions such as asthma, diabetes, COPD, heart disease<br>• Maternal and infant morbidity and mortality |
| Justice-Involved Reentry | Improve the coordination of care and supports available before and during transitions. | Better coordination and supports for justice-involved individuals to prepare for and assist in community integration will result in lower rates of recidivism, decrease ED utilization, increase use of preventive care, and improve health outcomes related to SUD and/or BH, as well as co-occurring conditions. | Process:<br>• Numbers of individuals auto enrolled<br>• HRSN service use<br>Outcome:<br>• Recidivism rates<br>• ED utilization<br>• Employment rates<br>• HEDIS measures such as: use of preventive services (e.g., primary care visits) and use of SUD and/or behavioral health services |
| Violence Prevention and Intervention | Prevent violence, including gun violence, as well as reduce the health impacts of prolonged and chronic stress and trauma resulting from violence. | Community-led violence prevention initiatives, coupled with person-centered and trauma-informed case management and other services will reduce violence, including gun violence, and will reduce health effects of prolonged and chronic stress and trauma. | Process:<br>• Violence Prevention Community Support team service use<br>• HRSN service utilization<br>Outcome:<br>• Violence rates<br>• Reports of chronic stress or trauma |
| Outreach and Engagement | To improve the health and well-being of individuals in underserved communities. | By coordinating primary care services with a focus on preventive health and culturally responsive enhanced care management services in underserved communities, this program will increase access to | Process:<br>• Service utilization<br>• Patient hub utilization<br>Outcome (stratified by race/ethnicity):<br>• ED utilization |

| Initiative | Initiative-Specific Goals | Hypotheses | Possible Measures |
|---|---|---|---|
| | | services, decrease avoidable ED use and hospitalizations, and improve health and quality of life. | • Hospital utilization and length of stay<br>• HEDIS measures such as: use of preventive services (e.g., primary care visits) and usage of SUD and/or behavioral health services<br>Health Outcomes (stratified by race/ethnicity):<br>• Control and prevalence of chronic conditions such as asthma, diabetes, COPD, heart disease<br>• Maternal and infant morbidity and mortality |
| Community Health Worker Training | To identify, recruit, train, and certify a workforce of CHWs who will serve in the communities where they live. | Investments in CHW training and certification will:<br>• Increase access to services through the Healthcare Transformation Collaboratives, thus reducing avoidable ED use and hospitalizations, improve maternal and infant health outcomes, other health outcomes, and enhance quality of life<br>• Promote a pathway for employment and career development, which will increase job satisfaction and retention<br>• Bridge the gap between health-related social and medical needs, which will increase use of preventive care | Process:<br>• Number of CHWs trained and certified in the state<br>• Number of trained and certified CHWs working in the Healthcare Transformation Collaboratives<br>• CHW retention and turnover rates within Healthcare Transformation Collaboratives<br>Outcome:<br>• CHW caseloads and ED utilization and hospitalization rates<br>• CHW caseloads and maternal and infant outcomes<br>Health Outcomes (stratified by race/ethnicity):<br>• Control and prevalence of |

| Initiative | Initiative-Specific Goals | Hypotheses | Possible Measures |
|---|---|---|---|
| | | | chronic conditions such as asthma, diabetes, COPD, heart disease<br>• Maternal and infant morbidity and mortality |
| Safety Net Hospital Health Equity Transformation Program | To ensure that vulnerable people and communities have access to quality healthcare. | Intentional investments in projects that reduce health disparities, advance health equity, improve access to providers of care, or the quality of healthcare services will improve the quality indicators of a hospital and improve the health outcomes in a community. | Process:<br>• Hospital quality indicators<br>Outcome (stratified by race/ethnicity):<br>• ED utilization<br>• Hospitalization and length of stay<br>• HEDIS measures such as: use of preventive services (e.g., primary care visits) and SUD and/or BH services<br>Health Outcomes (stratified by race/ethnicity):<br>• Control and prevalence of chronic conditions such as asthma, diabetes, COPD, heart disease<br>• Maternal and infant morbidity and mortality |
| Housing Support Services | To provide care coordination and other proven strategies to help people experiencing homelessness, or at risk of becoming homeless, to stay in stable and secure housing situations. | Coordinated and comprehensive housing support services will reduce the burden of chronic health conditions as well as reducing costs related to ED/hospitalizations and institutional care. | Process:<br>• HRSN service use<br>Outcome:<br>• Report of stable housing<br>• Control and prevalence of chronic conditions such as asthma, diabetes, COPD, heart disease<br>• ED utilization<br>• Hospital utilization and length of stay |
| Supported Employment Services | To promote an Illinois workforce that is sufficiently | Coordinated and comprehensive employment support services will improve | Process:<br>• HRSN service use<br>Outcome: |

| Initiative | Initiative-Specific Goals | Hypotheses | Possible Measures |
|---|---|---|---|
| | sized, diversified, culturally competent, and trained. | quality of life, mental health, and global functioning. | • Employment rates<br>• Service utilization for mental health related issues<br>• Global function assessment |
| Continuum of Care Licensure | To protect the welfare, safety, and rights of individuals with I/DD by establishing a model of care that can transition persons in a seamless and timely manner across the continuum. | Promote disability inclusion by addressing SDOH to increase the health and well-being of these Medicaid beneficiaries.<br><br>There will be a decrease in resident and family reports of administrative burden related to any transition as a result in a change in level of care needed. | Process:<br>• Employment Support Services usage<br>• Transitions between locations<br>Outcome: Resident/family report of administrative burden |

# XI. Budget Neutrality over Current Demonstration Period (DY01 – DY05)

As mentioned in the Historical Program Overview, Section II, the overall start-up and implementation of the original 10 demonstration pilots (as listed on pages 2-3) were delayed due to a combination of circumstances, some unforeseen, within the state. In summary, those challenges were: a) significant overhaul of Illinois' managed care landscape into a single streamlined program, b) changes in Illinois' gubernatorial administration, and c) the designation of the COVID-19 PHE and related immediate priorities to address this crisis. Only four of the 10 original pilots were implemented to varying degree. As implementation of these four pilots began to ramp up, HFS experienced another unforeseen complication caused by an internal system edit to the state's Medicaid eligibility system that affected the department's ability to separately identify certain claims derived from the coverage authorized under the 1115 demonstration.

Thereby, certain 1115 derived services are being reimbursed as part of MCOs capitated payment. This change did not affect services provided to demonstration enrollees. The impact of this generally routine eligibility system edit on 1115 claiming was not fully realized until the third year (i.e., mid-2020) of the currently approved demonstration period, as reported to CMS. Since identifying the issue, HFS has worked diligently to fully assess and develop a solution to the claiming issue going forward with the extension of the demonstration that will be discussed further below. However, while the current claiming system edit is still in effect, HFS has used alternative approaches to extract available enrollment and expenditure data for the current demonstration approval period. Data were pulled from the HFS Enterprise Data Warehouse (EDW) using a known set of identifiers for the providers (Provider Type 75), the Participants (OBRA Code RB, RC, or RD) and the Pilot service procedure (HCPCS Code H0006, H0012, or H2014). To confirm the claim was valid, the delivering provider NPI was checked against a known set of Eligible Provider Participating in the Pilots.

**<u>SUD Case Management Pilot</u>**

The current approved budget neutrality "without waiver" capped enrollment for each demonstration year. HFS was able to extract some data on the unduplicated number of individuals who received a

service under this pilot and cost data when certain service procedure codes were applied in alignment with the benefit. The claims data reviewed allowed a calculation of individuals by unique ID but did not support a calculation of member months for a per person, per month (PMPM) assessment.

**Table 8. SUD Case Management Enrollment and Funding Levels**

| Demonstration Year (DY) | Estimated 1115 Enrollees Who Received SUD Case Management | Estimated 1115 Expenditures SUD Case Management |
|---|---|---|
| DY01 | 351 | $1,067 |
| DY02 | 1,008 | $3,645 |
| DY03 | 911 | $75,367 |
| DY04 | 1,054 | $196,139 |
| DY05 | 1,054 | $196,139 |

Though the above enrollment and expenditure data do not lend to a traditional "without waiver" versus "with waiver" comparative approach to budget neutrality, we believe the data does soundly suggest that this 1115 pilot did not exceed the expected "without waiver" ceiling for the current demonstration period. The state stayed well within the established STC enrollment limits that ranged from 2,040 in DY1 up to 2,835 enrollees in DY5. Per the approved STCs, the "without waiver" ceiling for this pilot just for demonstration year one was expected to be $3,236,746 (this number is based on the full enrollment limit of 2,040 enrollees or 24,480 member months at the "without waiver" PMPM cost of $132.22). Because of the limited ability to fully implement this pilot as discussed, the total estimated five-year cost of $472,357 (totaling the above annual estimated costs) is far lower than the level of spending that was anticipated for the demonstration pilot. Thereby, though not a traditional PMPM budget neutrality calculation, it does align with the intended nature of budget neutrality in that is indicates that the expenditures were no more than expected federal Medicaid outlays.

**<u>Peer Recovery Support Services Pilot</u>**

The approved budget neutrality "without waiver" authorized capped enrollment for each demonstration year. The implementation of this pilot occurred nearly concurrent to the effective date of the HFS eligibility system edit that limited the separate identification of 1115 specific service costs. Consequently, no claims data or utilization data could be identified in the MCO data set examined for the initial five-year demonstration period. Because payment for peer recovery support services happened through capitated MCO payments, the level of spending is expected to be within the parameters of the STC PMPM without waiver expenditure ceilings for this pilot, which ranged from $162.50 in DY1 up to $173.83 in DY5. Enrollment also was limited because of implementation challenges; however, the claims data reviewed allowed identification of unduplicated person counts by unique ID. The state stayed well within the established enrollment limits as reflected in Table 9.

**Table 9. Peer Recovery Support Services Enrollment Levels**

| Demonstration Year (DY) | Estimated "Without Waiver" Enrollee Limit per STCs | Estimated 1115 Enrollees that Received Peer Recovery Support |
|---|---|---|
| DY01 | 160 | 23 |
| DY02 | 240 | 38 |
| DY03 | 240 | 54 |
| DY04 | 320 | 47 |
| DY05 | 320 | 47 (estimated) |

Although the data do not permit a traditional PMPM budget neutrality calculation, the limited implementation of this pilot, along with the level of funding for MCO capitation payments, suggests that this pilot did not exceed expected federal Medicaid outlays for current the demonstration period.

**Clinically Managed Withdrawal Management Services Pilot**

The current approved budget neutrality "without waiver" capped enrollment for each demonstration year. The implementation of the HFS eligibility system edit similarly affected the ability to develop a traditional "without waiver" versus "with waiver" comparative approach to budget neutrality. The limited implementation of this demonstration pilot was compounded by low beneficiary take-up of this 1115 service. Minimal expenditures are reported on the MBES/CBES CMS 64 for the first two demonstration years as ramp up was starting just before the effective date of the eligibility system edit. Those expenditures are reported in Table 10. HFS was able to extract data on the unduplicated number of individuals who received a service under this pilot as reflected in the below table. The claims data reviewed allowed identification of persons by unique ID but did not support a calculation of "member months." Further, the expenditures reported on the MBES/CBES CMS 64 were too limited to produce a traditional PMPM assessment.

**Table 10. Clinically Managed Withdrawal Management Services Enrollment and Funding Levels**

| Demonstration Year (DY) | Estimated Number of 1115 Enrollees that Received Withdrawal Management Services | 1115 Expenditures Reported on CMS 64 as of Qtr 1/2023 |
|---|---|---|
| DY01 | 15 | $1,003 |
| DY02 | 45 | $3,620 |
| DY03 | 8 | $0 |
| DY04 | 1 | $0 |
| DY05 | 1 | $0 |

While the above enrollment and expenditure data does not lend to a traditional without waiver versus with waiver comparative approach to budget neutrality, we believe they do suggest that this 1115 pilot did not exceed the expected without waiver ceiling for the current demonstration period. Per the approved STCs, the without waiver ceiling for this pilot just for DY1 was expected to be $25,947,000 (this number is based on the full enrollment limit of 3,875 enrollees or 46,500 member months at the DY1 PMPM cost ceiling of $558.00). Although the data do not permit a traditional PMPM budget neutrality calculation, the limited implementation of this pilot, along with the level funding for MCO capitation payments, suggests that this pilot did not exceed expected federal Medicaid outlays for current the demonstration period.

**SUD IMD Pilot**

The aforementioned system edits similarly affected HFS' ability to develop a traditional "without waiver" versus "with waiver" comparative approach to budget neutrality. Expenditures are reported on the MBES/CBES CMS 64 for the first three demonstration years, but these expenses do not reflect full implementation of this service initiative based on the reporting issues. The expenditures in Table 10 are derived from HFS EDW fee-for-service and encounter claims that had certain procedure codes that aligned with the SUD criteria. HFS was able to extract data on the unduplicated number of individuals who received a service under this pilot (see Table 11). The claims data reviewed allowed identification of

individuals by unique ID but did not support a calculation of member months. Further, the expenditures reported on the MBES/CBES CMS 64 were too limited to produce a traditional PMPM assessment.

**Table 11. Estimated SUD IMD Enrollment and Funding Levels**

| Demonstration Year (DY) | Estimated Number of 1115 Enrollees that Received SUD IMD Services | Estimated "With Waiver" Expenditures (total computable) |
|---|---|---|
| DY01 | 1,581 | $ 5,355,026 |
| DY02 | 2,323 | $ 10,745,703 |
| DY03 | 4,051 | $ 20,902,571 |
| DY04 | 4,110 | $ 22,855,131 |
| DY05 | 1,989 | $ 9,416,253 |

Though the above enrollment and expenditure data do not lend to a traditional "without waiver" versus "with waiver" comparative approach to budget neutrality, we believe the total estimated cost of $69,274,684 did not exceed the expected "without waiver" expenditure levels approved for the current five-year demonstration period.

**Program Adjustments for the Extension**

As indicated above, HFS has assessed the full reach of the current eligibility system edit as it pertains to the HRSN benefits proposed for the 1115 extension of this demonstration. Learning from early implementation challenges, HFS is implementing the following steps to ensure data are captured, tracked, and available for reporting in accordance with CMS's expectations for budget neutrality:

- Recipient Data Base (RDB): Clients eligible for the demonstration will be flagged on the RDB with begin and end dates denoting their eligibility for the demonstration.
- Provider Enrollment (PE): Providers participating in the waiver will be enrolled in the PE system with the services they are eligible to provide under the demonstration.
- Edits in the system will be configured to allow the providers eligible to provide the demonstration services to bill for those services and the claims will be flagged in the system as demonstration services for federal reporting.
- MCO reporting will include members eligible for the demonstration so the MCOs can ensure they are receiving the services as part of their care coordination.

HFS will closely monitor claims upon effectuation of these eligibility system edits to ensure no further programming edits may be needed, though none are foreseen at this time.

# XII. Budget Neutrality for the Demonstration Extension (DY06 – DY10)

In accordance with other CMS 1115 approvals with HRSN related authorities, HFS is requesting a hypothetical budget neutrality methodology for the HRSN service and infrastructure initiatives to be implemented over the extension period. CMS's articulated budget neutrality principles indicate that when expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a "without waiver" spending baseline for certain "with waiver" expenditures is difficult to estimate because of variable and volatile cost data resulting in anomalous trend rates, CMS generally considers these expenditures to be "hypothetical," such that the

expenditures are treated as if the state could have received federal financial participation (FFP) for them absent the demonstration. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services.

The HRSN pilot initiatives and the Cook County DSH/Community Reinvestment Pool proposed for this demonstration extension aligns with CMS' parameters for hypothetical treatment. These initiatives will provide coverage or support the provision of clinically appropriate HRSN services to Medicaid eligibles. These initiatives are central to testing new approaches to help reimagine healthcare delivery to address health disparities and build sustainable equity models for healthcare delivery. As alluded to in Section II of this application, HFS' overall vision for this healthcare transformation effort is being driven by an unprecedented multifaceted restructuring that addresses critical gaps in both service and infrastructure across Illinois' healthcare system. The below annual, aggregate spending estimates for each demonstration year (i.e., DY6 through 10) reflect total costs to implement all benefit service initiatives.

HFS is similarly requesting hypothetical (i.e., "pass-through") expenditures to implement the legislatively directed continuum of care license and the Cook County DSH/Community Reinvestment pool. Benefit service estimates are derived from historical Medicaid state plan expenditures and actuarily appropriate evidence-based econometric methodologies to determine the budget neutrality expenditure limits for the hypothetical expenditures to implement the nine service and infrastructure SDOH pilots, as well as for the proposed hypothetical cap for the provision of the HRSN services. Total estimated expenditures to implement all program initiatives as described in this extension proposal are listed below. These expenditure estimates reflect total costs for the approximate 400,000 Medicaid-eligible individuals who will be enrolled in each year of the proposed demonstration extension period as mentioned in application Section IV.

**Table 12. Projected Expenditures for Proposed 1115 Services**

| DEMONSTRATION YEARS (DY) | | | | | | |
|---|---|---|---|---|---|---|
| **1115 Initiatives** | **DY 06** | **DY 07** | **DY 08** | **DY 09** | **DY 10** | **5-YEAR TOTALS** |
| **SUD Case Management** | $7,582,856 | $7,924,141 | $8,280,742 | $8,653,326 | $9,042,890 | $41,483,955 |
| **SUD Services in IMD** | $22,810,135 | $23,836,610 | $24,909,274 | $26,030,189 | $27,201,546 | $124,787,755 |
| **Justice-Involved Community Reintegration – Transitioning from Incarceration** | $47,115,847 | $92,317,613 | $115,766,286 | $127,696,645 | $140,466,310 | $523,362,701 |
| **HRSN Infrastructure** | $176,074,473 | $126,177,738 | $152,940,779 | $179,908,084 | $199,664,459 | $834,765,533 |
| **HRSN Services** | $697,922,016 | $715,007,183 | $866,664,412 | $1,019,479,142 | $1,131,431,937 | $4,430,504,690 |
| **Cook County Community Reinvestment Pool** | $331,000,000 | $331,000,000 | $331,000,000 | $331,000,000 | $331,000,000 | $1,655,000,000 |
| **Continuum of Care** | $56,191,914 | $58,720,550 | $61,362,975 | $64,124,309 | $67,009,903 | $307,409,650 |
| **TOTAL** | **$1,338,697,241** | **$1,354,983,835** | **$1,560,924,469** | **$1,756,891,694** | **$1,905,817,045** | **$7,917,314,284** |

# XIII. Waivers and Expenditure Authorities

**Waiver Authority**

The state is requesting the waivers listed in Table 12 under authority of section 1115(a)(1) of the Social Security Act to enable Illinois to implement the demonstration extension:

**Table 13. Requested Waivers**

| Section 1902 Provisions Proposed for Waiver | Rationale |
|---|---|
| Section 1902(a)(1) – State wideness | To enable Illinois to implement waiver elements on a regional and/or county basis |
| Section 1902(1)(10)(B) Amount, Duration, and Scope and Comparability | To enable Illinois to provide different services or interventions in various regions of the state and for different populations with the goal of directly addressing issues that affect health disparities and increase health equity |
| Section 1902(a)(23) Freedom of Choice | To the extent necessary to require default enrollment of the justice-involved populations into selected managed care entities |
| Section 1902(a)(13)(A) (insofar as it incorporates Section 1923) DSH | To exempt Illinois from making DSH payments to otherwise qualified institutions in cases where DSH funds are redirected toward approved Healthcare Transformation Collaborative activities focused on health equity |

**Expenditure Authority**

Under the authority of section 1115(a)(2) of the Social Security Act, we request authorization for costs not otherwise matchable as expenditures under section 1903 of the Social Security Act:

1. Payments directly to Healthcare Transformation Collaboratives and to the Outreach and Engagement Initiative for activities not traditionally included as Medicaid State Plan services to advance health equity and build capacity in underserved areas
2. Payments to support Violence Prevention and Intervention community-led activities not traditionally included as Medicaid state plan services to advance health equity and improve safety in Illinois communities
3. Services provided by continuum of care licensed facilities
4. Payments to cover infrastructure spending as part of the state's HRSN framework, including technology, development of business or operational practices, workforce development, and outreach, education, and stakeholder convening, including expenditure authority to cover Community Health Worker (CHW) training, certification, and recruitment activities not traditionally included as Medicaid state plan services to advance health equity, promote individual meaningful employment, and expand the workforce that provides high-quality care and services to Medicaid-eligible Illinoisans
5. Payments to cover the HRSN activities implemented under the Cook County Community Reinvestment Pool (Redirected DSH)
6. Payments to support projects identified through the Safety Net Hospital Health Equity Transformation Program

7. Services provided in residential and inpatient treatment settings that qualify as an institution for mental disease (IMD)
8. Substance Use Disorder (SUD) case management services
9. The following services to address HRSN:
    - Housing Support
    - Medical Respite
    - Food and Nutrition
    - Employment Assistance
    - Violence Prevention and Intervention
    - Non-Medical Transportation
    - Justice-Involved Community Reintegration: Transitioning from Incarceration
    - Community Reintegration: Transitioning from Institutions

# XIV. Public Notice and Public Comment Process

**Post-Award Public Meeting Forums**

Illinois uses the MAC as its Post-Award Forum. These committee meetings are accessible to the public and notices, agendas, and meeting minutes are posted on the HFS website. Notices are posted at least 30 days prior and include the date, time, and location of the meeting. Since the COVID-19 pandemic, virtual meetings occurred via WebEx in accordance with CMS guidance, though the 2020 and 2021 post-award annual meetings were deferred to address the urgent priorities of COVID-19 as well as due to the pilot implementation delays discussed under the "Historical Overview" section of this proposal. Illinois resumed its annual post-award meeting using the above-described MAC process and held its latest post-award forum on May 12, 2023.

**Public Notice and Input Process for Demonstration Extension**

**THIS SECTION RESERVED PENDING COMPLETION OF THE PUBLIC NOTICE PROCESS FOR THIS PROPOSED EXTENSION APPLICATION IN ACCORDANCE WITH FEDERAL REQUIREMENTS AT 42 CFR 431.408.**

Illinois will complete this section on the public notice and comment process for final submission to CMS.

## Attachment A: Budget Neutrality Worksheet

**5 YEARS OF HISTORIC DATA**

**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**

| SUD Case Management | HY 1 | HY 2 | HY 3 | HY 4 | HY 5 | 5-YEARS |
|---|---|---|---|---|---|---|
| TOTAL EXPENDITURES | $ 1,067 | $ 3,645 | $ 75,367 | $ 196,139 | $ 196,139 | $ 472,357 |
| ELIGIBLE MEMBER MONTHS | 3,939 | 11,293 | 10,735 | 12,379 | 12,379 | |
| PMPM COST | $ 0.27 | $ 0.32 | $ 7.02 | $ 15.84 | $ 15.84 | |
| TREND RATES | | | ANNUAL CHANGE | | | 5-YEAR AVERAGE |
| TOTAL EXPENDITURE | | 241.61% | 1967.68% | 160.25% | 0.00% | 268.21% |
| ELIGIBLE MEMBER MONTHS | | 186.73% | -4.94% | 15.31% | 0.00% | 33.15% |
| PMPM COST | | 19.14% | 2075.13% | 125.69% | 0.00% | 176.54% |

| Peer Recovery Support | HY 1 | HY 2 | HY 3 | HY 4 | HY 5 | 5-YEARS |
|---|---|---|---|---|---|---|
| TOTAL EXPENDITURES | N/A | N/A | N/A | N/A | N/A | $ - |
| ELIGIBLE MEMBER MONTHS | 264 | 445 | 643 | 556 | 556 | |
| PMPM COST | NA | NA | NA | NA | NA | |
| TREND RATES | | | ANNUAL CHANGE | | | 5-YEAR AVERAGE |
| TOTAL EXPENDITURE | | NA | NA | NA | NA | NA |
| ELIGIBLE MEMBER MONTHS | | 68.46% | 44.56% | -13.55% | 0.00% | 20.46% |
| PMPM COST | | NA | NA | NA | NA | NA |

| Withdrawal Management | HY 1 | HY 2 | HY 3 | HY 4 | HY 5 | 5-YEARS |
|---|---|---|---|---|---|---|
| TOTAL EXPENDITURES | $ 1,003 | $ 3,620 | $ - | $ - | $ - | $ 4,623 |
| ELIGIBLE MEMBER MONTHS | 31 | 81 | 15 | 2 | 2 | |
| PMPM COST | $ 32.79 | $ 44.56 | $ - | $ - | $ - | |
| TREND RATES | | | ANNUAL CHANGE | | | 5-YEAR AVERAGE |
| TOTAL EXPENDITURE | | 260.92% | -100.00% | NA | NA | -100.00% |
| ELIGIBLE MEMBER MONTHS | | 165.57% | -80.96% | -86.44% | 0.00% | -48.83% |
| PMPM COST | | 35.90% | -100.00% | NA | NA | -100.00% |

| Residential & Inpatient Treat | HY 1 | HY 2 | HY 3 | HY 4 | HY 5 | 5-YEARS |
|---|---|---|---|---|---|---|
| TOTAL EXPENDITURES | $ 5,355,026 | $ 10,745,703 | $ 20,902,571 | $ 22,855,131 | $ 9,416,253 | $ 69,274,684 |
| ELIGIBLE MEMBER MONTHS | 2,161 | 3,184 | 6,379 | 6,646 | 2,867 | |
| PMPM COST | $ 2,478.03 | $ 3,374.91 | $ 3,276.78 | $ 3,438.93 | $ 3,284.36 | |
| TREND RATES | | | ANNUAL CHANGE | | | 5-YEAR AVERAGE |
| TOTAL EXPENDITURE | | 100.67% | 94.52% | 9.34% | -58.80% | 15.15% |
| ELIGIBLE MEMBER MONTHS | | 47.34% | 100.35% | 4.19% | -56.86% | 7.32% |
| PMPM COST | | 36.19% | -2.91% | 4.95% | -4.49% | 7.30% |

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

| ELIGIBILITY GROUP | TREND RATE 1 | MONTHS OF AGING | BASE YEAR DY 00 | TREND RATE 2 | DEMONSTRATION YEARS (DY) DY 06 | DY 07 | DY 08 | DY 09 | DY 10 | TOTAL WOW |
|---|---|---|---|---|---|---|---|---|---|---|
| **SUD Case Management** | | | | | | | | | | |
| **Pop Type:** | **Hypothetical** | | | | | | | | | |
| Eligible Member Months | | | | 0.0% | 33,296 | 33,296 | 33,296 | 33,296 | 33,296 | |
| PMPM Cost | | | | 4.5% | $ 227.74 | $ 237.99 | $ 248.70 | $ 259.89 | $ 271.59 | |
| Total Expenditure | | | | | $ 7,582,856 | $ 7,924,141 | $ 8,280,742 | $ 8,653,326 | $ 9,042,890 | $ 41,483,955 |
| **SUD Services in IMD** | | | | | | | | | | |
| **Pop Type:** | **Hypothetical** | | | | | | | | | |
| Eligible Member Months | | | 6,646 | 0.0% | 6,646 | 6,646 | 6,646 | 6,646 | 6,646 | |
| PMPM Cost | | | $ 3,284.36 | 4.5% | $ 3,432.16 | $ 3,586.61 | $ 3,748.01 | $ 3,916.67 | $ 4,092.92 | |
| Total Expenditure | | | | | $ 22,810,135 | $ 23,836,610 | $ 24,909,274 | $ 26,030,189 | $ 27,201,546 | $ 124,787,755 |
| **Justice Involved Community Reintegration - Transitioning from Incarceration** | | | | | | | | | | |
| **Pop Type:** | **Hypothetical** | | | | | | | | | |
| Eligible Member Months | | | | | 28,549 | 53,530 | 64,236 | 67,804 | 71,373 | |
| PMPM Cost | | | | 4.5% | $ 1,650.34 | $ 1,724.60 | $ 1,802.21 | $ 1,883.31 | $ 1,968.06 | |
| Total Expenditure | | | | | $ 47,115,847 | $ 92,317,613 | $ 115,766,286 | $ 127,696,645 | $ 140,466,310 | $ 523,362,701 |
| **HRSN Infrastructure** | | | | | | | | | | |
| **Pop Type:** | **Hypothetical** | | | | | | | | | |
| Eligible Member Months | | | | | | | | | | |
| PMPM Cost | | | | | | | | | | |
| Total Expenditure | | | | | $ 176,074,473 | $ 126,177,738 | $ 152,940,779 | $ 179,908,084 | $ 199,664,459 | $ 834,765,533 |
| **HRSN Services** | | | | | | | | | | |
| **Pop Type:** | **Hypothetical** | | | | | | | | | |
| Eligible Member Months | | | | | | | | | | |
| PMPM Cost | | | | | | | | | | |
| Total Expenditure | | | | | $ 697,922,016 | $ 715,007,183 | $ 866,664,412 | $1,019,479,142 | $1,131,431,937 | $ 4,430,504,690 |
| **Continuum of Care** | | | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | | | |
| Eligible Member Months | | | 6,272 | 0.0% | 6,272 | 6,272 | 6,272 | 6,272 | 6,272 | |
| PMPM Cost | | | $ 8,025.59 | 4.5% | $ 8,959.17 | $ 9,362.33 | $ 9,783.64 | $ 10,223.90 | $ 10,683.98 | |
| Total Expenditure | | | | | $ 56,191,914 | $ 58,720,550 | $ 61,362,975 | $ 64,124,309 | $ 67,009,903 | $ 307,409,650 |
| **Cook County Community Reinvestment Pool** | | | | | | | | | | |
| **Pop Type:** | **Hypothetical** | | | | | | | | | |
| Eligible Member Months | | | | | | | | | | |
| PMPM Cost | | | | | | | | | | |
| Total Expenditure | | | | | $ 331,000,000 | $ 331,000,000 | $ 331,000,000 | $ 331,000,000 | $ 331,000,000 | $ 1,655,000,000 |

## DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

| ELIGIBILITY GROUP | DY 00 | DEMO TREND RATE | DY 06 | DY 07 | DY 08 | DY 09 | DY 10 | TOTAL WW |
|---|---|---|---|---|---|---|---|---|
| | | | DEMONSTRATION YEARS (DY) | | | | | |
| **SUD Case Management** | | | | | | | | |
| **Pop Type: Hypothetical** | | | | | | | | |
| Eligible Member Months | - | 0.0% | 33,296 | 33,296 | 33,296 | 33,296 | 33,296 | |
| PMPM Cost | $ - | | $ 227.74 | $ 237.99 | $ 248.70 | $ 259.89 | $ 271.59 | |
| Total Expenditure | | | $ 7,582,856 | $ 7,924,141 | $ 8,280,742 | $ 8,653,326 | $ 9,042,890 | $ 41,483,955 |
| **SUD Services in IMD** | | | | | | | | |
| **Pop Type: Hypothetical** | | | | | | | | |
| Eligible Member Months | 6,646 | 0.0% | 6,646 | 6,646 | 6,646 | 6,646 | 6,646 | |
| PMPM Cost | $ 3,284.36 | | $ 3,432.16 | $ 3,586.61 | $ 3,748.01 | $ 3,916.67 | $ 4,092.92 | |
| Total Expenditure | | | $ 22,810,135 | $ 23,836,610 | $ 24,909,274 | $ 26,030,189 | $ 27,201,546 | $ 124,787,755 |
| **Justice Involved Community Reintegration - Transitioning from Incarceration** | | | | | | | | |
| **Pop Type: Hypothetical** | | | | | | | | |
| Eligible Member Months | - | | 28,549 | 53,530 | 64,236 | 67,804 | 71,373 | |
| PMPM Cost | $ - | | $ 1,650.34 | $ 1,724.60 | $ 1,802.21 | $ 1,883.31 | $ 1,968.06 | |
| Total Expenditure | | | $ 47,115,847 | $ 92,317,613 | $ 115,766,286 | $ 127,696,645 | $ 140,466,310 | $ 523,362,701 |
| **HRSN Infrastructure** | | | | | | | | |
| **Pop Type: Hypothetical** | | | | | | | | |
| Eligible Member Months | - | 0.0% | - | - | - | - | - | |
| PMPM Cost | $ - | | $ - | $ - | $ - | $ - | $ - | |
| Total Expenditure | | | $ 176,074,473 | $ 126,177,738 | $ 152,940,779 | $ 179,908,084 | $ 199,664,459 | $ 834,765,533 |
| **HRSN Services** | | | | | | | | |
| **Pop Type: Hypothetical** | | | | | | | | |
| Eligible Member Months | - | 0.0% | - | - | - | - | - | |
| PMPM Cost | $ - | | $ - | $ - | $ - | $ - | $ - | |
| Total Expenditure | | | $ 697,922,016 | $ 715,007,183 | $ 866,664,412 | $ 1,019,479,142 | $ 1,131,431,937 | $ 4,430,504,690 |
| **Continuum of Care** | | | | | | | | |
| **Pop Type: Medicaid** | | | | | | | | |
| Eligible Member Months | 6,272 | 0.0% | 6,272 | 6,272 | 6,272 | 6,272 | 6,272 | |
| PMPM Cost | $ 8,025.59 | | $ 8,959.17 | $ 9,362.33 | $ 9,783.64 | $ 10,223.90 | $ 10,683.98 | |
| Total Expenditure | | | $ 56,191,914 | $ 58,720,550 | $ 61,362,975 | $ 64,124,309 | $ 67,009,903 | $ 307,409,650 |
| **Cook County Community Reinvestment Pool** | | | | | | | | |
| **Pop Type: Hypothetical** | | | | | | | | |
| Eligible Member Months | - | 0.0% | - | - | - | - | - | |
| PMPM Cost | $ - | | $ - | $ - | $ - | $ - | $ - | |
| Total Expenditure | | | $ 331,000,000 | $ 331,000,000 | $ 331,000,000 | $ 331,000,000 | $ 331,000,000 | $ 1,655,000,000 |

**NOTES**

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

**Budget Neutrality Summary**

**Without-Waiver Total Expenditures**

| | DEMONSTRATION YEARS (DY) | | | | | TOTAL |
|---|---|---|---|---|---|---|
| | DY 06 | DY 07 | DY 08 | DY 09 | DY 10 | |
| Medicaid Populations | | | | | | |
| Continuum of Care | $ 56,191,914 | $ 58,720,550 | $ 61,362,975 | $ 64,124,309 | $ 67,009,903 | $ 307,409,650 |
| TOTAL | $ 56,191,914 | $ 58,720,550 | $ 61,362,975 | $ 64,124,309 | $ 67,009,903 | $ 307,409,650 |

**With-Waiver Total Expenditures**

| | DEMONSTRATION YEARS (DY) | | | | | TOTAL |
|---|---|---|---|---|---|---|
| | DY 06 | DY 07 | DY 08 | DY 09 | DY 10 | |
| Medicaid Populations | | | | | | |
| Continuum of Care | $ 56,191,914 | $ 58,720,550 | $ 61,362,975 | $ 64,124,309 | $ 67,009,903 | $ 307,409,650 |
| TOTAL | $ 56,191,914 | $ 58,720,550 | $ 61,362,975 | $ 64,124,309 | $ 67,009,903 | $ 307,409,650 |

| VARIANCE | $ - | $ - | $ - | $ - | $ - | $ - |
|---|---|---|---|---|---|---|

**HYPOTHETICALS ANALYSIS**

**Without-Waiver Total Expenditures**

| | DEMONSTRATION YEARS (DY) | | | | | TOTAL |
|---|---|---|---|---|---|---|
| | DY 06 | DY 07 | DY 08 | DY 09 | DY 10 | |
| SUD Case Management | $ 7,582,856 | $ 7,924,141 | $ 8,280,742 | $ 8,653,326 | $ 9,042,890 | $ 41,483,955 |
| SUD Services in IMD | $ 22,810,135 | $ 23,836,610 | $ 24,909,274 | $ 26,030,189 | $ 27,201,546 | $ 124,787,755 |
| Justice Involved Community Reintegration - T | $ 47,115,847 | $ 92,317,613 | $ 115,766,286 | $ 127,696,645 | $ 140,466,310 | $ 523,362,701 |
| HRSN Infrastructure | $ 176,074,473 | $ 126,177,738 | $ 152,940,779 | $ 179,908,084 | $ 199,664,459 | $ 834,765,533 |
| HRSN Services | $ 697,922,016 | $ 715,007,183 | $ 866,664,412 | $ 1,019,479,142 | $ 1,131,431,937 | $ 4,430,504,690 |
| Cook County Community Reinvestment Pool | $ 331,000,000 | $ 331,000,000 | $ 331,000,000 | $ 331,000,000 | $ 331,000,000 | $ 1,655,000,000 |
| TOTAL | $ 1,282,505,328 | $ 1,296,263,284 | $ 1,499,561,494 | $ 1,692,767,385 | $ 1,838,807,143 | $ 7,609,904,634 |

**With-Waiver Total Expenditures**

| | DEMONSTRATION YEARS (DY) | | | | | TOTAL |
|---|---|---|---|---|---|---|
| | DY 06 | DY 07 | DY 08 | DY 09 | DY 10 | |
| SUD Case Management | $ 7,582,856 | $ 7,924,141 | $ 8,280,742 | $ 8,653,326 | $ 9,042,890 | $ 41,483,955 |
| SUD Services in IMD | $ 22,810,135 | $ 23,836,610 | $ 24,909,274 | $ 26,030,189 | $ 27,201,546 | $ 124,787,755 |
| Justice Involved Community Reintegration - T | $ 47,115,847 | $ 92,317,613 | $ 115,766,286 | $ 127,696,645 | $ 140,466,310 | $ 523,362,701 |
| HRSN Infrastructure | $ 176,074,473 | $ 126,177,738 | $ 152,940,779 | $ 179,908,084 | $ 199,664,459 | $ 834,765,533 |
| HRSN Services | $ 697,922,016 | $ 715,007,183 | $ 866,664,412 | $ 1,019,479,142 | $ 1,131,431,937 | $ 4,430,504,690 |
| Cook County Community Reinvestment Pool | $ 331,000,000 | $ 331,000,000 | $ 331,000,000 | $ 331,000,000 | $ 331,000,000 | $ 1,655,000,000 |
| TOTAL | $ 1,282,505,328 | $ 1,296,263,284 | $ 1,499,561,494 | $ 1,692,767,385 | $ 1,838,807,143 | $ 7,609,904,634 |

| HYPOTHETICALS VARIANCE | $ - | $ - | $ - | $ - | $ - | $ - |
|---|---|---|---|---|---|---|

# Attachment B: Draft Preliminary Interim Evaluation Report

**Illinois Behavioral Health Transformation Section 1115(a) Demonstration**

**Interim Evaluation Report**

Prepared by:
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# Executive Summary

Illinois embarked on a transformation of the Health and Human Services (HHS) system beginning in 2016. The focus of this transformation was on behavioral health (mental health and substance use) service delivery. This was a priority for two reasons. First, data from the Illinois Department of Public Health[1,2] indicated that Illinois was experiencing a public health crisis related to opioids. Second, while only 25% of Medicaid beneficiaries have behavioral health needs, they account for 56% of all spending in Illinois. Therefore, Illinois proposed to implement limited pilots of certain services that were not previously available to Medicaid beneficiaries, which included less costly community-based services that were expected to improve the health and well-being of beneficiaries in Illinois.

The 1115 Medicaid Substance Use Disorder (SUD) demonstration waiver began on July 1, 2018, and is scheduled to end on June 30, 2023. Illinois identified 6 milestones to measure the impact of the waiver on Medicaid beneficiaries. These include:

1. Increased rates of identification, initiation, and engagement in treatment
2. Increased adherence to and retention in treatment
3. Reductions in overdose deaths, particularly those due to opioids
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate
6. Improved access to care for physical health and behavioral health conditions among beneficiaries

However, the start of the waiver experienced several delays due to current re-bidding of provider contracts, a change in administration following the 2018 election cycle, and the worldwide COVID-19 pandemic and related shutdowns. There were also several staffing changes and shortages throughout administrative and provider agencies, which led to transitions in processes between the Department of Human Services – Substance Use Prevention and Recovery (SUPR) and the Department of Healthcare and Family Services (HFS). By the end of demonstration year 1, four pilots had begun, another 4 pilots were moved to the State Plan Authority 1915(i) and are now part of the Pathways to Success Program, and the remaining two pilots are planned for incorporation into the waiver extension. With the revisions to the 1115 that removed the 1915(i)-like and home visiting pilots from its financial authority, HFS is concentrating the 1115 demonstration waiver on the improvement of Illinois' SUD delivery system. An effort that underscores the state's overall commitment to SUD transformation and aligns with ongoing efforts from SUPR to move the SUD service delivery system forward.

The evaluation provided in this report, conducted by the Center for Prevention Research and Development (CPRD) at the University of Illinois (independent evaluator), aims to describe progress and challenges experienced through demonstration year 3. The evaluation compares data from the year prior (2017) until just over halfway through the 5-year waiver. Eighteen metrics were chosen by CPRD, with input from SUPR, HFS, and CMS to address evaluation questions based on the 6 milestones identified above. These metrics were evaluated using Medicaid claims data provided by the Office of Medicaid Innovation (OMI) at the University of Illinois. Despite various challenges with the data, CPRD was able to analyze changes over time and conduct significance testing to measure progress on each of the metrics.

The analysis found that 7 of the 18 (39%) metrics are trending in the expected direction, 10 (56%) have remained consistent, and 1 (5%) is moving in the opposite direction. The progress shown was statistically significant when analyzed with Pearson's Chi-Square. Looking across the data, the metrics that are preventative of consequences are

showing change (i.e., less beneficiaries are using a high dosage of opioids or using benzodiazepines and opioids at the same time), while consequences (emergency room visits and overdose deaths) are remaining steady.

It is very likely that not enough time has passed to show change at this juncture. The implementation of pilots began only two years prior to the most recent data provided in this report and the COVID-19 pandemic occurred during this same timeframe, so the actual implementation was not two full years. Additionally, several programmatic and administrative rules that would likely impact the metrics experienced delays. For example, Illinois passed 4 public acts between 2019-2022 and started more than 8 new programs, including toolkits and a Helpline that are targeted at SUD/OUD services. The State Opioid Response (SOR) grants by SUPR were granted no-cost extensions. The data in this report, however, only demonstrates changes that occurred up until the end of 2021. The passage of time with the new policies and programs will likely further increase the progress that has been shown.

There have been several lessons learned and plans for the future. First, the largest barrier to the demonstration waiver involved multiple delays due to administrative reasons and the pandemic. This has had a lasting impact on the ability of provider agencies throughout the state to staff and administer treatments and programs to Medicaid beneficiaries diagnosed with an SUD. Like other states, Illinois had to pivot their focus during the pandemic and have only recently been able to pass policies and begin new programs. However, the data overall is showing that Illinois is on the right path and, given more time with policies and programs in place, we believe that the impact of the waiver on Medicaid beneficiaries will be resoundingly positive.

# Section I: General Background Information

## A. Introduction

Illinois is one of the largest funders of health and human services (HHS) in the country. With approximately $32 billion spent across its HHS agencies (40% of the total budget), the state is deeply invested in the health and well-being of its 12.7 million residents and 3.4 million Medicaid members. There is an urgent need to get more from this investment - the state must improve health outcomes for residents while slowing the growth of healthcare costs and putting the state on a more sustainable financial trajectory.

As a result, Illinois embarked on a transformation of the HHS system. The transformation was announced in 2016 and has a broad aim of improving population health, improving experience of care, and reducing costs. It is based in five themes:

1. Prevention and population health
2. Paying for value, quality, and outcomes
3. Rebalancing from institutional to community care
4. Data integration and predictive analytics
5. Education and self sufficiency

The initial focus of the transformation effort was on behavioral health (mental health and substance use), specifically the integration of behavioral and physical health service delivery. Behavioral health was chosen due to the urgency of the issue as well as the potential financial and human impact. Building a nation-leading behavioral health strategy will not only help bend the healthcare cost curve in Illinois but also help turn the tide of the opioid epidemic, reduce violent crime and violent encounters with police, and improve maternal and child health. There is a large financial payoff in improving behavioral health: Medicaid members with behavioral health needs represent 25% of Illinois Medicaid members but account for 56% of all Medicaid spending. Medicaid beneficiaries with behavioral health needs, such as mental illness or drug and alcohol use disorders, incur costs that are 2-3 times higher than those who do not have co-occurring disorders.

Under the demonstration, which was approved May 7, 2018, Illinois proposed the introduction and limited piloting of certain services that were not directly available to Medicaid beneficiaries. The additional services were expected to inform the state's efforts to transform the behavioral health system in Illinois as some beneficiaries would have access to less costly community-based services, which in turn are expected to help beneficiaries improve their health and avoid costlier services provided by institutions. The demonstration period is July 1, 2018, through June 30, 2023.

### Rationale for this Waiver Project

Prior to the start of the waiver, a 2017 comprehensive report on opioids by the Illinois Department of Public Health[1] reported alarming increases in consequences of use. Emergency department visits increased by 77% from 2015 to 2016, with the largest increase due to heroin overdoses. Hospitalizations also increased by 42% from 2014-2016. Naloxone administrations by EMS personnel increased 250% from 2013 to 2016, and neonatal abstinence syndrome increased 53% from 2011 to 2016. Overdose data provided in a dashboard maintained by the Illinois Department of Public Health[2] showed that overdoses from heroin and other opioids nearly tripled from 6,868 in 2013 to 15,702 in 2018. In 2018, 2,086 overdoses were fatal. Overdoses were primarily seen in white males between the ages of 25-34 and 45-54. This is especially alarming given that the total number of prescription opioids filled decreased from 7,562,123 in 2015 to 4,850,691 in 2018. Based on these results, it was evident an opioid crisis was ongoing in Illinois and provided ample rationale for the 1115 Medicaid waiver.

The 1115 Medicaid Waiver project addresses several pressing needs in the state of Illinois. First, it fills gaps left at the intersection of the state substance use authority and state Medicaid program regarding the opioid crisis. Specifically, there is a need for high quality residential treatment for individuals, withdrawal management services (i.e., detoxification), case management, and peer recovery support services. Second, there is a strong need to emphasize community-based care for individuals that are severely or persistently mentally ill (SMI). For such individuals, there is recognition that services are needed, and the critical goal was to enhance the quality of life for these citizens by attempting to alleviate the stress of crisis events.

## B. Name, Approval Date and Time Period Covered

The Illinois Behavioral Health Transformation Section 1115(a) Demonstration was approved on May 7, 2018, by the Centers for Medicare and Medicaid (CMS). The demonstration began on July 1, 2018, and is currently set to end on June 30, 2023. The evaluation covers the year prior to the start of the demonstration (January 1, 2017-December 30, 2017) through last calendar year of the demonstration (January 1, 2023-December 30, 2023). This interim report includes data from the baseline year (CY2017) through the most recent calendar year available (CY2021).

## C. Demonstration Goals

Illinois identified 6 key milestones to address through the implementation of the 1115 Medicaid waiver:

1. Access to critical care levels of care for OUD and other SUDs
2. Use of evidence-based, SUD-specific patient placement criteria
3. Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities
4. Sufficient provider capacity at each level of care
5. Implementation of comprehensive treatment and prevention strategies to address OUD
6. Improved care coordination and transitions between levels of care

As outlined in the state's Implementation Plan, Illinois will test whether the demonstration is likely to assist in achieving the milestones through the following goals:

1. Increased rates of identification, initiation, and engagement in treatment
2. Increased adherence to and retention in treatment
3. Reductions in overdose deaths, particularly those due to opioids
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate
6. Improved access to care for physical health and behavioral health conditions among beneficiaries

## D. History of Implementation

Illinois proposed 10 pilot programs to address the 6 goals for the 1115 Medicaid waiver. By the end of demonstration year 1, four pilots had begun, four additional pilots were incorporated into a state plan amendment through 1915(i) authority and are now part of the Pathways to Success Program, which uses System of Care principles and utilizes an intensive model of care coordination to meet the needs of the child and family, and the remaining two pilots are planned for incorporation into the waiver extension. With the revisions to the 1115 that

removed the 1915(i)-like and home visiting pilots from its financial authority, HFS is concentrating the 1115 Medicaid waiver on the improvement of Illinois' SUD delivery system.

Illinois' initial implementation of four pilots included: 1) SUD Implementation Protocol featuring up to 30-Day IMD Funding; 2) Clinically Managed Withdrawal Management Services; 3) SUD Case Management; and 4) Peer Recovery Support Services. The aim of these pilots was to facilitate the state's ability to maintain critical access to OUD and SUD services and continue delivery system improvements to provide more coordinated and comprehensive treatment for Medicaid beneficiaries. The pilots enabled the provision of targeted treatment services in certain residential/inpatient treatment settings that otherwise would not be eligible for federal financial participation.

Below is a table that indicates the 10 original pilots, the start dates, and the current status.

| Service Name | Start Date | Status in 1115 |
|---|---|---|
| 1. SUD Implementation Protocol featuring up to 30 Day IMD Funding | 1/1/2019 | Ongoing |
| 2. Clinically Managed Withdrawal Management Services Pilot | 2/1/2019 | Ongoing |
| 3. SUD Case Management Pilot | 2/1/2019 | Ongoing |
| 4. Peer Recovery Support Services Pilot | 2/1/2019 | Ongoing |
| 5. Crisis Intervention Services Pilot | N/A | Anticipated transition to State Plan Authority |
| 6. Evidence-Based Home Visiting Services | N/A | Anticipated transition to State Plan Authority |
| 7. Assistance in Community Integration Services | Forthcoming | Will be included in the 1115 extension |
| 8. Supported Employment Services | Forthcoming | Will be included in the 1115 extension |
| 9. Intensive In-Home Services | N/A | Anticipated transition to State Plan Authority |
| 10. Respite Services | N/A | Anticipated transition to State Plan Authority |

As indicated by the start dates in the table above, the implementation of the 1115 Medicaid waiver was delayed. This occurred because of several circumstances and changes in the Medicaid behavioral health landscape in Illinois. At the time of demonstration approval, the Illinois Department of Healthcare and Family Services (HFS) rebid most of the state's existing Medicaid managed care program contracts, consolidating multiple programs into a single streamlined program and expanded managed care statewide. This unprecedented procurement consolidated the Family Health Plans/ACA Adults (FHP/ACA), the Integrated Care Program (ICP) and the Managed Long-Term Services and Supports (MLTSS) program into a single contracting approach while reducing the number of contracted managed care organizations (MCOs) from 11 to 6. Implementation of the new contracts began in January 2018 for existing enrollees, with the full transition timeline for existing and new enrollees taking place by the end of 2018. HFS was still managing the transition to the new MCO contracts when the approval of this demonstration was received in May 2018, which resulted in delays in the initial planning. The second delay was the Illinois gubernatorial election in November 2018 and subsequent change in administration. In 2019, the start-up and ongoing implementation of the demonstration was paused while program and policy decisions, along with staffing assignments, were realigned in accordance with the new administration.

Perhaps the most significant impact on the 1115 Medicaid waiver was the COVID-19 pandemic and subsequent shutdowns nationwide. On January 31, 2020, U.S. Department of Health and Human Services Secretary declared a public health emergency for the United States. Illinois, like the rest of the healthcare world, had to shift focus to address the needs of Illinois' healthcare community in responding to COVID-19. The COVID-19 pandemic had an

unprecedented, substantial impact on Medicaid in the state of Illinois. First, many providers closed during the pandemic, temporarily or permanently. Workforce shortages contributed to the state's issues with addressing capacity and the types of Medicaid services provided shifted away from residential and inpatient treatment to increased outpatient and telehealth services. Fortunately, this impact was short-lived during the shutdown period; however, there are still lasting impacts to Medicaid as the state proceeds with the implementation.

Due to the delays noted above during the first couple of years, there were several changes in staffing and staffing assignments. Initially eligibility determination for the pilot programs was assigned to DHS Division of Substance Use Prevention and Recovery (SUPR), however due to staffing shortages at SUPR, HFS assumed responsibility for pilot eligibility enrollment in the summer of 2020. Additionally, waiver providers experienced issues early on with claims being denied or rejected through the Medicaid MCOs. HFS worked with MCOs to identify the reasons for claim denials and provided billing guidance to approved providers to improve billing and claim submissions for the 1115 Medicaid waiver pilots. Currently the HFS Bureau of Behavioral Health is responsible for reviewing and determining eligibility and tracking eligibility for the SUD Pilots.

The four pilots were set to begin during the first few months of the waiver in 2018, but the first (IMD funding) was delayed for Medicaid Managed Care populations until 1/1/2019 due to the rebidding of contracts. This pilot included a total of 24 residential (Level 3.5) programs and one Medically Monitored Withdrawal Management (Level 3.7) program designated as eligible to participate in the SUD IMD Residential pilot. These 25 SUD residential IMD programs are operated by 14 organizations licensed by SUPR. Between July 1, 2018, and September 30, 2020, six of the original 24 Residential Level 3.5 IMD programs have closed and are no longer in operation. Additionally, one provider has 12 site locations, but a review of available claims records for the past four demonstration years indicates that only five (Belleville, IL; Rock Island, IL; and 3 in Chicago, IL) of the 12 locations have been actively participating and submitting eligibility requests. A second provider with one location has been active and submitting eligibility requests. The other three pilot programs were delayed until February of 2019 to allow the new administration time to make program and policy decisions impacting these pilots.

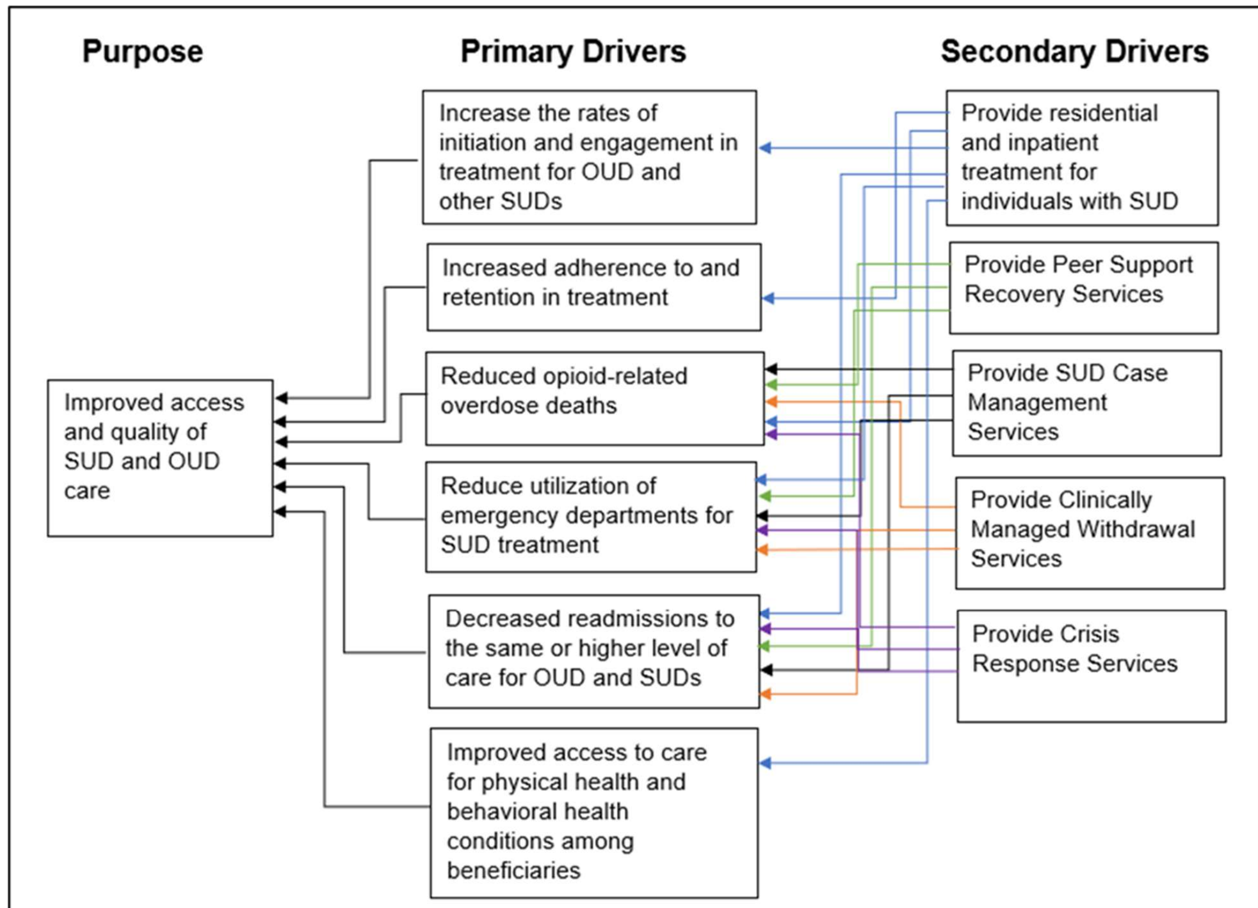
## E. Population Groups Impacted

Under the demonstration, there is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan. All affected groups derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable. Eligibility for the third pilot, SUD case management, is targeted to beneficiaries with an OUD/SUD diagnosis that qualify for diversion into treatment from the criminal justice system.

# Section II: Evaluation Questions and Hypotheses

## A. Defining Relationships: Aims, Primary Drivers, and Secondary Drivers

Based on the overall goal of improved access and quality of SUD and OUD care, Illinois identified the 6 goals in Section I.C. above. These goals served as the primary drivers for the evaluation. Five pilot programs were also identified as secondary drivers. The following driver diagram presented below shows the relationships between the demonstration's purpose, the primary drivers that contribute directly to achieve the purpose, and secondary drivers necessary to achieve the primary drivers.




## B. Hypotheses and Research Questions

The overall goal of the evaluation is to conduct a robust and data-driven analysis to identify, to the greatest extent possible, a causal relationship between the intervention component and the key outcomes of interest. Where possible, it will be important to explore mechanisms either aiding or hindering the impact of the waiver component. The table below outlines the state's 6 goals as well as the evaluation questions and hypotheses.

| Goals | Evaluation Questions | Hypotheses |
|---|---|---|
| 1. Increased rates of identification, initiation, and engagement in treatment. | 1. Does the demonstration increase access to and utilization of SUD treatment services? | 1. The demonstration will increase the percent of members referred to and engaging in SUD treatment. |

| | | |
|---|---|---|
| 2. Increased adherence to and retention in treatment | 2. Does the demonstration increase adherence to and retention of SUD treatment services? | 2. The demonstration will increase the percent of members adhering to SUD treatment. |
| 3. Reductions in overdose deaths, particularly those due to opioids. | 3. Are rates of opioid-related overdose deaths impacted by the demonstration? | 3. The demonstration will result in decreased opioid-related overdose deaths. |
| 4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services. | 4. Does the waiver result in fewer preventable ER visits for SUD? | 4. The demonstration will result in fewer ER visits for SUD in the member population. |
| 5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate. | 5. Do waiver enrollees receiving SUD/OUD services experience reduction in readmissions to the same or higher levels of care for SUD/OUD? | 5. The demonstration will reduce readmissions to the same or higher levels of SUD care. |
| 6. Improved access to care for physical health and behavioral health conditions among beneficiaries | 6. Do enrollees receiving SUD services experience improved access to care for physical health conditions? | 6. The demonstration will increase the percentage of members with SUD who access care for physical health conditions. |

## C. Current Report and Previous Findings

The interim evaluation presented here expands on earlier findings in the mid-point assessment report submitted to CMS in September 2022. The mid-point assessment provided the data points for the metrics during the first year of the demonstration waiver (2018) compared to the most recent data available at the time (2021) and calculated the percent change between the two time points. The results below present a deeper exploration of the data by comparing the rates from the year prior to the start of the demonstration (2017) and each year of the wavier until the most recent available data (2018, 2019, 2020, and 2021). This provides a more full and complete picture of the fluctuations in the data over time. In addition, our team conducted Chi-Square analyses on 4 of the metrics to test for significant changes from pre-waiver to the most recent data available.

## D. Connection of Waiver Project to Broader Transformation Efforts

At the point of its introduction in 2018, this waiver was the first of a planned series of initiatives under Illinois' HHS transformation initiative. The HHS transformation intended to focus on prevention and public health strategies, pay for performance, and data-driven health efforts. At the core of Illinois' 1115 Medicaid waiver was a package of substance use disorder (SUD) initiatives that targeted the opioid epidemic in Illinois and efforts to serve as a catalyst for a modernization of the Illinois SUD infrastructure. Testing the Medicaid sustainability potential of previously grant-funded services and the introduction of health infrastructure to help inform and reduce problematic prescription practices of medical professionals – the 1115 could clearly be characterized as a SUD-based initiative. Additionally, HFS sought to take advantage of the 1115 financial authority and test several new community-based behavioral health services focused on the more traditional mental health service continuum.

In the two and a half years since the approval and initial implementation of the Illinois Behavioral Health Transformation Demonstration, HFS has refined its healthcare strategy for individuals with complex healthcare needs – those with and without behavioral health conditions. In a more nuanced approach, the Medicaid agency is seeking to replace its original multifaceted approach to testing multiple system enhancements for a more targeted, population management approach. Introducing a new 1915(i) State Plan Amendment in 2020, HFS appears to be implementing services and supports that it once intended to test as a limited-scale pilot under the 1115 now as services available statewide to all individuals that qualify. Additionally, legislation proposed by the Illinois legislature in Spring 2021 seeks to introduce evidence-based home visiting and doula services more broadly into the Illinois Medicaid program.

With the revisions to the 1115 that removed the 1915(i)-like and home visiting pilots from its financial authority, HFS is concentrating the 1115 Medicaid waiver on the improvement of Illinois' SUD delivery system. This effort underscores the state's overall commitment to SUD transformation and aligns with ongoing efforts from SUPR to move the SUD service delivery system forward. At a time when SUPR finds itself re-basing individualized provider rates in favor of cost-based rate structures to establish service equity and introducing system enhancements via federal grants (SAMHSA's State Opioid Response federal grant and CMS' Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act: Section 1003 – Planning Grant) Illinois' 1115 Medicaid Waiver, when considered without its 1915(i)-like and home visiting components, fits within the context of the state seeking to transform its SUD service delivery system.

The state is requesting to continue the IMD/SUD measures forward. Due to implementation delays, the state hasn't learned enough to date, but sufficient progress was made that they want to continue with the metrics to monitor success with these pilots and continue to inform progress in Illinois' healthcare transformation efforts. The direction of the extension will incorporate activities that are aligned with federal initiatives around Social Determinants of Health (SDOH) and recent Health-Related Social Needs (HRSN) approvals, complementing and building on the initiatives Illinois is currently engaged in around SDOH and health equity as part of healthcare transformation.

# Section III: Methodology

The results provided in the next section are the first step of a multi-step evaluation as described in the approved Evaluation Plan (Appendix A). For this report, the independent evaluator (Center for Prevention Research and Development – CPRD) used the Medicaid claims data for Illinois beneficiaries to compare the year prior to the start of the 1115 Medicaid waiver (2017) with the most current available data (2021) across 18 proposed metrics. This includes the first three demonstration years of the 5-year waiver. No comparison data has been utilized to date but may be incorporated for the next part of the evaluation proposed for the summative report (i.e., Interrupted Time Series, Propensity Score Matching, etc.) using either a comparison state's data or internal data from non-SUD beneficiaries. Additionally, the individual pilot demonstrations will be evaluated and incorporated into the summative report. The current report analyzes the changes in metrics over time, as well as the significance of these changes where appropriate.

## Metrics Used for Interim Evaluation

The 18 metrics were chosen based on research questions and hypotheses to directly measure changes that were experienced by Medicaid beneficiaries in the state of Illinois. Metrics were identified with feedback from CMS and incorporated into the evaluation plan. Each of the metrics directly addresses a primary driver listed in the driver diagram in the evaluation plan and are presented in the table below.

| Primary Driver | Associated Metrics |
|---|---|
| 1 - Increase the rates of initiation and engagement in treatment for OUD and other SUDs | Metric 15 – Initiation and Engagement in Treatment |
| 2 - Increase adherence to and retention in treatment | Metric 3 – Percentage of Beneficiaries with an SUD (monthly)<br><br>Metric 22 – Continuity of Pharmacotherapy for OUD |
| 3 - Reduce opioid-related overdose deaths | Metrics 26/27 - Opioid Drug Overdose Deaths<br><br>Metric 18 – Use of Opioids at High Dosage in Persons without Cancer per 1,000 Medicaid Beneficiaries<br><br>Metric 21 – Concurrent Use of Opioids and Benzodiazepines per 1,000 Medicaid Beneficiaries |
| 4 - Reduce utilization of emergency departments for SUD treatment | Metric 23 – Emergency Department Utilization for SUD/OUD per 1,000 Medicaid Beneficiaries<br><br>Metric 24 – Inpatient Stays for SUD/OUD per 1,000 Medicaid Beneficiaries |
| 5 – Decrease readmissions to the same or higher level of care for OUD and SUDs | Metric 25 – 30-Day Readmission for SUD Treatment |
| 6 – Improve access to care for physical health and behavioral health conditions among beneficiaries | Metric 32 – Access to preventative/ambulatory health services for adult Medicaid Beneficiaries with SUD<br><br>Annual Dental Visits<br><br>Child and Adolescent Well-Care Visits<br><br>Prenatal and Postpartum Care |

The metrics above are calculated using technical specifications manuals published by CMS or other contractors. Several instructions change from year-to-year within Medicaid technical specifications that would make the data not comparable across time (i.e., per 1,000 beneficiaries vs. per 100 beneficiaries, changes in MMEs defined as "high dosage", etc.). Therefore, to ensure consistency and comparability over time, all metrics were calculated using the same version or year of technical specifications. CPRD consulted with the state to identify Version 4, or 2021, as the most recent versions during the development of this report. Of the metrics above, those with a number assigned (15, 3, 22, 18, 26/27, 21, 23, 24, 25, 32) were calculated based on the instructions in the "Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics".[3] A disclaimer for these technical specifications is below:

*Measures IET-AD, FUA-AD, FUM-AD, and AAP [Metrics #15, 17(1), 17(2), and 32] are Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are owned and copyrighted by the National Committee for Quality Assurance (NCQA). HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided "as is" without warranty of any kind. NCQA makes no representations, warranties, or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures and NCQA has no liability to anyone who relies on HEDIS measures or specifications or data reflective of performance under such measures and specifications.*

*The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications but has granted CMS permission to adjust. A calculated measure result (a "rate") from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on adjusted HEDIS specifications, may not be called a "HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as "Adjusted, Uncertified, Unaudited HEDIS rates."*

Analysis for the 4 metrics that were not assigned a number (Annual Dental Visits, Child and Adolescent Well-Care Visits, and 2 Prenatal and Postpartum Care metrics) were calculated using the technical specifications found in the Healthcare Effectiveness Data and Information Set (HEDIS) MY2020-2021 Volume 2 manual.[4]

## Target Population and Data Transfer

The target population for the evaluation was limited to Illinois Medicaid and Medicaid Managed Care Organization (MCO) recipients diagnosed with a substance use disorder (identified using ICD-9 and ICD-10 diagnostic codes) who were 18 to 64 years of age during in the study period. SUD individuals that were enrolled in the waiver demonstration were flagged to identify the target population. Of the 3.4 million Medicaid beneficiaries, around 150,000 had been diagnosed with an SUD (about 4.4%) and were included in the evaluation. Note that this is lower than nationally represented research estimates,[5] suggesting that there may be some issues with under detection.

Medicaid claims data was the only data used for the Interim Evaluation report. For the summative report at the end of the waiver, CPRD intends on using comparison group data for the overall evaluation as well as individual pilot evaluations that may include other sources of quantitative or qualitative data to evaluate the success of the implementation of the pilot programs during the waiver period. This was originally proposed in the evaluation plan and will help delay the evaluation of the pilot programs to allow for a longer period of implementation post COVID-19 pandemic. The pandemic resulted in several delays for the pilot programs, so it is essential to allow time for these programs to have an impact. Finally, claims data for Medicaid beneficiaries is the most accurate data to assess the changes that may be occurring in the lives of beneficiaries throughout the state and for this reason the evaluators chose to use claims data as the primary source for this evaluation.

Medicaid claims data was obtained from the Department of Healthcare and Family Services' Enterprise Data Warehouse and transferred to the independent evaluator (CPRD). Currently, this data is housed on Nightingale, a HIPAA compliant cluster at the National Center for Supercomputing Applications (NCSA) at the University of Illinois, in contract with CPRD. Here, the evaluation team has been able to explore and analyze the data for trends over time using a variety of statistical software packages and techniques including SQL, SPSS, and SAS.

Data validation and cleaning was conducted in several stages. CPRD collaborated with SQL programmers at NCSA to build and store an infrastructure to query the claims data to process each metric. The query of each metric using SQL followed the technical specifications outlined by either CMS or HEDIS.[3, 4] Multiple members of the evaluation team worked to ensure that the SQL syntax correctly identified recipients, including verifying that value sets used in metrics such as PPC were aligned with the specifications that were in effect. In addition, to validate the queries, the evaluation team took multiple steps to verify the data after bringing it into SPSS software. Furthermore, the evaluation team collaborated with the Office of Medicaid Innovation (OMI) to ensure that all the computational aspects of generating metric data were correct, and that the team had correctly interpreted the sometimes-vague specifications.

Once beneficiaries eligible for inclusion in the denominator or eligible population were identified, the methods for calculating metrics varied. In some instances, such as metric 18, 21, 23, and 24, the evaluation team at CPRD opted to complete the denominator and/or numerator calculation through SPSS; while in other instances, SQL was used to finalize the numerator. In either case, the team then checked the data while calculating the metrics, by selecting at random cases from each dataset and checking them to ensure no irregularities were present, adding an extra layer of verification. Furthermore, in datasets where fixed values were present (e.g., Metric 18 could only include beneficiaries who received their first prescription prior to October 3rd of the measure year), the team checked the data to ensure that calculations had not inadvertently included beneficiaries who should have been excluded. Finally, the team began a lengthy process of reviewing the SQL syntax used to generate the metrics alongside programmers from OMI, and while this process is still underway, those metrics which were reviewed were almost universally calculated correctly, with any errors being marginal. Where SPSS syntax was used to calculate metrics, no fewer than three analysts at CPRD checked and rechecked the syntax and resulting datasets to validate the output.

The analyses used for the current report include descriptive statistics for all metrics and Pearson's Chi-Square for 6 metrics. Chi-Square was only utilized where feasible for some of the metrics due to the type of data yielded (i.e., rates vs. numbers). Where metrics were analyzed using the Chi-square test, effect size was measured as well, using Cramer's V.

# Section IV: Methodological Limitations

As described above, CPRD received claims data from the Office of Medicaid Innovation (OMI) and the data was subsequently transferred to the Nightingale cluster at the NCSA. The claims data that was received included only paid claims for beneficiaries diagnosed with an SUD for 2017-2021. CPRD does not have access to the Enterprise Data Warehouse (EDW) that contains all Medicaid claims data. A few weeks prior to the submission of this report, several data transfer errors were identified by OMI and the evaluation team at CPRD corrected these as soon as they were identified. To help OMI identify any other potential errors, CPRD compared data previously reported by OMI in quarterly and annual reports (when applicable, this report contains several metrics that OMI does not report). While this data is not expected to be the same as previously reported data due to variations in technical specification versions and other factors, it should be similar. CPRD has not been able to independently identify errors without access to the EDW for comparison, so there is some reliance on OMI to double-check this work. OMI and CPRD were able to double-check some, but not all, of the metric data. We anticipate further evaluation and correction in the coming months and there is potential that this data will change.

Version 4 (2021) of the technical specifications includes not only paid claims, but also denied, pending or suspended claims for several metrics. Because the data received included only paid claims, metric 15, annual dental visits (ADV), child and adolescent well-care visits (WCV), timeliness of prenatal care and postpartum care (PPC) only include paid claims. This is indicated in footnotes for the corresponding metrics in the results section. CPRD has requested this data from OMI, and this will be included in the next draft.

CPRD received claims data for calendar years 2017-2021. The EDW has experienced several changes in the past that have rendered 2016 data unavailable. Metrics 3, 15, 23 (OUD Substratum), 24 (OUD Substratum), and 32 require data from 11 months prior, so some baseline data for these metrics was not available. This is indicated in footnotes for the corresponding metrics in the results section.

While the evaluation plan called for metric 3 to be measured as a rate, the CMS technical specifications called for a count to be calculated. Therefore, metric 3 was assessed using the guidelines outlined in the technical specification's manual. Chi-square tests were not performed for Medicaid Beneficiaries with an SUD Diagnosis as it is based on numbers and not percentage rates.

An additional metric "Tobacco use screening and follow-up for people with alcohol or other drug dependence" was included in the approved evaluation plan under Primary Driver 6; however, no analysis was conducted, and it is not included in this report. The last known steward of the measure (NQF 2600), the Physician Consortium for Performance Improvement (PCPI), was dissolved as of June 23, 2020, making the technical specifications for the measure impossible to retrieve. While the non-technical measure specifications are still available on the NQF website, these specifications discuss the rate calculation in very general terms, lacking the details needed for a meaningful analysis. Additionally, the NQF's own endorsement for the measure was removed on December 19, 2019, and the measurement was retired.[6] As such, with a lack of an endorsement, technical specifications, and a steward, the decision was made to not analyze the tobacco use screening metric.

Where tests of statistical significance were conducted, the evaluation team opted to use Pearson's Chi Square test to determine if the changes from the baseline period to the latest available time in the demonstration period were significant. However, there may be some concerns regarding the choice of the Chi-Square test since the samples are not entirely independent of each other. Some Medicaid beneficiaries have been included in both samples due to ongoing eligibility, although these beneficiaries make up a minority of the test samples. Despite these concerns regarding independence, the choice was made to continue using the Chi-Square test, as detailed in the evaluation plan, owing to the large sample sizes used in the analyses, with *n* regularly exceeding 15,000 beneficiaries. Furthermore, the evaluation team ran paired t-tests for several of the metrics and found no meaningful differences in statistical significance; again, this is presumed to be due to the large sample sizes available. Finally, it was felt that

it would be better to use the robust Chi-Square test to have an analysis which encompasses all beneficiaries possible rather than drastically reduce the scope of the analysis using a paired t-test, which itself would be subject to room for error due to non-continuous enrollment, in the likely event that a beneficiary was eligible for Medicaid in 2017 and 2021, but not eligible during one of the intervening demonstration years.

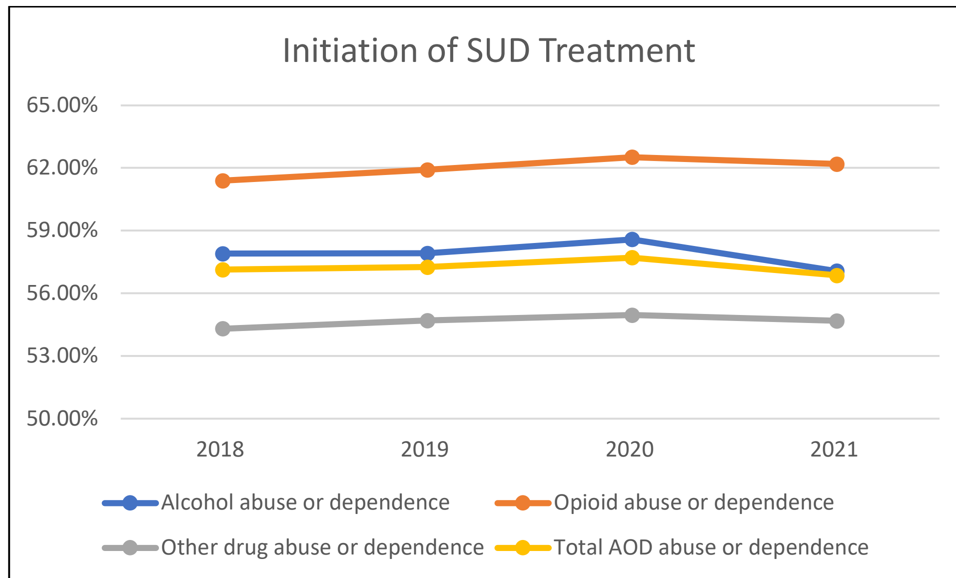
# Section V: Results

## A. Primary Driver 1 – Increase the rates of initiation and engagement in treatment for OUD and other SUDs

Evaluation Question 1: Does the demonstration increase access to and utilization of SUD treatment services?

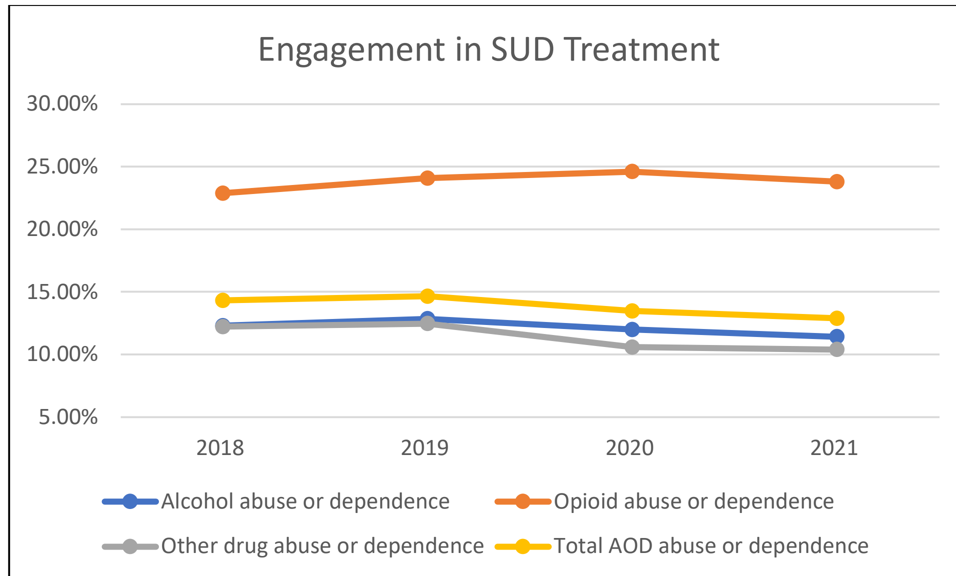
***Evaluation Hypothesis 1:*** *The demonstration will increase the percent of members referred to and engaging in SUD treatment.*

Metric 15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment




| Initiation in SUD Treatment | | | | | | |
|---|---|---|---|---|---|---|
| *Metric Name* | *Metric #* | *2018** | *2019* | *2020* | *2021* |
| Alcohol abuse or dependence | S1 | 57.89% | 57.91% | 58.58% | 57.07% |
| Opioid abuse or dependence | S2 | 61.39% | 61.91% | 62.52% | 62.19% |
| Other drug abuse or dependence | S3 | 54.31% | 54.69% | 54.96% | 54.69% |
| Total AOD abuse or dependence | S4 | 57.13% | 57.26% | 57.71% | 56.86% |

Note: CMS Metric 15 was calculated using only paid claims.
*2017 data was not available for Metric 15 at the time of writing




| Engagement in SUD Treatment | | | | | |
|---|---|---|---|---|---|
| *Metric Name* | *Metric #* | *2018** | *2019* | *2020* | *2021* |
| Alcohol abuse or dependence | S5 | 12.31% | 12.85% | 12.00% | 11.42% |
| Opioid abuse or dependence | S6 | 22.89% | 24.07% | 24.60% | 23.80% |
| Other drug abuse or dependence | S7 | 12.23% | 12.47% | 10.60% | 10.40% |
| Total AOD abuse or dependence | S8 | 14.33% | 14.65% | 13.48% | 12.89% |

Note: CMS Metric 15 was calculated using only paid claims.
*2017 data was not available for Metric 15 at the time of writing

Metric 15 was broken down into 8 sub-metrics, split into treatment and engagement categories stratified by treatment or engagement for alcohol abuse or dependence, opioid abuse or dependence, other abuse or dependence, and a total trend.

Regarding treatment initiation, the total trend was relatively consistent, scarcely rising above the baseline year in calendar years 2018, 2019, and 2020, but dropping (marginally) below the baseline year in 2021. Examining the substrata reveals that there is slight growth in initiation for alcohol use treatment, a larger drop in opioid treatment initiation, and a consistent trend for initiation of other drug treatment. As a result of the consistent trends demonstrated, the initiation in SUD treatment element of metric 15 neither supports, nor fails to support, the overall hypothesis that the demonstration increases referrals and initiation in SUD treatment.

The trend for engagement in treatment is similarly defined by steady trends, although there is seemingly more variation. Opioid engagement seems to rise across the measurement period, although this rise is blunted in 2021 with a slight drop. The other substratum seems to drop, although these changes are incredibly marginal, dropping by less than 2 percentage points across the measurement period. As a result of these very small changes, it is concluded that metric 15 engagement measures neither support nor fail to support the hypothesis.

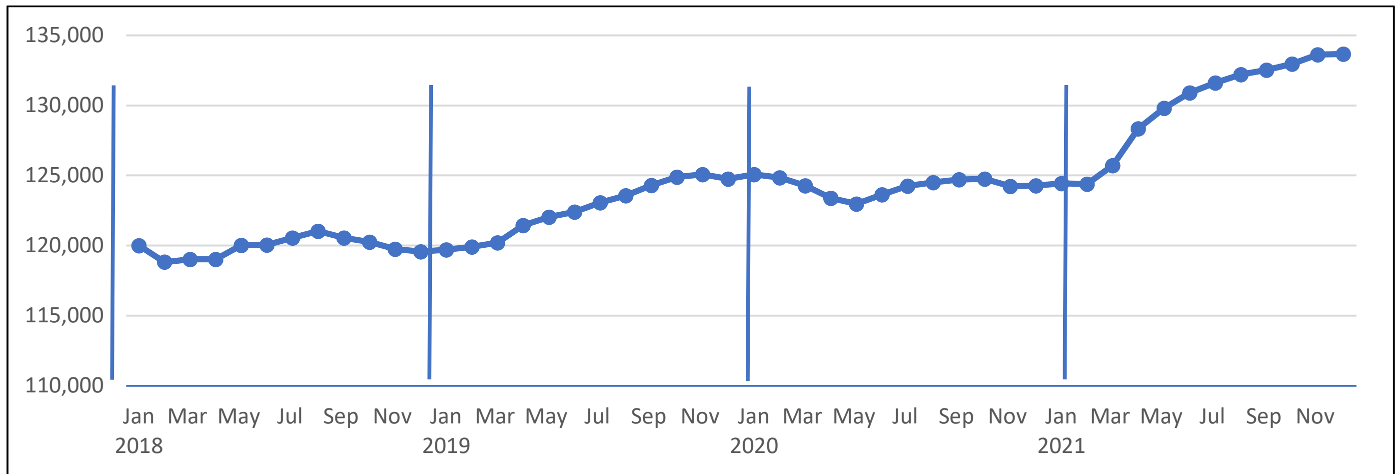
## B. Primary Driver 2 – Increase adherence to and retention in treatment

Evaluation Question 2: Does the demonstration increase adherence to and retention of SUD treatment services?

*__Evaluation Hypothesis 2:__ The demonstration will increase the percent of members adhering to SUD treatment.*

Two of the four metrics for this primary driver do not list descriptive statistics or Chi-square in the evaluation plan so they are not included in the Interim Evaluation report. The two metrics, Continuity of Care after Inpatient or Residential Treatment for SUD (NQF #3453) and Continuity of Care after Medically Managed Withdrawal from Alcohol and/or Drugs (NQF #3312), will be included alongside detailed analysis in the summative report.

Metric 3: Medicaid Beneficiaries with an SUD Diagnosis (monthly)

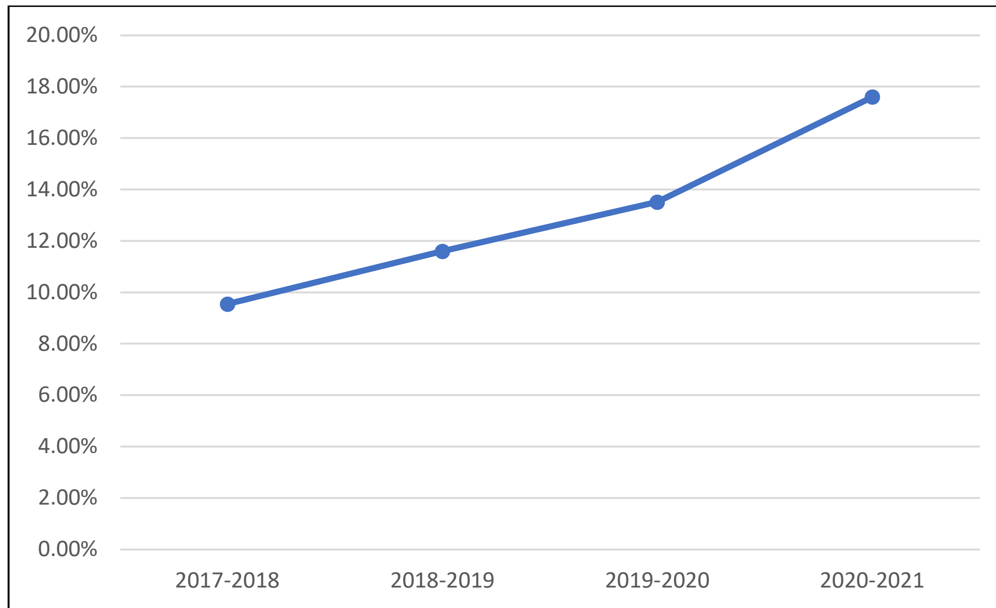



| Medicaid Beneficiaries with an SUD Diagnosis (monthly) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Jan* | *Feb* | *Mar* | *Apr* | *May* | *Jun* | *Jul* | *Aug* | *Sep* | *Oct* | *Nov* | *Dec* |
| *2018** | 119,989 | 118,826 | 119,014 | 119,026 | 120,016 | 120,050 | 120,541 | 121,022 | 120,541 | 120,258 | 119,747 | 119,561 |
| *2019* | 119,702 | 119,917 | 120,210 | 121,441 | 122,035 | 122,395 | 123,070 | 123,568 | 124,306 | 124,886 | 125,071 | 124,749 |
| *2020* | 125,063 | 124,840 | 124,281 | 123,393 | 122,976 | 123,632 | 124,249 | 124,500 | 124,697 | 124,750 | 124,226 | 124,269 |
| *2021* | 124,430 | 124,394 | 125,718 | 128,336 | 129,798 | 130,893 | 131,084 | 131,084 | 130,888 | 130,741 | 130,865 | 130,385 |

*2017 data is not available for Metric 3

The results from the monthly Medicaid Beneficiaries with an SUD Diagnosis have gradually increased from January 2018 through December 2021. The increase in the count supports the hypothesis put forward by this evaluation.

Metric 22: Continuity of Pharmacotherapy for OUD




| | *Baseline (2017-2018)* | *CY 2018-2019* | *CY 2019-2020* | *CY 2020-2021* | *p-value* | *Effect Size* |
|---|---|---|---|---|---|---|
| **Rate** | 9.55% | 11.60% | 13.52% | 17.60% | <.001 | .111 |
| **Count** | 1706 | 2,693 | 3,511 | 4894 | | |

CMS Metric 22, Continuity of Pharmacotherapy for OUD is an annual metric calculated over a two-year rolling period. The descriptive statistics show improvement, with a growing proportion of Medicaid beneficiaries with OUD receiving continuous care. The number of individuals receiving continuous pharmacotherapy rose from 1,711 in the baseline period to 4,894 by 2020-2021; thus, the overall proportion rose from 9.55% to 17.60%. These results are statistically significant ($p < .001$) but the effect was quite small, indicating that the state has made progress in improving access to and continuity of OUD care, supporting the hypothesis of increasing adherence to treatment.

The COVID-19 pandemic seemed to pose no issue for the upward trend in improving continuity of care – this is possibly due to a decline in in-person services being supplanted by greater use in telehealth. Saloner and colleagues[7] conducted a multi-state survey (which excluded Illinois) and found despite concerns of barriers introduced by telemedicine, the changes in substance use treatment were "generally reported to be successful among our sample respondents, a group with large proportions over the age of 50, homeless, Medicaid enrollment, and low levels of education." Therefore, indicating that changes in access to care were either no obstacle or effective in improving the continuity of pharmacotherapy for OUD.

## C. Primary Driver 3 – Reduce opioid-related overdose deaths

**Evaluation Question 3:** Are rates of opioid-related overdose deaths impacted by the demonstration?

***Evaluation Hypothesis 3:*** *The demonstration will result in decreased opioid-related overdose deaths.*

Metric 26/27: Opioid Drug Overdose Deaths

| Demonstration Year | Certified Total OUD Deaths (Count) | Certified Total OUD Deaths (Rate per 1,000 Medicaid Beneficiaries) |
|---|---|---|
| *Pre-Waiver (7/1/2017-6/30/2018)* | 2,950 | .480 |
| *DY1 (7/1/2018-6/30/2019)* | 2,663 | .742 |
| *DY2 (7/1/2019-6/30/2020)* | 3,533 | .996 |
| *DY3 (7/1/2020-6/30/2021)* | 1,772 | .442 |

There is no discernible trend in opioid drug overdose deaths. Examining the count of OUD deaths, there is a drop from the pre-waiver period in the first demonstration year, followed by a sharp increase in deaths in Demonstration Year 2, before the count suddenly drops in the third demonstration year. There is a steady increase in the rate of OUD deaths among Medicaid beneficiaries from the pre-waiver period until the third demonstration year, before it is followed by another sharp drop, from 1 death per 1,000 beneficiaries to .44 deaths, alongside a drop in the count of deaths.

Without further information, it is impossible to say where the variation in both the count and rate of OUD deaths comes from, although some portion of the rise in the rate from the pre-waiver period to the third demonstration year may be speculatively attributed to the 'fourth wave' of the opioid epidemic in the United States, in which the widespread availability of illicit fentanyl has fueled a rising number of fatalities due to OUD nationwide.[8] However, this still does not adequately account for the subsequent drop in both the count and rate of opioid overdose deaths in demonstration year 3. It is likely that a more identifiable trend will emerge over time; however, for the interim report, there is not enough data to create an informative analysis of OUD deaths among Medicaid beneficiaries in Illinois. Consequently, these results do not support, nor do they fail to support the hypothesis.

Metric 18: Use of Opioids at High Dosage in Persons without Cancer per 100 Medicaid Beneficiaries

| | *Baseline (CY 2017)* | *CY 2018* | *CY 2019* | *CY 2020* | *CY 2021* | *p-value* | *Effect Size* |
|---|---|---|---|---|---|---|---|
| **Rate** | 4.45 | 3.87 | 3.31 | 3.47 | 2.62 | <.001 | .046 |
| **Count** | 573 | 456 | 319 | 300 | 186 | | |

The use of opioids at a high dosage (defined as more than 180 morphine milligram equivalents per day over a period of 90 or more days) in persons without cancer shows a significant ($p<.001$) decline over the demonstration period. Though the effect size was small, these results support the hypothesis that the state of Illinois has made progress towards reducing opioid-related overdose deaths, indirectly through the reduction of high-risk opioid usage. Not only does the rate decrease dramatically, the denominator of the measure (defined as beneficiaries who had 15 or more days' supply over an opioid episode of 90 days or more) also sees a steady decrease. This indicates that the number of opioid prescriptions is being curtailed, and, of those that are prescribed, in lower doses over shorter periods of time.

Metric 21: Concurrent Use of Opioids and Benzodiazepines per 100 Medicaid Beneficiaries

| | *Baseline (CY 2017)* | *CY 2018* | *CY 2019* | *CY 2020* | *CY 2021* | *p-value* | *Effect Size* |
|---|---|---|---|---|---|---|---|
| **Rate** | 30.5 | 29.6 | 24.4 | 23.0 | 21.4 | <.001 | .098 |
| **Count** | 5,415 | 4,857 | 3,342 | 2,795 | 2,236 | | |

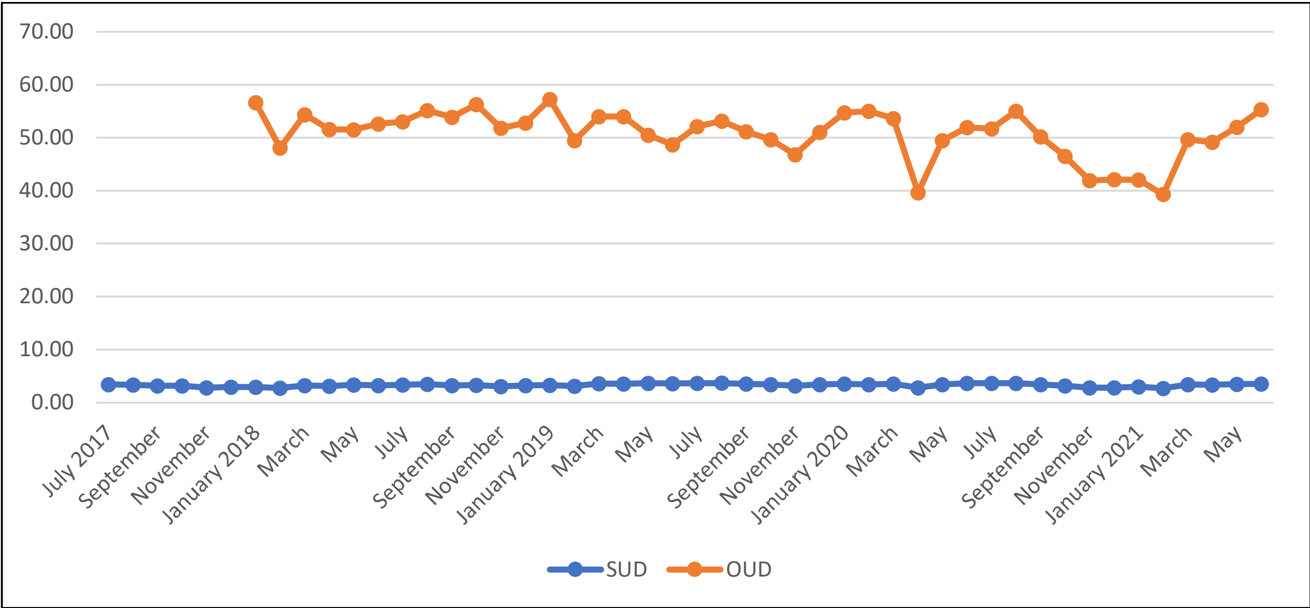
Like metric 18 above, the concurrent use of opioids and benzodiazepines demonstrated a statistically significant decrease ($p<.001$) with a relatively small effect from the baseline period to calendar year 2021. Therefore, this measure supports the hypothesis. The most significant decrease was seen from 2018 to 2019, indicating that the 1115 Medicaid waiver may have had an immediate effect on opioid and benzodiazepine prescriptions as well as generating a sustained downwards trend. These results show progress in decreasing high-risk use of opioids, and therefore the reduction of opioid-related overdose deaths. Additionally, as in metric 18, the denominator for this measure had a sustained decline throughout the demonstration period, again pointing towards an overall decrease in opioid prescriptions alongside the decrease in the overall rate of high concurrent use of opioids and benzodiazepines.

## D. Primary Driver 4 – Reduce utilization of emergency departments for SUD treatment

**Evaluation Question 4:** Does the waiver result in fewer preventable ER visits for SUD?

***Evaluation Hypothesis 4:*** *The demonstration will result in fewer ER visits for SUD in the member population.*

Metric 23: Emergency Department utilization for SUD/OUD per 1,000 Medicaid beneficiaries



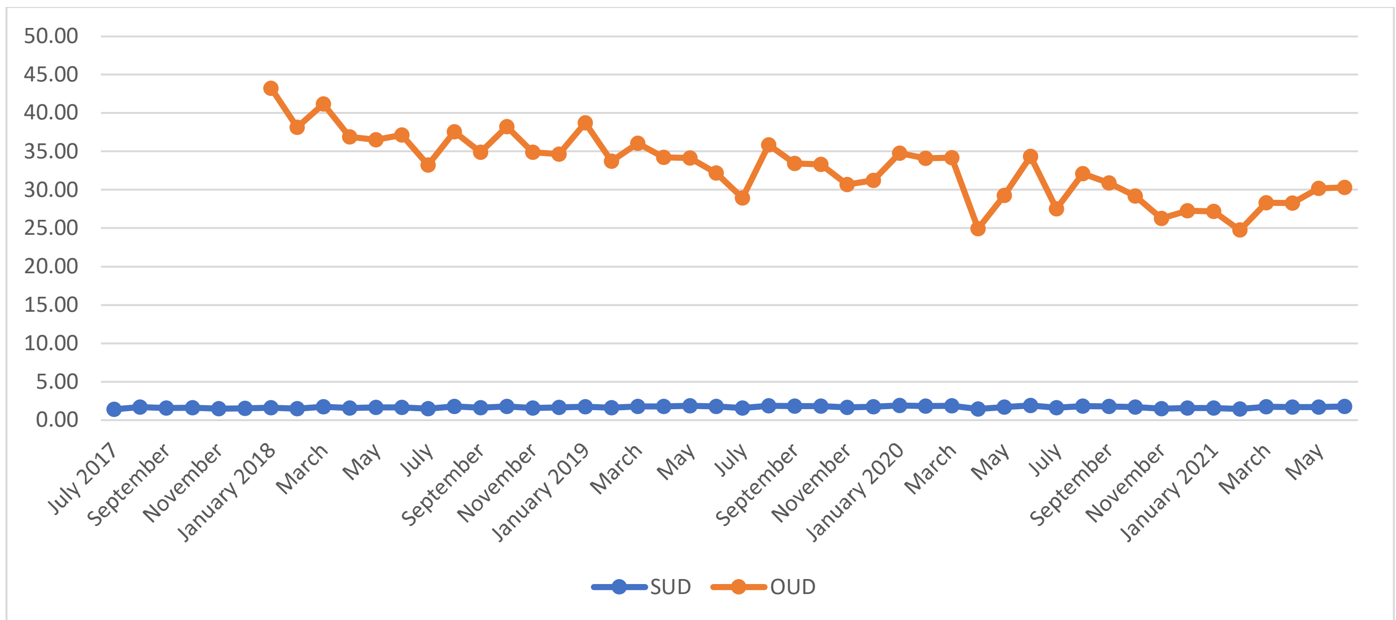
| Emergency Department utilization for SUD per 1,000 Medicaid beneficiaries | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Jul* | *Aug* | *Sep* | *Oct* | *Nov* | *Dec* | *Jan* | *Feb* | *Mar* | *Apr* | *May* | *Jun* |
| *2018* | 3.40 | 3.34 | 3.16 | 3.13 | 2.80 | 2.94 | 2.90 | 2.72 | 3.22 | 3.12 | 3.34 | 3.25 |
| *2019* | 3.34 | 3.47 | 3.22 | 3.28 | 3.02 | 3.24 | 3.26 | 3.09 | 3.58 | 3.53 | 3.67 | 3.61 |
| *2020* | 3.65 | 3.69 | 3.53 | 3.41 | 3.17 | 3.38 | 3.52 | 3.39 | 3.53 | 2.77 | 3.39 | 3.64 |
| *2021* | 3.62 | 3.66 | 3.39 | 3.18 | 2.78 | 2.83 | 2.98 | 2.69 | 3.41 | 3.36 | 3.49 | 3.52 |
| *OUD Substratum* | | | | | | | | | | | | |
| | *Jul* | *Aug* | *Sep* | *Oct* | *Nov* | *Dec* | *Jan* | *Feb* | *Mar* | *Apr* | *May* | *Jun* |
| *2018** | NA | NA | NA | NA | NA | NA | 56.67 | 48.06 | 54.33 | 51.58 | 51.51 | 52.61 |
| *2019* | 53.05 | 55.15 | 53.90 | 56.27 | 51.83 | 52.81 | 57.27 | 49.44 | 54.01 | 53.99 | 50.51 | 48.67 |
| *2020* | 52.11 | 53.13 | 51.14 | 49.66 | 46.83 | 51.05 | 54.70 | 55.04 | 53.62 | 39.64 | 49.45 | 51.94 |
| *2021* | 51.69 | 55.00 | 50.21 | 46.48 | 41.89 | 42.08 | 42.06 | 39.30 | 49.63 | 49.15 | 52.01 | 55.35 |

* Metric 23 data was not available for Q1 and Q2 of FY 2018 for the OUD substratum

Metric 23 consisted of two metrics, emergency room utilization for SUD per 1,000 Medicaid Beneficiaries, and the same utilization rate for the OUD substratum. For the overall rate, there seemed to be a consistent trend in SUD stays, with little variation in the pre-demonstration period and within the demonstration period. Although there is not enough data to make a meaningful conclusion, there seems to be a drop and subsequent rebound in ED utilization in fiscal year 2021, potentially related to COVID-19. Overall, Metric 23 neither supports nor fails to support the hypothesis due to the steady trend.

The first two financial quarters of 2018, OUD substratum data was not available, as the metric requires that beneficiaries have an OUD diagnosis in the measurement month or the 11 prior months, or the prior 3 quarters, and 2016 data was not available for use in calculating the denominator of the metric. Regardless, OUD ED utilization among beneficiaries with OUD faced a steady, if variable, trend from the demonstration period until Quarter 2 of 2020, when the rate of ED utilization spikes suddenly, before entering a period of fluctuations with a downward trend, finally concluding with a dramatic rise in Quarter 4 of 2021. This drop followed by a rebound aligns temporally with the COVID-19 pandemic and mimics a wider national trend in which "ED visits for SUD returned to baseline [after the COVID-19 pandemic] and increased above baseline for OUD ever since May 2020".[9] The trend in Illinois does exceed Venkatesh's baseline year of 2019, although it does return to a downwards trend, indicating a possible effect of the COVID-19 pandemic. As such, this metric neither supports the hypothesis nor fails to support the hypothesis due to the fluctuations in the data.

Metric 24: Inpatient stays for SUD/OUD per 1,000 Medicaid beneficiaries




| Inpatient stays for SUD/OUD per 1,000 Medicaid beneficiaries | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Jul* | *Aug* | *Sep* | *Oct* | *Nov* | *Dec* | *Jan* | *Feb* | *Mar* | *Apr* | *May* | *Jun* |
| *2018* | 1.41 | 1.70 | 1.59 | 1.62 | 1.50 | 1.54 | 1.60 | 1.50 | 1.72 | 1.56 | 1.64 | 1.64 |
| *2019* | 1.47 | 1.76 | 1.62 | 1.76 | 1.58 | 1.64 | 1.74 | 1.63 | 1.79 | 1.78 | 1.86 | 1.76 |
| *2020* | 1.56 | 1.86 | 1.81 | 1.83 | 1.66 | 1.73 | 1.90 | 1.80 | 1.85 | 1.45 | 1.69 | 1.92 |
| *2021* | 1.60 | 1.84 | 1.76 | 1.71 | 1.49 | 1.55 | 1.56 | 1.43 | 1.75 | 1.68 | 1.71 | 1.77 |
| *OUD Substratum* | | | | | | | | | | | | |
| | *Jul* | *Aug* | *Sep* | *Oct* | *Nov* | *Dec* | *Jan* | *Feb* | *Mar* | *Apr* | *May* | *Jun* |
| *2018** | NA | NA | NA | NA | NA | NA | 43.24 | 38.16 | 41.20 | 36.88 | 36.51 | 37.14 |
| *2019* | 33.22 | 37.57 | 34.88 | 38.24 | 34.88 | 34.64 | 38.73 | 33.71 | 36.06 | 34.21 | 34.14 | 32.20 |
| *2020* | 28.95 | 35.83 | 33.44 | 33.33 | 30.69 | 31.22 | 34.78 | 34.10 | 34.17 | 24.95 | 29.28 | 34.34 |
| *2021* | 27.52 | 32.09 | 30.87 | 29.19 | 26.26 | 27.28 | 27.19 | 24.75 | 28.31 | 28.28 | 30.19 | 30.31 |

*Metric 24 data was not available for Q1 and Q2 of FY 2018

Similar to Metric 23 above, the overall rate of inpatient stays for SUD remains steady, with a similar drop and rebound in fiscal year 2021, again this is a potential effect of the COVID-19 pandemic, but there is not enough data to draw any certain conclusions, nor is there enough data to determine if the variation beginning in roughly quarter 2 of 2020 will lead to a break from the consistent trend observed over the pre- and post-demonstration periods. As a result, the rate of overall SUD inpatient stays neither supports nor fails to support the hypothesis.

As stated above, metrics 23 and 24 share the same denominator, and OUD substratum rates were not available for the first two quarters of 2018. Nonetheless, the OUD substratum's rate sees a steady, if somewhat saw-toothed,

drop across the demonstration period. Although there is a noticeable drop in inpatient stays in April of 2020, it is difficult to ascertain if this change is due to the COVID-19 pandemic for reasons detailed earlier. Therefore, change in inpatient stay rates for the OUD substratum supports the overall hypothesis.

## E. Primary Driver 5 – Decrease readmissions to the same or higher level of care for OUD and SUDs

**Evaluation Question 5:** Do waiver enrollees receiving SUD/OUD services experience reduction in readmissions to the same or higher levels of care for SUD/OUD?

***Evaluation Hypothesis 5:*** *The demonstration will reduce readmissions to the same or higher levels of SUD care.*

Metric 25: 30-Day Readmission for SUD Among Beneficiaries

| | *FY 2018* | *FY 2019* | *FY 2020* | *FY 2021* |
|---|---|---|---|---|
| **Percentage** | 25.52% | 26.27% | 27.26% | 26.67% |
| **Count** | 21,252 | 21,945 | 22,136 | 21,780 |

Across the demonstration period, the rate of all-cause readmissions during the measurement period among Medicaid beneficiaries with SUD remained consistent, with neither the overall change over time nor any individual measurement year exceeding 2 percentage points of the baseline measurement. Furthermore, of the marginal changes, there is no discernible trend, with a slight upwards trend from FY 2018-2020 followed by a decrease in 2021. While it is possible that this downwards shift in the data is due to a drop in overall healthcare utilization globally due to the COVID-19 pandemic, there is not enough data to draw any conclusions beyond a consistent trend in the data based on the available descriptive statistics, especially since there is not a subsequent rebound in visits in during 2021.[10] Therefore, this neither supports nor fails to support the hypothesis.

## F. Primary Driver 6 – Improve access to care for physical and behavioral health conditions

**Evaluation Question 6:** Do enrollees receiving SUD services experience improved access to care for physical health conditions?

***Evaluation Hypothesis 6:*** *The demonstration will increase the percentage of members with SUD who access care for physical health conditions.*

Metric 32: Access to preventive/ambulatory health services for adult Medicaid beneficiaries with SUD

| | *Baseline CY 2017* | *CY 2018* | *CY 2019* | *CY 2020* | *CY 2021* | *p-value* | *Effect Size* |
|---|---|---|---|---|---|---|---|
| **Percentage** | 72.67% | 79.11% | 81.53% | 79.33% | 75.32% | <.001 | .009 |
| **Count** | 68,729 | 76,809 | 79,931 | 84,685 | 92,962 | | |

Note: Metric PPC was calculated using only paid claims.

Compared to the baseline period, the count of beneficiaries with ambulatory or preventive care increased by a large amount, from 68,729 beneficiaries having had a visit to over 92,962 beneficiaries per calendar year following the implementation of the 1115 Medicaid waiver. Likewise, the proportion of eligible beneficiaries increased from 72.67% in 2017 (prior to the waiver) to 79.11% in 2018, 81.53% in 2019, and 79.33% in 2020. However, the proportion decreases in 2021, with only 75.32% of beneficiaries with an SUD diagnosis having had a preventive care or ambulatory visit. Overall, the results are significant (p<.001) but the effect size is very small. Overall, this demonstrates positive progress towards improving access to preventive and ambulatory healthcare for Medicaid beneficiaries with SUD, supporting the hypothesis.

Metric ADV (NQF #1388): Annual Dental Visits (SUD stratum)

| | *Baseline CY 2017* | *CY 2018* | *CY 2019* | *CY 2020* | *CY 2021* |
|---|---|---|---|---|---|
| **Percentage** | 3.40% | 3.35% | 3.94% | 3.18% | 3.80% |
| **Count** | 2,470 | 2,362 | 2,638 | 1,863 | 2,147 |

Note: Metric PPC was calculated using only paid claims.

Annual dental visits among beneficiaries with an SUD diagnosis have some interesting fluctuations, although the general trend seems to be consistent. The overall count and proportion of beneficiaries with SUD grows from 2017-2018, with a year-over-year change of .54 percentage points once the 1115 waiver came fully into effect in fiscal year 2019 (the waiver was only in place for the last six months of CY 2018). However, the proportion begins to fall, along with the count, suggesting that the eligible population shrank while dental care utilization fell. Consequently, this metric neither supports nor fails to support the hypothesis.

Once again, it is possible that the dramatically reduced count of beneficiaries with an annual dental visit is attributable to COVID-19, as dental visits plummeted due to the pandemic and, once widespread reopening had begun, “dental care use among the publicly insured [e.g. Medicaid] population remained lower than the pre-pandemic level” nationwide, indicating that the drop in the count of beneficiaries with an annual dental visit in 2020 is likely due in large part to the impact of COVID-19.[11] Interestingly, the rate of annual dental visits in Illinois continues to decline, which may mean that the impact of the COVID-19 pandemic is having a more long-term effect than that discussed by Choi et al., or there is another factor hampering access to dental care by Medicaid beneficiaries with SUD in Illinois.

Metric WCV (NCQA W30): Child and Adolescent Well-Care Visits

| | *Baseline CY 2017* | *CY 2018* | *CY 2019* | *CY 2020* | *CY 2021* |
|---|---|---|---|---|---|
| **Percentage** | 1.32% | 1.30% | 1.47% | 1.30% | 1.83% |
| **Count** | 1,119 | 1,114 | 1,190 | 956 | 1,311 |

Note: Metric PPC was calculated using only paid claims.

Child and adolescent well-care visits saw very little change across both the pre-demonstration period and throughout the demonstration years. There seems to be a negligible impact upon the start of the waiver, with a drop of just 5 beneficiaries from 2017 to 2018. This is likely due to the eligible population (Medicaid beneficiaries between the ages of 3 and 21 with an SUD diagnosis) being very small. Furthermore, much of the eligible population was between the ages of 17 and 21. Interestingly, the rate of well-care visits seems to have been impacted by COVID-19, as the count of visits falls by 234 beneficiaries year on year from 2019 to 2020, a drop of 11.46%. This is

followed by a rebound in 2021, having more visits than even 2019. However, it is difficult to determine the causes of these year over year changes, especially given the relatively small changes compared with other metrics. Consequently, this metric does not support nor fails to support the hypothesis that the 1115 Waiver improves access to care for physical health conditions.

### Metric PPC (NQF #1517): Prenatal and Postpartum Care– Timeliness of Prenatal Care (SUD stratum)

| | *FY 2018* | *FY 2019* | *FY 2020* | *FY 2021* | *p-value* | *Effect Size* |
|---|---|---|---|---|---|---|
| **Percentage** | 14.39% | 24.90% | 23.67% | 44.14% | <.001 | .222 |
| **Count** | 284 | 494 | 449 | 561 | | |

Note: Metric PPC was calculated using only paid claims.

The proportion of beneficiaries with an SUD diagnosis receiving prenatal care in the first trimester increased dramatically across the demonstration period, with the raw count of beneficiaries almost doubling by 2021. The proportion of beneficiaries increases to reflect this as well, with a rise of 29.75 percentage points from the baseline fiscal year 2018 to fiscal year 2021. Unsurprisingly, this change is statistically significant (p<.001), and the effect size indicates a substantial, though small, change over time. Additionally, the proportion of beneficiaries in the SUD subpopulation receiving prenatal care jumped 10.51 percentage points upon the beginning of the 1115 waiver implementation, reflecting an immediate, widespread expansion of access to prenatal care during the demonstration period. While the actual count changes by <100 beneficiaries from year to year aside from the initial shift, this indicates that the denominator, beneficiaries with an SUD diagnosis and a live birth during the measurement year, shrank intensely; this indicates that the state of Illinois has made promising progress on the provision of care and the expansion of access to prenatal care, supporting the hypothesis.

### Metric PPC (NQF #1517): Prenatal and Postpartum Care– Postpartum Care (SUD stratum)

| | *FY 2018* | *FY 2019* | *FY 2020* | *FY 2021* | *p-value* | *Effect Size* |
|---|---|---|---|---|---|---|
| **Percentage** | 54.54% | 53.18% | 49.82% | 47.99% | .04 | .029 |
| **Count** | 1076 | 1055 | 945 | 610 | | |

Note: Metric PPC was calculated using only paid claims.

Unfortunately, the proportion of deliveries by beneficiaries with an SUD diagnosis receiving postpartum visits between 1 and 12 weeks after delivery exhibited a steady and significant (p<.04) decline across the demonstration period. The count of beneficiaries receiving postpartum care is nearly half, with 466 fewer beneficiaries receiving care in fiscal year 2021 than fiscal year 2018. However, the proportion of beneficiaries does not decrease as sharply, only falling by 6.55 percentage points. This indicates that there were less beneficiaries in need of postpartum care during the demonstration period, although this does not sufficiently account for the overall decrease in access and utilization. Furthermore, with a relatively small sample size compared to the other metrics, postpartum care is vulnerable to shocks, such as the one caused by COVID-19, as reflected by the steep drop in 2021, as July-December 2020 is included in FY 2021. However, as the decline is significant, this fails to support the hypothesis that the 1115 Medicaid waiver improved access to care among beneficiaries with SUD for physical health conditions in general.

## Section VI: Conclusions

Below is a table that summarizes the results:

| Goal | Outcome | Result | |
|---|---|---|---|
| Increase rates of identification, initiation, and engagement in treatment. | **Metric 15a:** Initiation in SUD Treatment | ↔ | No discernible trends across measurement period for total SUD treatment initiation. |
| | **Metric 15b:** Engagement in SUD Treatment | ↔ | Potential downwards trend. However, this trend is marginal, changing by less than 2 percentage points. |
| Increased adherence to and retention in treatment. | **Metric 3:** Medicaid Beneficiaries with a SUD Diagnosis. | ↑ | Steady increase in number of Medicaid beneficiaries across the demonstration period. |
| | **Metric 22:** Continuity of Pharmacotherapy for OUD | ↑ | Rise of 8.05 percentage points in the post-1115 period (p<.001) |
| Reduction in overdose deaths, particularly due to opioids | **Metric 26:** Certified Total OUD Deaths (Count) | ↔ | No discernible trends, with high variance across demonstration period for both the rate and raw count of OUD deaths. More data is needed. |
| | **Metric 27:** Certified Total OUD Deaths (Rate per 1,000 Medicaid Beneficiaries) | ↔ | |
| | **Metric 18:** Use of Opioids at High Dosage in Persons without Cancer per 100 Medicaid Beneficiaries | ↓ | Fall of 1.25 percentage points over the demonstration period (p<.001). |
| | **Metric 21:** Concurrent Use of Opioids and Benzodiazepines per 100 Medicaid Beneficiaries | ↓ | Fall of 9.1 percentage points over the demonstration period (p<.001). |
| Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services. | **Metric 23:** Emergency Department utilization for SUD per 1,000 Medicaid beneficiaries. | ↔ | High variation throughout demonstration period, especially during COVID-19 pandemic. Overall trend is steady for SUD, OUD sees more variation, but no directionality. |
| | *OUD substratum* | ↔ | |
| | **Metric 24:** Inpatient stays for SUD per 1,000 Medicaid beneficiaries. | ↔ | Steady trend throughout demonstration period for SUD, OUD sees high variation with an overall drop. |
| | *OUD substratum* | ↓ | |
| Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate. | **Metric 25:** Readmissions Among Beneficiaries with SUD. | ↔ | No distinct change in readmission rate over the demonstration period. |
| Improved access to care for physical health and behavioral health conditions among beneficiaries. | **Metric 32:** Access to preventive/ambulatory health services for adult Medicaid beneficiaries with SUD. | ↑ | Despite fluctuations over the demonstration period, significant (p<.001) increase in access. |
| | **Metric ADV (NQF #1388):** Annual Dental Visits (SUD stratum). | ↔ | Small n and high variation across demonstration period, although the overall trend is consistent. |

| | | | |
|---|---|---|---|
| | **Metric WCV (NCQA W30):** Child and Adolescent Well-Care Visits | ↔ | Small n and minor fluctuations, with no distinct trend. |
| | **Metric PPC (NQF #1517):** Prenatal and Postpartum Care– Timeliness of Prenatal Care (SUD stratum) | ↑ | Significant (p<.001) rise of 29.75 percentage points in the post-waiver period. |
| | **Metric PPC (NQF #1517):** Prenatal and Postpartum Care– Postpartum Care (SUD stratum) | ↓ | Steady and significant decline in postpartum care throughout the demonstration period (p=.04). |

Overall, 7 of the 18 (39%) metrics are trending in the expected direction, 10 (56%) have remained consistent, and 1 (5%) is moving in the opposite direction. For metric 24, the OUD substratum seems to be making more progress than the overall SUD population. While postpartum care has been decreasing, this directionality was less significant than other metrics (p=0.04 versus p<.001).

Based on the data presented, it is highly likely that more time is needed to see progress on the metrics used for this evaluation. The COVID-19 pandemic prevented the full implementation of several pilot programs and delayed care across the healthcare spectrum. Furthermore, there were unexpected changes in care due to the pandemic, including higher usage of telehealth services, increased ER visits due to the closure of some services, and potential delays in care post-shutdown due to closures and staffing shortages.

Despite all of this, 39% of the metrics are progressing as expected. Of the 10 metrics that have remained consistent, a few are beginning to stabilize and have the potential to show change in the final two years of the 5-year waiver period. The metric that is moving in the opposite direction could also be due to the delays in services post-pandemic. Postpartum care is an ongoing service that may not have had time to recover due to the closure of certain services and known staffing shortages.

One example that helps to illustrate this is that significant progress has been shown in metrics 18 and 21 (use of opioids at high dosage and concurrent use of benzodiazepines and opioids); however, this has not yet translated to decreases in overdose deaths (metrics 26/27), emergency department visits (metric 23), or inpatient stays (metric 24). Further evidence that changes made due to the waiver are working is shown in the increased number of people diagnosed with an SUD (metric 3), though this has not yet impacted initiation and engagement in treatment (metric 15). Finally, increased access to preventive/ambulatory services (metric 32) and prenatal care (metric PPC) have shown progress, but there is still work to be done regarding follow-up services such as dental visits (metric ADV), well-care visits (metric WCV), and postpartum care.

## Section VII: Interpretations, Policy Implications, and Interactions with Other State Initiatives

There have been several state-level policy changes that likely impacted the data presented in this report. While policy changes related to SUD can potentially impact all metrics, a few may have impacted specific metric data over the course of the waiver.

Metric 15 (Initiation and Engagement in Treatment) has remained consistent across the first 3 years of the demonstration, but there are two policies that have the potential to move this metric from being consistent to showing increases over the next two years.

1. Illinois passed the Emergency Opioid and Addiction Treatment Access Act (PA 100-1023) restricting the use of prior authorization for all SUD treatments, while PA 100-1024 eliminated the use of prior authorization and step-therapies requirements for all FDA approved MAR for Opioid Use Disorder. Both became effective 1/1/2019.
2. Public Act 102-0598 Screening Brief Intervention and Referral to Treatment (SBIRT) benefit for Medicaid populations served in primary care, hospital, or community behavioral health settings. In addition,

development of opioid specific SBIRT services in emergency departments to include services for initiation of MAR. Effective 1/1/2022.

Metric 22 (Continuity of Pharmacotherapy for OUD) has already shown remarkable increases over the demonstration. However, there are two projects that began recently in demonstration years 3 and 4 related to these metrics that have not yet had sufficient time to impact the data but are likely to do so moving forward. These include:

1. IDHS/SUPR Access to Medication Assisted Recovery (AMAR) Project broadens services in MAR "deserts" - counties with no providers who are approved and actively dispensing or prescribing methadone, buprenorphine, or naltrexone. Five MAR network models (Hub and Spoke) are being implemented in areas of Illinois that currently have relatively few treatment resources for persons with OUD. This Hub and Spoke Model was mentioned in the 1115 demonstration application and began in quarter 3 of demonstration year 3.
2. IDHS/SUPR, and the Chicago Department of Public Health (CDPH) launched the MAR NOW pilot program in Chicago in May 2022 and expanded the program statewide starting on September 1, 2022. Funded through SUPR programming, MAR NOW connects callers through the Illinois Helpline for opioids and other substances (https://helplineil.org/app/home) to immediate treatment for opioid use disorder, including telephonic prescription and home induction on buprenorphine or same-day clinic appointments for methadone, buprenorphine, or naltrexone. MAR NOW can also connect individuals to withdrawal management and residential treatment.
3. Illinois has begun providing a digital toolkit for recovery support services to retain patients in MAR and offer additional support. Illinois Recovery Community Organizations (RCOs) and SUPR-licensed providers have been awarded funds and technical assistance to develop digital recovery support toolkits including secure messaging, web resources, and recovery support mobile applications (apps) for persons with OUD who are active in some form of MAR. Through the NOFO process five providers were identified and began services in December 2019. As of June 30, 2022, 596 clients have been admitted to these services.

Thus far, no progress has been shown in metric 25 (30-Day Readmission for SUD Treatment) as this has remained consistent. However, Public Act 102-0043, passed on April 27, 2021, specifically targets metric 25 (30-Day Readmission for SUD Treatment). Public Act 102-0043 is the sunset of the provision requiring concurrent review to prevent repeat admissions, limiting admission to any hospital-based inpatient detoxification to once every 60 days.

While significant progress was made in increasing prenatal care for the SUD stratum, the steady decline of postpartum care is concerning. However, Illinois is implementing the Service Enhancement for Pregnant and Postpartum Women with OUD program where enhanced services are made available to pregnant and postpartum women with OUD by staff who are certified in the following evidenced-based practices: Community Reinforcement and Family Training (CRAFT), Motivational Interviewing, Seeking Safety, Real Life Parenting, Individual Placement and Support (IPS) Employment. The staffing pattern for the supported enhancement includes Doula Certified Recovery Coaches. A Doula Certified Recovery Coach is a person in active recovery who obtains dual certification as both a birth and a postpartum doula to assist the recovering mother through prenatal and postpartum phases, and with recovery from her addiction. Services have been initiated by the five providers which were selected through the NOFO process. As of June 30, 2022, 1,258 women have been admitted to these enhanced services.

There are also several policy changes/programs that address the entire SUD system in Illinois:

1. In September of 2020, SUPR performed a rate study and analysis of ASAM residential Level of Care (3.1, 3.2, 3.5, and 3.7) and developed a statewide single rate methodology. The new rate methodology established a new state rate of $261 for Level 3.5 residential, increasing rates for 62% of providers. The other 38% had residential rates that exceeded $261 so these providers kept their existing rates. On average, residential providers saw a 46% increase in their rates.
2. The state continues to implement initiatives funded through State Opioid Response (SOR) grants by SUPR. A no-cost extension of this ended on 9/29/2021.

3. HFS was awarded the SUPPORT Act Section 1003 Demonstration Project to Increase Substance Use Provider Capacity planning grant (March 2019-September 2022) to perform an assessment of the behavioral health treatment needs of the state. The goals were to: determine the extent to which providers are needed to address the SUD treatment and recovery needs of Medicaid beneficiaries, develop training and technical assistance to educate practitioners on the data waiver process, and to increase the number and overall capacity of providers delivering MAR.
4. Residential Stabilization Centers for Patients with Opioid Use Disorder - These resources are targeted to the current gap in the service continuum for persons with OUD who lack housing and other supports to effectively engage in MAR during the early stage of their recovery process. Residential/inpatient care is expensive and unnecessarily restrictive for many persons with MAR, but many individuals still need safe, stable, temporary housing and supports like clothing, meals, and access to mental health services and primary health care. As of June 30, 2022, 810 clients have been admitted to the Residential Stabilization Centers.
5. Recovery Homes - Recovery Homes are alcohol and drug free homes whose rules, peer-led groups, staff activities and/or other structured operations are meant to help with maintaining sobriety. ORF grants have allowed IDHS/SUPR to expand Recovery Home services for persons with OUD who have unstable living arrangements and are active in some form of MAR. As of June 30, 2022, 1,012 clients have been admitted to a Recovery Home.
6. Correctional Facility-Based MAR Services - Injectable naltrexone is the form of medication assistance for OUD that is most often preferred by correctional facility administrators because it has no risk of diversion. Federal ORF grant funds support six organizations providing injectable Naltrexone services for persons with OUD in county jails and at the Sheridan Correctional Center, one of Illinois' prisons. These services consist of screening, assessment, initial injections, and post-release treatment referrals before discharge. Through June 30, 2022, 426 persons have been served. About 95% of these offenders were admitted by the community-based treatment providers to which they were referred.
7. Community-based Outreach/Linkage/Referral Services - Specialized and specific community-based outreach, referral, and linkage services are offered for persons with OUD in high-need areas. As a means of identifying individuals who are currently using heroin or other illicit opioids, peer outreach workers canvass multiple locations that are frequented by high-risk individuals, such as parks, street corners, public transportation stations, mini-marts, and liquor stores. Through the end of June 2022: 8,294 persons were provided outreach services; 5,503 of these persons screened positive for opioid and other illegal substance use and expressed an interest in treatment; 3,253 of these completed a meeting with a linkage manager; and 2,572 presented for the treatment intake.

As illustrated here, significant progress on state-level policy changes and the implementation of new programs has occurred over the past 2-3 years. The data in this report, however, only demonstrates changes that occurred up until the end of 2021. The passage of time with the new policies and programs in place will likely further impact the progress that has been shown as well as changing metrics from staying consistent or declining to showing progress.

## Section VIII: Lessons Learned and Recommendations

There were several lessons learned from compiling this Interim report. First, the impacts of the COVID-19 pandemic and subsequent shutdowns had a meaningful impact on the state's ability to show change in the first 3 demonstration years. In addition to this, there were delays due to rebidding and changes in administration. While the majority of these impacts were unexpected and unavoidable, CPRD (the independent evaluator) was able to use claims data from the pre-waiver baseline year (2017) through the most recent data available (2021) to identify progress achieved for most metrics. However, due to the delays, CPRD did not have access to the data until recently and therefore is only able to provide basic descriptive statistics and significance testing (Pearson's Chi-Square) at this time. Furthermore, several data transfer and other problems were identified in the data. Moving forward, it will be imperative that CPRD have access to more/all claims data as well as assistance from the state to identify errors

and ensure the data provided is accurate to the best of our ability. We look forward to further investigating changes over time and for specific pilot programs.

## Pilot Programs

The state plans to use the information found in this Interim Evaluation report to inform the continued pilot programs. For the 6 pilots that the state will not be asking for renewed authority, the following is an update on the status and lessons learned:

**Clinically Managed Withdrawal Services**: There was a low uptake during the demonstration. Due to COVID-19, providers stopped delivering this level of service in March 2020 and did not resume service until the beginning of 2021. The providers in this pilot experienced significant staff turnover which resulted in a loss of knowledge related to 1115 waiver pilot implementation. There were periods of time when providers did not submit requests for eligibility, which resulted in claims being denied by Managed Care. HFS will continue to work with providers, managed care plans, and other stakeholders to increase accountability around withdrawal monitoring and to identify innovative, evidence-based services to best serve Medicaid enrollees.

**Peer Recovery Support Services:** There is only one designated provider for Peer Recovery Support. This provider consistently submitted requests for eligibility in accordance with established plan for pilot enrollment, but there are no fee-for-service claims records found in the EDW Fee For Service indicating that services were billed. There are also no records of claims being submitted to Managed Care Organizations for pilot services. The state has been unable to determine the amount or frequency of peer recovery support services delivered to the identified eligible enrollees. Outside of the waiver SUPR began allowing providers to use contract funding (GRF and Block Grant) to pay for the delivery of peer recovery services. There was a theory that the provider may have submitted peer recovery services delivered under the pilot with other services delivered through the waiver. However, after further review SUPR was unable to identify any services specific to PRS delivered by the provider to Medicaid enrollees. HFS plans to include these services in an upcoming state plan amendment.

**Crisis Intervention Services and Evidence-Based Home Visiting Services:** HFS plans to include these services in an upcoming state plan amendment.

**Intensive In-Home Services and Respite Services:** These services have been incorporated into a state plan amendment through 1915(i) authority.

**Criminal Justice Case Management**: Two providers have delivered pilot services to eligible participants, but there have been ongoing issues with the providers submitting claims to Managed Care and claims being rejected or denied. There have been periods of staffing issues that have contributed to delays in the state approving eligibility. This was most prevalent during the first 12 months of the PHE. HFS and the Bureau of Behavioral Health took ownership of the eligibility process and dedicated staff responsibilities to ensure timely completion of the pilots' eligibility process moving forward.

For the 4 pilots that have been implemented, CPRD will conduct individual evaluations using claims data, but the impact may be less than expected since the implementation started later than anticipated. Due to this, the evaluator may consider alternatives to the originally proposed evaluation, such as interviews with providers.

## Rule 2060

Rule 2060 was a large part of the implementation plan and mid-point assessment. SUPR is continuing to work toward appropriate administrative rule changes – with a plan for submission for rule promulgation in April/May with anticipated approval in the fall of 2023.

SUPR does not contract for Medicaid funds. When these milestones were originally developed, SUPR planned to merge the State Medicaid Rule (Part 2090) into Administrative Rule Part 2060. It was subsequently decided to focus only on the licensure components of Part 2060 and leave Part 2090 as the singular Medicaid Rule for SUD services. Therefore, SUPR will amend Part 2090 upon adoption of Part 2060. It is anticipated that the revision process for Part 2090 will begin in late 2023.

Furthermore, regarding case management, clinically managed withdrawal, providers offering MAT on-site or facilitating off-site, and the implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays, all are written and required in the provider contracts with SUPR. Therefore, these services should already be in place despite the delay in passing/updating Rules 2060 and 2090.

## Other Recommendations

There are three additional areas where we have recommended actions; addressing workforce challenges, addressing structural factors that may drive differences in access and quality for specific racial and ethnic groups, and better defining recovery capital. First, as workforce shortages have plagued the service delivery system since the pandemic, we recommend estimating the number of additional providers required to serve the Medicaid population and invest in additional workforce development initiatives as appropriate. The state could also consider an initiative where SUPR provides student loan relief to qualified professionals that stay in the SUD field for a specific number of years after obtaining licensure.

Regarding structural factors that are driving race/ethnicity differences in access and quality of care, one potential solution to dismissal issues or cultural humility issues in contracted providers may be to a) require all providers to report their length of stay/engagement metrics by racial/ethnicity, and b) offer enhanced rates to providers that have a very low racial/ethnic disparities in such metrics. Additionally, technical assistance to agencies that have high disparities could be offered or beneficiary studies of experiences of racial/ethnic microaggressions during care could be conducted.

Recovery capital, an organizing concept in the recovery movement, needs better definition among low-income Medicaid beneficiaries. Research on which aspects of recovery capital improve outcomes is important, especially the aspects of recovery capital that are modifiable and potentially addressable through beneficiary plan adaptations.

## Conclusion

Overall, the state has shown some promise in achieving the goals for the 1115 Medicaid waiver according to the evaluation of key metrics using Medicaid claims data. The implementation was delayed and experienced further challenges during the COVID-19 pandemic that have stalled progress, so pilot programs will need more time to reach beneficiaries. Illinois has also recently implemented programs and passed public acts that are likely to impact progress moving forward. Our recommendations will assist this progress but are few because we believe the most significant factor needed to show change is simply more time, as not enough time has passed to overcome the challenges experienced or for recent programs to impact claims data.

## Appendix A: Approved Evaluation Design Plan

# Illinois 1115 Substance Use Disorder Demonstration Evaluation Plan (Revised Per CMS Feedback on March 15th, 2021)

Illinois is one of the largest funders of health and human services (HHS) in the country. With approximately $32 billion spent across its HHS agencies, amounting to more than 40% of its total budget, the State is deeply invested in the health and well-being of its 12.7 million residents and 3.4 million Medicaid members. There is an urgent need to get more from this investment - the State must improve health outcomes for residents while slowing the growth of healthcare costs and putting the State on a more sustainable financial trajectory.

To this end, Illinois has embarked on a transformation of its HHS system. The transformation, which was originally announced in 2016, has the broad aim of improving population health, improving experience of care, and reducing costs. It is grounded in five themes:

1. Prevention and population health
2. Paying for value, quality, and outcomes
3. Rebalancing from institutional to community care
4. Data integration and predictive analytics
5. Education and self sufficiency

The initial focus of the transformation effort is on behavioral health (mental health and substance use) and specifically the integration of behavioral and physical health service delivery. Behavioral health was chosen due to the urgency of the issue as well as the potential financial and human impact. Building a nation-leading behavioral health strategy will not only help bend the healthcare cost curve in Illinois but also help turn the tide of the opioid epidemic, reduce violent crime and violent encounters with police, and improve maternal and child health. There is also a large financial payoff in improving behavioral health: Medicaid members with behavioral health needs (referred to henceforth as “behavioral health members”) represent 25% of Illinois Medicaid members but account for 56% of all Medicaid spending. Medicaid beneficiaries with behavioral health needs, such as mental illness or drug and alcohol use disorders incur costs that are 2-3 times higher than those who do not have co-occurring disorders.

Under the demonstration, which was approved May 7, 2018, Illinois proposed the introduction and limited piloting of certain services that are currently not directly available to Illinois Medicaid beneficiaries. The additional services are expected to inform the state’s efforts to transform the behavioral health system in Illinois as some beneficiaries will have access to less costly community-based services, which are expected to help beneficiaries improve their health and avoid costlier services provided in an institution. The demonstration period is July 1, 2018 through June 30, 2023.

At the point of its introduction in 2018, HFS' Section 1115 Medicaid Demonstration Waiver, entitled: Illinois Behavioral Health Transformation Demonstration, was the first of a planned series of initiatives under Illinois' *Health and Human Services (HHS) Transformation* initiative. The HHS Transformation intended to focus on prevention and public health strategies, pay for performance, and data-driven health efforts. At the core of Illinois' 1115 Waiver was a package of Substance Use Disorder (SUD) initiatives that targeted the opioid epidemic in Illinois and efforts to serve as a catalyst for a modernization of the Illinois SUD infrastructure. Testing the Medicaid sustainability potential of previously grant-funded services and the introduction of health infrastructure to help inform and reduce problematic prescription practices of medical professionals – the 1115 could clearly be characterized as a SUD-based initiative. Additionally, HFS sought to take advantage of the 1115 financial authority and test several new community-based behavioral health services focused on the more traditional mental health service continuum.

In the two and a half years since the approval and initial implementation of the Illinois Behavioral Health Transformation Demonstration, HFS has refined its healthcare strategy for individuals with complex healthcare needs – those with and without behavioral health conditions. In a more nuanced approach, the Medicaid agency is seeking to replace its original multifaceted approach to testing multiple system enhancements for a more targeted, population management approach. Introducing a new 1915(i) State Plan Amendment in 2020, HFS appears to be implementing services and supports that it once intended to test as a limited-scale pilot under the 1115 now as services available statewide to all individuals that qualify. Additionally, legislation proposed by the Illinois Legislature in Spring 2021 seeks to introduce evidence-based home visiting and doula services more broadly into the Illinois Medicaid program.

With the impending revisions to the 1115 that will surely remove the 1915(i)-like and home visiting pilots from its financial authority, HFS appears to be concentrating the Demonstration Waiver on the improvement of Illinois' SUD delivery system. An effort that underscores the State's overall commitment to SUD transformation and aligns with ongoing efforts from the State's Department of Human Services, Division of Substance Use Prevention and Recovery (SUPR) to move the SUD service delivery system forward. At a time when SUPR finds itself re-basing individualized provider rates in favor of cost-based rate structures to establish service equity and introducing system enhancements via federal grants (SAMHSA's State Opioid Response federal grant and CMS' Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act: Section 1003 – Planning Grant) Illinois' 1115 Demonstration Waiver, when considered without its 1915(i)-like and home visiting components, fits within the context of the State seeking to transform its SUD service delivery system.

**List of 1115 Demonstration Waiver Pilot Programs**

| Service Name | Start Date | Status in 1115 |
|---|---|---|
| 1. SUD Implementation Protocol featuring up to 30 Day IMD Funding | 7/1/2018 | Ongoing |
| 2. Clinically Managed Withdrawal Management Services Pilot | 2/1/2019 | Ongoing |
| 3. SUD Case Management Pilot | 2/1/2019 | Ongoing |
| 4. Peer Recovery Support Services Pilot | 2/1/2019 | Ongoing |
| 5. Crisis Intervention Services Pilot | Anticipated 2021 | Ongoing |
| 6. Evidence-Based Home Visiting Services | N/A | Anticipated transition to State Plan authority |
| 7. Assistance in Community Integration Services | N/A | Transition to 1915(i) |
| 8. Supported Employment Services | N/A | Transition to 1915(i) |
| 9. Intensive In-Home Services | | Transition to 1915(i) |
| 10. Respite Services | N/A | Transition to 1915(i) |

**Rationale for this Waiver Project**

This 1115 Medicaid Waiver project will address several pressing needs in the state of Illinois. First, it will fill gaps left at the intersection of the state substance use authority and state Medicaid program regarding the opioid crisis. Specifically, there is a need for high quality residential treatment for individuals, withdrawal management services (i.e., detoxification), case management, and peer recovery support services. Second, there is a strong need to emphasize community-based care for individuals that are severely or persistently mentally ill (SMI). For such individuals, there is recognition that services will be needed, and the critical goal is to enhance these citizens' quality of life by attempting to alleviate the stress of crisis events. Below, we briefly discuss the impact of the opioid crisis on the State of Illinois and rationale for the pilots Illinois will implement to address the crisis. Additionally, we will discuss the need for improving the quality of life of individuals with severe and persistent mental illnesses, and how we address it with our pilot that focuses on crisis intervention services.

**Overview of the Opioid Crisis in Illinois**

In a 2017 comprehensive report on opioids, the Illinois Department of Public Health[1] reported alarming increases in consequences of opioid use across the board. Emergency department visits increased by 77% from 2015 to 2016, with the largest increase due to heroin overdoses. Hospitalizations also increased by 42% from 2014-2016. Naloxone administrations by EMS personnel increased 250% from 2013 to 2016, and neonatal abstinence syndrome increased 53% from 2011 to 2016. The most recent data from the Illinois Department of Public Health[2] showed that overdoses from heroin and other opioids nearly tripled from 6,868 in 2013 to 15,702 in 2018. In 2018, 2,086

overdoses were fatal. Overdoses were primarily seen in white males between the ages of 25-34 and 45-54. This is especially alarming given that the total number of prescription opioids filled decreased from 7,562,123 in 2015 to 4,850,691 in 2018.

**Illinois 1115 SUD Demonstration Goals**

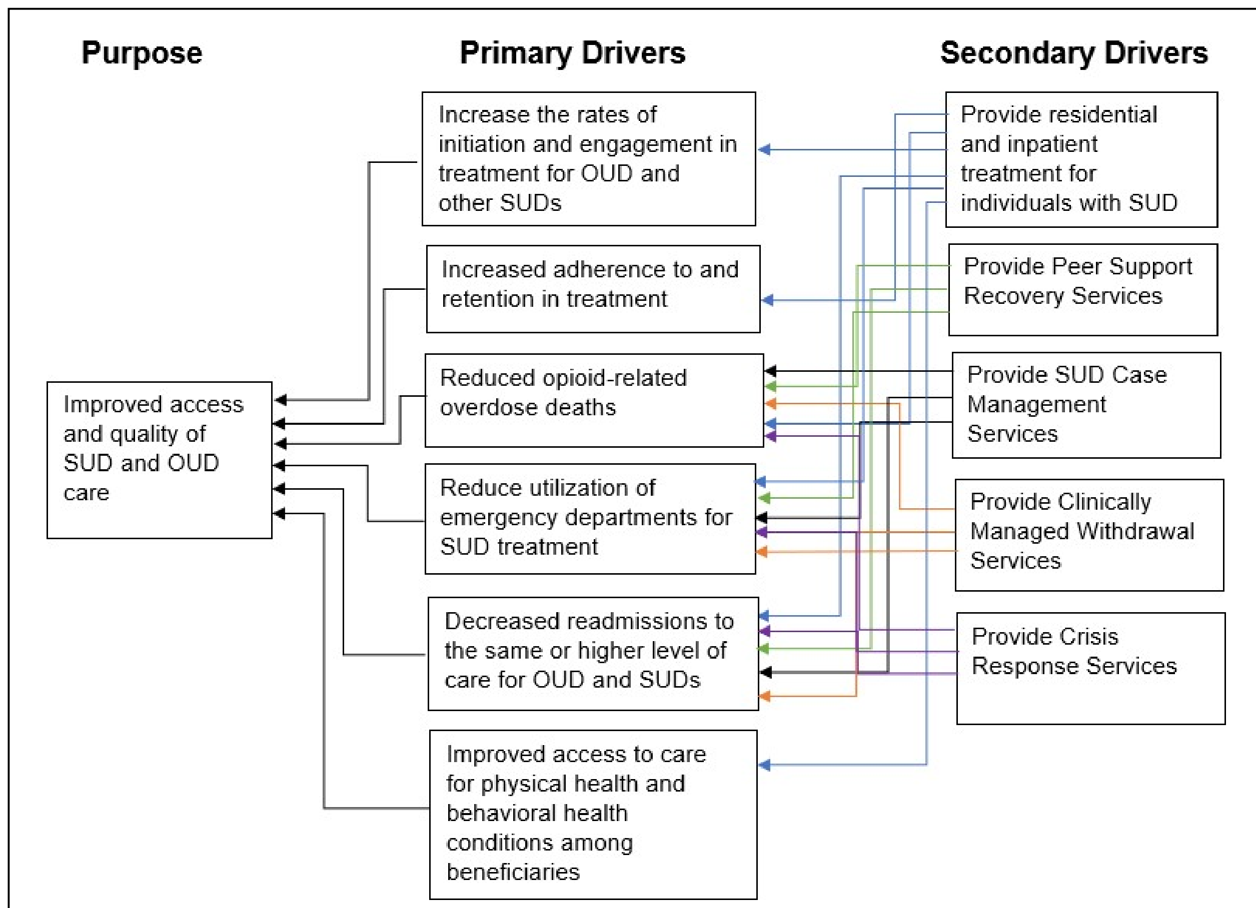
Against the backdrop provided, this project has six goals, including:

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health and behavioral health conditions among beneficiaries.

### Evaluation Questions and Hypotheses

The following driver diagram presented in Figure B-1 shows the relationships between the demonstration's purpose, the primary drivers that contribute directly to achieve the purpose, and secondary drivers necessary to achieve the primary drivers.

Figure B-1. Purpose and Drivers




### Illinois 1115 SUD Demonstration Goals, Evaluations Questions and Hypotheses

The overall goal is to conduct a robust and data-driven analysis to identify, to the greatest extent possible, a causal relationship between the intervention component and the key outcomes of interest. Where possible, it will be important to explore mechanisms either aiding or hindering the impact of the Waiver component. Table B-1 outlines our goals, evaluation questions and hypotheses.

| Table B-1. Illinois 1115 SUD Demonstration Goals, Evaluation Questions, and Hypotheses | | |
|---|---|---|
| **Goals** | **Evaluation Questions** | **Hypotheses** |
| 1. Increased rates of identification, initiation, and engagement in treatment. | 1. Does the demonstration increase access to and utilization of SUD treatment services? | 1. The demonstration will increase the percent of members referred to and engaging in SUD treatment. |
| 2. Increased adherence to and retention in treatment | 2. Does the demonstration increase adherence to and retention of SUD treatment services? | 2. The demonstration will increase the percent of members adhering to SUD treatment. |
| 3. Reductions in overdose deaths, particularly those due to opioids. | 3. Are rates of opioid-related overdose deaths impacted by the demonstration? | 3. The demonstration will result in decreased opioid-related overdose deaths. |
| 4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services. | 4. Does the waiver result in fewer preventable ER visits for SUD? | 4. The demonstration will result in fewer ER visits for SUD in the member population. |
| 5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate. | 5. Do waiver enrollees receiving SUD/OUD services experience reduction in readmissions to the same or higher levels of care for SUD/OUD? | 5. The demonstration will reduce readmissions to the same or higher levels of SUD care. |
| 6. Improved access to care for physical health and behavioral health conditions among beneficiaries | 6. Do enrollees receiving SUD services experience improved access to care for physical health conditions? | 6. The demonstration will increase the percentage of members with SUD who access care for physical health conditions. |

### Outcome Evaluation – Primary Drivers

As shown in the driver diagram for the overall SUD Demonstration (Figure B-1, above), the six primary drivers and five secondary drivers support the hypotheses for the evaluation questions (Table B-1, above) to the performance of the SUD Demonstration. The SUD Demonstration evaluation questions and hypotheses are matched to their respective drivers and measure details within tables B-2 through B-7 below. Additional information about a cost analysis is provided in table B-8.

**Table B-2. Summary of Measures and Analytic Approach for Primary Driver 1**

**Demonstration Goal 1**: ***Increased rates of identification, initiation, and engagement in treatment.***

**Evaluation Question 1:** *Does the demonstration increase access to and utilization of SUD treatment services?*

**Evaluation Hypothesis 1:** *The demonstration will increase the percent of members referred to and engaging in SUD treatment.*

| Measure Description | Steward | Numerator | Denominator | Data Source | Analytic approach |
|---|---|---|---|---|---|
| Initiation and Engagement in SUD Treatment (IET) | NQF #0004 NCQA | Initiation: Number of members who began initiation of treatment through an inpatient admission, residential, outpatient visits, intensive outpatient encounters, or partial hospitalization within 14 days of the index episode start date | Initiation: Members who were diagnosed with a new episode of SUD during the first 10½ months of the measurement year | State Medicaid Claims Data | Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison) |
| Initiation and Engagement of SUD Treatment (IET) | NQF #0004 NCQA | Engagement: Initiation of treatment and two or more engagement events (inpatient admissions, residential, outpatient visits, intensive outpatient encounters or partial hospitalizations) with any SUD diagnosis within 34 days after the initiation event | Engagement: Members who were diagnosed with a new episode of SUD during the first 10½ months of the measurement year | State Medicaid Claims Data | Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison) |

| Table B-3. Summary of Measures and Analytic Approach for Primary Driver 2 | | | | | |
|---|---|---|---|---|---|
| **Demonstration Goal 2: Increased adherence to and retention in treatment.**<br>**Evaluation Question 2:** *Does the demonstration increase adherence to and retention of SUD treatment services?*<br>**Evaluation Hypothesis 2:** *The demonstration will increase the percent of members adhering to SUD treatment.* | | | | | |
| **Measure Description** | **Steward** | **Numerator** | **Denominator** | **Data Source** | **Analytic approach** |
| Percentage of beneficiaries with an SUD diagnosis (including beneficiaries with an OUD diagnosis) who used SUD services per month (CMS Metric #3) | CMS | Number of enrollees who receive a service during the measurement period by service type | Number of enrollees | State Medicaid Claims Data | Descriptive statistics; chi square tests of significance comparing target population to baseline and to the comparison group |
| Continuity of pharmacother-apy for OUD | NQF #3175 | Number of participants who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days | Individuals who had a diagnosis of OUD and at least one claim for an OUD medication | State Medicaid Claims Data | Descriptive statistics; chi square tests of significance comparing target population to baseline and to the comparison group |
| Continuity of Care after Inpatient or Residential Treatment for SUD | NQF #3453 | Members with an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or filled a prescription for or were administered or ordered a medication for SUD within 7 and 14 days after discharge | Adult Medicaid beneficiary discharges from inpatient or residential treatment for SUD with a principal diagnosis of SUD during from January 1 to December 15 of the measurement year | State Medicaid Claims Data | Propensity-score matching- with control groups (i.e., pre-test period beneficiaries; beneficiaries not receiving case management) after matching on demographic characteristics. Logistic regression (i.e., predicting dichotomous variable of |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | receipt of subsequent services, coded 0 for no and 1 for yes) |
| Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs | NQF#3312 | Discharges in the denominator who have an inpatient, intensive outpatient, partial hospitalization, outpatient visit, residential, or drug prescription or procedure within 7 or 14days after discharge from an inpatient hospital, residential addiction program, or ambulatory medically managed withdrawal. | Adult Medicaid beneficiary discharges from medically managed withdrawal from January 1 to December 15 of the measurement year. | State Medicaid Claims Data | Propensity-score matching- with control groups (i.e., pre-test period beneficiaries; beneficiaries not receiving case management) after matching on demographic characteristics. Logistic regression (i.e., predicting dichotomous variable of receipt of subsequent services, coded 0 for no and 1 for yes) |

| Table B-4. Summary of Measures and Analytic Approach for Primary Driver 3 | | | | | |
|---|---|---|---|---|---|
| **Demonstration Goal 3**: ***Reduction in overdose deaths, particularly those due to opioids.*** **Evaluation Question 3:** *Are rates of opioid-related overdose deaths impacted by the demonstration?* **Evaluation Hypothesis 3:** *The demonstration will result in decreased opioid-related overdose deaths.* | | | | | |
| **Measure Description** | **Steward** | **Numerator** | **Denominator** | **Data Source** | **Analytic approach** |
| Opioid Drug Overdose Deaths (CMS Metric #27, OUD Stratum) | CMS | Number of overdose deaths due to opioids among eligible beneficiaries | Number of adult Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the Measurement Period | Mortality data (Vital Statistics); State Medicaid Eligibility and Enrollment data | Descriptive statistics; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher's Exact test for comparison of percentages for final year (2023) and pretest year (2017) |
| Use of Opioids at High Dosage in Persons without Cancer per 1,000 Medicaid beneficiaries (CMS Metric #18) | NQF #2940 (Adult Core Set) PQA NCQA | Number of beneficiaries with opioid prescription claims with daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer | Number of adult Beneficiaries without cancer divided by 1,000. Note: Hospice patients will be Excluded | State Medicaid Claims Data | Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison. |
| Concurrent use of opioids and benzodiaze-pines per 1,000 Medicaid beneficiaries (CMS Metric #21) | PQA (Adult Core Set) | Number of beneficiaries with concurrent use of prescription opioids and benzodiazepines for at least 30 days | Number of adult Beneficiaries without cancer divided by 1,000. Note: Excludes patients in hospice care and those with Cancer | State Medicaid Claims Data | Descriptive statistics; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher's Exact test for comparison of percentages for final year (2023) and pre-test year (2017). |

| Table B-5. Summary of Measures and Analytic Approach for Primary Driver 4 | | | | | |
|---|---|---|---|---|---|
| **Demonstration Goal 4**: ***Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.*** **Evaluation Question 4:** *Does the waiver result in fewer preventable ER visits for SUD?* **Evaluation Hypothesis 4:** *The demonstration will result in fewer ER visits for SUD in the member population.* | | | | | |
| **Measure Description** | **Steward** | **Numerator** | **Denominator** | **Data Source** | **Analytic approach** |
| ED utilization for SUD per 1,000 Medicaid beneficiaries (CMS Metric #23) | CMS | Number of ED visits for SUD during the measurement period | Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000 | State Medicaid Claims Data | Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison). |
| ED utilization for OUD per 1,000 Medicaid beneficiaries (CMS Metric #23, OUD stratum) | CMS | Number of ED visits for SUD during the measurement period | Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000 | State Medicaid Claims Data | Descriptive statistics; ITS design; Trend analysis |
| Inpatient stays for SUD per 1,000 Medicaid beneficiaries (CMS Metric #24) | CMS | Number of inpatient discharges related to a SUD stay during the measurement period. | Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000 | Encounter, eligibility, and enrollment data | Descriptive statistics; ITS design; Trend analysis. |
| Inpatient stays for OUD per 1,000 Medicaid beneficiaries (CMS Metric #24, OUD stratum) | CMS | Number of inpatient discharges related to an OUD stay during the measurement period. | Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000 | Encounter, eligibility, and enrollment data | Descriptive statistics; ITS design; Trend analysis. |

| Table B-6. Summary of Measures and Analytic Approach for Primary Driver 5 | | | | | |
|---|---|---|---|---|---|
| Demonstration Goal 5: ***Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.*** **Evaluation Question 5:** *Do waiver enrollees receiving SUD/OUD services experience reduction in readmissions to the same or higher levels of care for SUD/OUD?* **Evaluation Hypothesis 5:** *The demonstration will reduce readmissions to the same or higher levels of SUD care.* | | | | | |
| **Measure Description** | **Steward** | **Numerator** | **Denominator** | **Data Source** | **Analytic approach** |
| 30-Day Readmission for SUD treatment (CMS Metric #25) | CMS | Number of discharges with a subsequent admission to a residential or inpatient facility for SUD treatment at the same or higher level of care within 30 days (i.e., inpatient-to-inpatient, inpatient-to-residential, and residential-to-residential) | Number of discharges from a residential or inpatient facility for SUD treatment. | State Medicaid Claims Data | Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison). |

| Table B-7. Summary of Measures and Analytic Approach for Primary Driver 6 | | | | | |
|---|---|---|---|---|---|
| **Demonstration Goal 6: Improved access to care for physical health and behavioral health conditions among beneficiaries**<br>**Evaluation Question 6:** *Do enrollees receiving SUD services experience improved access to care for physical health conditions?*<br>**Evaluation Hypothesis 6:** *The demonstration will increase the percentage of members with SUD who access care for physical health conditions.* | | | | | |
| **Measure Description** | **Steward** | **Numerator** | **Denominator** | **Data Source** | **Analytic approach** |
| Access to preventive/ ambulatory health services for adult Medicaid beneficiaries with SUD | NCQA | Number of beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period | Number of beneficiaries with an SUD diagnosis | State Medicaid Claims Data | Descriptive statistics; chi square tests of significance comparing target population to baseline and to the comparison group |
| Tobacco use screening and follow-up for people with alcohol or other drug dependence | NQF #2600 | Tobacco use screening and follow-up for people with alcohol or other drug dependence | Total number of beneficiaries | State Medicaid Claims Data | Descriptive statistics; chi square tests of significance comparing target population to baseline and to the comparison group |
| Annual Dental Visits (ADV) (SUD stratum) | NCQA | Eligible beneficiaries 2–20 years of age with SUD diagnosis enrolled in Medicaid | Number of members 2–20 years of age who had one or more dental visits with a dental practitioner during the measurement year | State Medicaid Claims Data | Descriptive statistics; ITS design; Trend analysis |
| Adults' Access to Preventive/ Ambulatory Health Services (AAP) (SUD stratum) | NCQA | Eligible beneficiaries 20 years and older with SUD diagnosis enrolled in Medicaid | Number of members 20 years and older who had an ambulatory or preventive care visit during the measurement year | State Medicaid Claims Data | Descriptive statistics; ITS design; Trend analysis |
| Adolescent Well-Care Visits (AWC) (SUD stratum) | NCQA | Eligible beneficiaries 12–21 years of age with SUD diagnosis enrolled in Medicaid | Number of members 12– 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during | State Medicaid Claims Data | Descriptive statistics; ITS design; Trend analysis |

| | | | the measurement year | | |
|---|---|---|---|---|---|
| Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care (SUD stratum) | NCQA | Number of deliveries with live births for eligible members with SUD diagnosis | Number of deliveries that received a prenatal care visit in first trimester, on or before enrollment start date, or within 42 days of enrollment in the Organization | State Medicaid Claims Data | Descriptive statistics; ITS design; Trend analysis |
| Prenatal and Postpartum Care (PPC) – Postpartum Care (SUD stratum) | NCQA | Number of deliveries with live births for eligible members with SUD diagnosis | Number of deliveries that had a postpartum visit on or b/w 7 & 84 days after delivery | State Medicaid Claims Data | Descriptive statistics; ITS design; Trend analysis |

**Cost Analysis**

As part of the overall evaluation and in addition to the evaluation measures listed above, a cost analysis of the 1115 Waiver in Illinois will be conducted using three approaches (see table B-8 below). Difference-in-difference analyses comparing beneficiaries two years pre-waiver with those who received services under the waiver will be used for Illinois beneficiaries if feasible, depending on data quality and availability. If not, comparison state data and/or Interrupted Time Series analysis will be considered as alternatives.

The first approach will examine total costs across all beneficiaries with a SUD diagnosis and/or treatment service by month. This will be based on the claims data for inpatient, outpatient, pharmacy, and long-term care claims. Second, the total SUD costs will be calculated, including IMD costs, other SUD costs, and non-SUD costs to determine the level of costs related to diagnosis and treatment of SUD. Third, changes in expenses as a predictor or driver will be considered, including ED visits, overdose deaths, service utilization, and any other relevant predictor variables encountered during our investigation that are reasonable to include in the analysis.

Approximately 80% of Illinois' Medicaid beneficiaries are in managed care. SUD treatment services, including demonstration pilot program costs, are built into the Managed Care capitation rates. Payment rates reported by MCOs on encounter claims will be used to identify costs for MCO-enrolled beneficiaries, depending on data quality and availability. If it is determined this data is not sufficient, the Medicaid FFS cost for the same service will be applied to encounter claims to calculate costs.

| Table B-8. Overall Evaluation Cost Analysis | | | | | |
|---|---|---|---|---|---|
| **Measure Description** | **Steward** | **Numerator** | **Denominator** | **Data Source** | **Analytic approach** |
| Total Cost PMPM | CMS-constructed | Total cost for all claims for beneficiaries with SUD | Total number of beneficiaries with SUD diagnosis and/or treatment services | State Medicaid Claims Data | Descriptive statistics; Difference-in-difference or ITS as appropriate |
| Non-IMD SUD Spending | CMS-constructed | Total cost of non-IMD claims for SUD diagnosis and treatment | Total number of beneficiaries with SUD diagnosis and/or treatment services | State Medicaid Claims Data | Descriptive statistics; Difference-in-difference or ITS as appropriate |
| SUD Spending within IMDs | CMS-constructed | Total cost of SUD IMD claims for beneficiaries with SUD | Total number of beneficiaries with SUD diagnosis and/or treatment services | State Medicaid Claims Data | Descriptive statistics; Difference-in-difference or ITS as appropriate |
| Outpatient costs, non-ED | CMS-constructed | Total cost of outpatient, non-ED claims for beneficiaries with SUD | Total number of beneficiaries with SUD diagnosis and/or treatment services | State Medicaid Claims Data | Descriptive statistics; Difference-in-difference or ITS as appropriate |
| Outpatient costs, ED | CMS-constructed | Total cost of outpatient, ED claims for beneficiaries with SUD | Total number of beneficiaries with SUD diagnosis and/or treatment services | State Medicaid Claims Data | Descriptive statistics; Difference-in-difference or ITS as appropriate |
| Inpatient costs | CMS-constructed | Total cost of inpatient claims for beneficiaries with SUD | Total number of beneficiaries with SUD diagnosis and/or treatment services | State Medicaid Claims Data | Descriptive statistics; Difference-in-difference or ITS as appropriate |
| Pharmacy costs | CMS-constructed | Total cost of pharmacy claims for beneficiaries with SUD | Total number of beneficiaries with SUD diagnosis and/or treatment services | State Medicaid Claims Data | Descriptive statistics; Difference-in-difference or ITS as appropriate |
| LTC costs | CMS-constructed | Total cost of LTC claims for beneficiaries with SUD | Total number of beneficiaries with SUD diagnosis and/or treatment services | State Medicaid Claims Data | Descriptive statistics; Difference-in-difference or ITS as appropriate |

## Individual SUD Pilot Demonstration Evaluations

In addition to the overall demonstration evaluation shown above, Illinois will also conduct evaluations for four of the individual pilots that are currently being implemented. Due to the varying implementation dates, the pre- and post-waiver data will be gathered according to reflect the demonstration period. These four pilots support the secondary drivers and the hypotheses for the evaluation questions (Table B-1, above) to the performance of the SUD Demonstration. The SUD Demonstration hypotheses and research questions are presented in tables B-9 through B-12 below, along with measure details and the analytic approach to be used. Demonstrations 1-3 began on February 1, 2019. Propensity score matching will compare pre-intervention groups from July 2017 through June 2018 and post-intervention groups who received services on or after February 1, 2019.

**Table B-9. Pilot Demonstration 1 (Clinically Managed Withdrawal Management Services Pilot)**

**Hypothesis 1**: *Individuals receiving clinically managed withdrawal management for OUD/SUD will have fewer ED visits relative to matched controls.*
**Research question 1**: *Will Medicaid recipients exposed to clinically managed withdrawal management have fewer ED visits?*

| Measure description | Steward | Numerator | Denominator | Data source | Analytic approach |
|---|---|---|---|---|---|
| Emergency department visits for SUD-related diagnoses and specifically for OUD | None | The number of ED visits for SUD during the measurement period | Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period | State Medicaid Claims data | Propensity score matching-comparing withdrawal management recipients in Waiver with control groups after matching on demographic characteristics. |

**Table B-10. Pilot Demonstration 2 (SUD Case Management Pilot)**

**Hypothesis 1**: *Individuals newly receiving SUD Case Management will have reduced criminal justice involvement.*
**Research question 1**: *Will Medicaid recipients receiving SUD case management report fewer arrests at discharge from treatment?*

| Measure description | Steward | Numerator | Denominator | Data source | Analytic approach |
|---|---|---|---|---|---|
| Number of Arrests reported in the 30 days prior to discharge from SUD treatment | None | Number of beneficiaries reporting any (i.e., 1+) arrests in the past 30 days prior to Discharge | Total number of beneficiaries receiving SUD case management services. | DARTS discharge data collected as part of monitoring SAMHSA's National Outcome Monitoring Standards (NOMS) | Propensity score matching comparing participants receiving case management in Pilot 3 vs. Matched controls reporting 1+ arrest but not receiving case management. |

| **Hypothesis 2:** *Individuals receiving SUD Case Management (CM) will have improved continuity of care.* **Research question 2**: *Will Medicaid recipients exposed to SUD CM have an additional SUD visit within 7 to 14 days post index service?* | | | | | |
|---|---|---|---|---|---|
| **Measure description** | **Steward** | **Numerator** | **Denominator** | **Data source** | **Analytic approach** |
| Continuity of Care after SUD CM | NQF #3453 | Members with an Outpatient visit, Intensive Outpatient encounter or Partial hospitaliza-tion, telehealth or filled a Prescription for or were administered or ordered a Medication for SUD within 7 and 14 days after Discharge | Adult Medicaid beneficiary discharges from inpatient or residential treatment for SUD with a principal diagnosis of SUD during from January 1 to December 15 of the measurement year | State Medicaid Claims Data | Propensity-score matching- with control groups (i.e., pre-test period beneficiaries; beneficiaries not receiving case management) after matching on demographic characteristics. Logistic regression (i.e., predicting dichotomous variable of receipt of subsequent services, coded 0 for no and 1 for yes) |

| **Table B-11. Pilot Demonstration 3 (Peer Recovery Support Services (PRSS) Pilot)** | | | | | |
|---|---|---|---|---|---|
| **Hypothesis 1**: *Individuals newly receiving peer recovery support services will have improved continuity of care after receiving the service.* **Research question 1**: *Will Medicaid recipients exposed to peer recovery support services have an additional SUD visit within 7 to 14 days post index service?* | | | | | |
| **Measure description** | **Steward** | **Numerator** | **Denominator** | **Data source** | **Analytic approach** |
| Continuity of Care after Peer Recovery Support Services (PRSS) | NQF-3453 | Members with an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or filled a prescription for or were administered or ordered a medication for SUD within 7 | Adult Medicaid beneficiary discharges from inpatient or residential treatment for SUD with a principal diagnosis of SUD during from January 1 to December 15 of the measurement year | State Medicaid Claims Data | Propensity-score matching with control groups (i.e., beneficiaries receiving residential from an MCO-covered facility not providing PRSS) after matching on demographic characteristics. Logistic regression (i.e., predicting dichotomous variable of receipt of subsequent services, coded 0 for no and 1 for yes) |

| | | and 14 days after discharge | | | |
|---|---|---|---|---|---|
| ED utilization for SUD per 1,000 Medicaid beneficiaries (CMS Metric #23) | None | Number of ED visits for SUD during the measurement period | Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000 | State Medicaid Claims Data | Propensity-score matching with control groups (i.e., beneficiaries receiving residential from an MCO-covered facility not providing PRSS) after matching on demographic characteristics<br>Logistic regression (i.e., predicting dichotomous variable of receipt of ED services, coded 0 for no and 1 for yes) |

**Crisis Intervention Pilot Demonstration Evaluation**

In addition to the SUD-based evaluation components detailed above (overall and individual pilots), Illinois seeks to evaluate its piloted introduction of Crisis Intervention, an alternative to inpatient hospitalization. Demonstration 4, the Crisis Intervention Pilot, is slated to begin in 2021. This evaluation's post-intervention comparison will be based on the actual start the date and the pre-intervention period will be the preceding year.

| **Table B-12. Pilot Demonstration 4 (Crisis Intervention Services Pilot)** | | | | | |
|---|---|---|---|---|---|
| **Hypothesis 1**: *Individuals Newly Receiving Crisis Intervention Services Will Have Greater Initiation and Engagement in Treatment*<br>**Research question 1**: *Does the demonstration increase access to and utilization of SUD treatment services?* | | | | | |
| **Measure description** | **Steward** | **Numerator** | **Denominator** | **Data source** | **Analytic approach** |
| Plan All-Cause Readmissions | None | At least one acute unplanned readmission for any diagnosis within 30 days of the date of discharge from the index hospital stay, that is on or between the second day of the measurement year and the end of the measurement year | Medicaid beneficiaries age 18 and older with a discharge from an acute inpatient stay (index hospital stay) on or between January 1 and December 1 of the measurement year. | State Medicaid Claims Data | Descriptive statistics; chi square tests of significance comparing target population to baseline and to the comparison group |

| | | | | | |
|---|---|---|---|---|---|
| Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF) | NQF # 2860 | The measure estimates the incidence of unplanned, all-cause readmissions to IPFs or short-stay acute care hospitals following discharge from an eligible IPF index admission. A readmission is defined as any admission that occurs within 3-30 days after the discharge date from an eligible index admission to an IPF, except those considered planned. | The target population for this measure is beneficiaries discharged from an inpatient psychiatric facility with a principal diagnosis of a psychiatric disorder. A readmission within 30 days is eligible as an index admission, if it meets all other eligibility criteria. | State Medicaid Claims Data | Logistic regression: Predicting dichotomously scored variable of readmission within 30 days after index event (coded as 0 for no and 1 for yes). |

## Methodology

### Overall Evaluation

Because the Illinois Medicaid Section 1115 Demonstration Waiver is open to all eligible Medicaid recipients, an experimental evaluation design is not feasible. The overall evaluation of the waiver demonstration will utilize a strong quasi-experimental pre-post design that compares trends in outcome measures before implementation of the waiver amendment to the time period directly after. Such designs are recommended by CMS for waiver demonstrations (see https://www.medicaid.gov/medicaid/section-1115- demo/downloads/evaluation-reports/causal-inference.pdf). In order to attribute any observed changes over time to the amendment, a comparison group will be matched to the target population, if possible. Comparison groups will be utilized on an outcome-by- outcome basis when an adequate comparison pool is available. The comparison group will be selected from a similar state who does not have the same community-based behavioral health transformation waiver.

### Interrupted Time Series

Interrupted Time Series is an increasingly popular quasi-experimental alternative to true experiments. It is particularly useful when a randomized trial is not feasible or unethical, but multiple measurements are still viable. It works best with short-term outcomes that are expected to change relatively quickly after a policy is implemented.

Interrupted Time Series involves collecting data at multiple time points before and after an interruption; an interruption of introducing a policy or program, such as the Illinois 1115 Waiver Demonstration for behavioral health transformation. It detects whether an intervention has a significantly greater effect than any underlying secular trend.

Interrupted Time Series assumes that in the absence of an intervention (waiver demonstration), the trend would remain constant when measuring the changes. It uses segmented regression to measure immediate level changes (i.e., a change in the intercept) in the rate of the outcome as well as changes in the trend (slope). 'Segmented' simply refers to a model with different intercept and slope coefficients for the pre- and post-interruption time periods. Figure C-1 below displays the intended one- year baseline measurements from July 2017 to June 2018 and the five-year intervention period from July 2018 – June 2023.

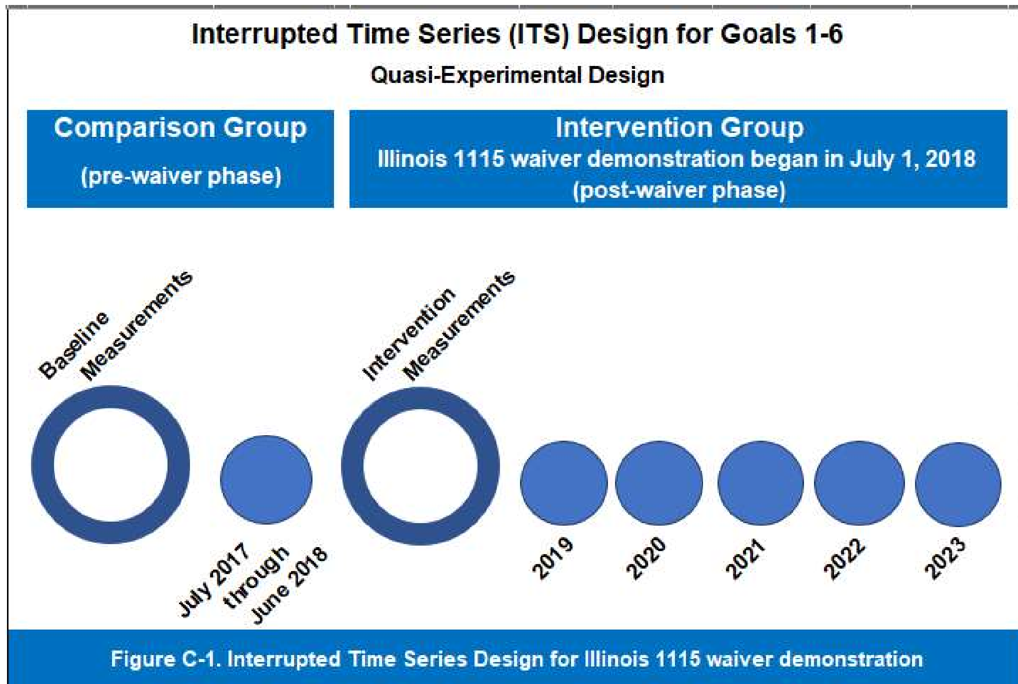


Figure C-1. Interrupted Time Series Design for Illinois 1115 waiver demonstration

A single time series describes only the interruption/waiver state. The pre-waiver trend projected into the waiver period serves as the counterfactual. Such a regression model can be explained as below:

$$Y = \beta_0 + \beta_1 T + \beta_2 X + \beta_3 XT + \varepsilon$$

Where T is the time elapsed beyond the start of the study (July 2017 to June 2018 as pre-period, July 2018 as interruption time, July 2019 to June 2023 as post- interruption time)

X is the study phase (pre-waiver=0, post-waiver=1) Y is the outcome at time T

XT is the time after interruption/waiver

$\beta_0$ represents the intercept or starting level of the outcome variable

$\beta_1$ is the slope or trajectory of the outcome variable until the introduction of the waiver in July 2018

$\beta_2$ represents the change in the level of the outcome that occurs in the period immediately following the introduction of the waiver (compared with the counterfactual)

$\beta_3$ represents the difference between pre-waiver and post-waiver slopes of the outcome

We will look for significant p-values in $\beta 2$ to indicate an immediate waiver effect, or in $\beta 3$

to indicate a waiver effect over time (Linden and Adams 2011).

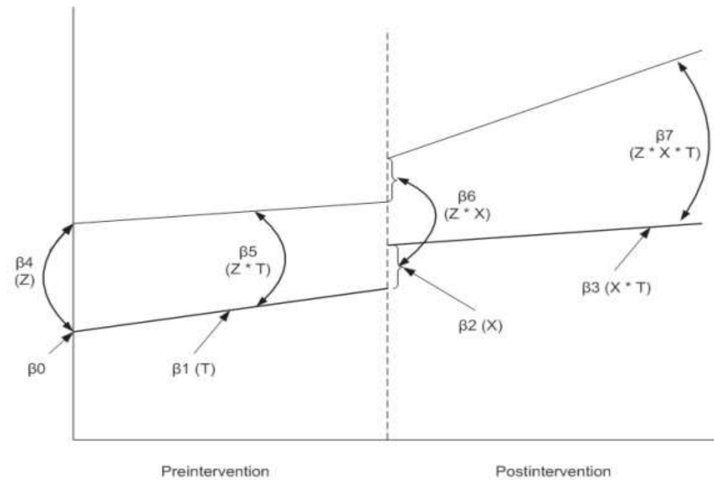



Figure 1. Visual depiction of a single group (lower line) and multiple group (upper and lower lines) interrupted time-series design, from Linden and Adams (2011)

A single interrupted time series cannot exclude confounding due to other interventions or events occurring around the time of the intervention. One approach to minimize such potential confounding events is to add a control series so that there are both before- after comparison and an intervention-control group comparison. Therefore, the above model can be strengthened by including a comparable “control” state where the 1115 waiver demonstration didn’t occur. In this case, data will be collected from both treatment state and control state during the same time period. This will compare the changes at the intervention/waiver state (IL) to changes at another state where no intervention/waiver occurred. In this case, the regression equation expands to:

$$y = \beta_0 + \beta_1 T + \beta_2 X + \beta_3 XT + \beta_4 Z + \beta_5 ZT + \beta_6 ZX + \beta_7 ZXT + \varepsilon$$

Where Z is a dummy variable indicating treatment (1) or control (0)

ZT is time for treatment and 0 for control

ZX is study phase for treatment and 0 for control

ZXT is time after interruption/waiver for treatment and 0 for control

$\beta_4$ is the difference in the level between treatment and control prior to the waiver $\beta_5$ is the difference in the slope between treatment and control prior to the waiver $\beta_6$ is the difference in the level between treatment and control in the period

immediately following the waiver

$\beta_7$ is the difference between treatment and control in the slope after initiation of the waiver

In order to estimate the level and slope changes, Interrupted Time Series requires a minimum of 8 data points before and 8 data points after the waiver implementation to maintain sufficient power to estimate the regression coefficients.[3] However, to incorporate any seasonality in time series data, if the unit of time is month, 12 data points are recommended to avoid seasonal biases.[4]

In selecting a comparison state, the state needs to be exposed to any other interventions or events that might affect the intervention/waiver state. However, it should not be exposed to any interventions or events that could impact on the comparison state alone. Our effort will be to select a comparison state that is similar to our state in terms of exposure to other interventions and demographic characteristics, if possible. Details regarding the selection of a comparison state and any challenges related to data access will be further outlined in the evaluation reports.

**Data Source**

De-identified Medicaid claims and encounter data covering one year prior to waiver (July 1, 2017 to June 30, 2018) and 5 years post waiver (July 1, 2018 to June 30, 2023) will be collected from the Illinois Department of Healthcare and Family Services (HFS). Additional data sources include the Illinois Department of Public Health's data on opioid overdoses, as well as the DARTS data forms collected by the Illinois DHS' Division of Substance Use Prevention and Recovery (SUPR).

The administrative Medicaid and Medicaid Managed Care claims data include the following:

- ICD-9/10 Diagnosis Codes
- CPT procedure codes
- Service dates
- Reimbursement amounts (allowed amounts)
- Deductibles/copays/coinsurance paid (Managed Care patients)
- Identity of the provider (Physician NPI codes)
- Identify of referring provider (Physician NPI code)
- Identity of the facility of service (Organization NPI codes)
- Provider 5-digit zip code
- Place of Service (POS) codes (e.g., physician office, outpatient clinic, etc.)
- Facility type codes (e.g., inpatient, outpatient, ER, Nursing Home, etc.)
- Individual patient identifiers (masked)
- Identifier for plan subscriber (masked)
- Patient age
- Patient income
- Patient gender
- Patient 5-digit zip code of residence
- Admission and discharge dates
- Reason for discharge
- Admission type code (e.g., admitted through ER, transfer from another hospital, etc.)
- Target population

Data will be limited to Illinois Medicaid and Medicaid Managed Care (MCO) recipients with Substance Use Disorder (identified using ICD-9 and ICD-10 diagnostic codes) who

are 18 to 64 years of age in the study period. SUD individuals that are enrolled in the waiver demonstration will be flagged to identify the target population.

**Comparison Group**

Following CMS's "SMI/SED AND SUD EVALUATION DESIGN GUIDANCE", we strive

to collect two ideal comparison groups that include another state Medicaid population similar to ours and/or prospectively collected information prior to the start of the intervention/waiver.[5]

**Limitations**

Limitations in this evaluation include the availability/comprehensiveness of records in the pre-test period and data lag. Per billing record trends, there were fewer than anticipated SUD claims in 2017 (pre-test period). This would result in a possible upward bias in the waiver effects. Because of this, analyzing comparison state data may help address shortcomings of our pre-test period data from the Illinois claims. While the evaluation aims to incorporate such comparison state data, difficulties in identifying an appropriate comparison state and/ or obtaining claims data would present a further limitation.

An additional limitation is that there is often a billing lag in submitting claims, as well as a lag in terms of posting clean statewide datasets. For example, at this writing (March 9th, 2021), the 2019 data for other states is listed as "pending." Thus, our project will access the most recent data possible to fulfill the analyses described above.

**Supplemental Pilot Evaluations**

The overall evaluation using the Interrupted Time Series design provides a strong quasi-experimental evaluation of the overall 1115 waiver demonstration project.

Additionally, whenever it adds value, we will complete supplemental evaluations on select pilots to enhance our understanding of the impact of each individual pilot.

For example, there is little data on whether adding Peer Recovery Support Services (PRSS) to residential treatment enhances outcomes. Thus, by matching those receiving PRSS to comparable control participants, we can isolate the potential benefits of the PRSS services. This adds substantial value to the overall evaluation, as there is much recent interest in adopting PRSS. Furthermore, understanding whether case management reduces criminal involvement, relative to matched controls not receiving case management, would be highly informative.

The outcomes for each pilot evaluation were listed above in tables B6-B8. These pilots include the following services: clinically managed withdrawal support, SUD case management, and peer recovery support.

Each of these evaluations are similar to the overall evaluation, with a key exception. When considering the effects of each of these services separately, we will construct control groups using propensity score matching.

**Propensity Score Matching**

In many settings, participation in a treatment (in our case, a particular pilot) is voluntary. As a result, outcomes across the participants and non-participants would likely differ even in the absence of any treatment. For example, if individuals who would participate in a given pilot are healthier on dimensions which are unobservable to researchers but contribute to good outcomes, then it would not be surprising to see them have better outcomes (than those who would not participate in the same pilot) even in the absence of any pilot participation or actual treatment.

What is of interest in the effect of the pilot on outcomes NET of any of these unobservable differences. In the absence of a randomized control trial, one could compare outcomes across individuals who participated in a pilot to those from very similar individuals who did not. Although finding a perfect "twin" among non-participants for each participant may be impossible (as it requires matching on all observable and unobservable dimensions), one could at least try to do so using available observable information.

**Matching Variables**

The following is a non-exhaustive list of potential variables on which participants can be matched.

- County of residence/treatment
- Age group
- Gender
- Income as a percentage of Federal Poverty Level (FPL) (<100% FPL, 100-138% FPL, 138%+ FPL)
- Medicaid plan type (traditional Medicaid, Medicaid Managed Care plan)
- Presence of children in the household
- Presence of comorbidities (i.e., other ICD psychiatric or physical health diagnoses)
- Number of prior hospitalizations for OUD/SUD-related diagnosis (ICD-9) codes
- Presence of a chronic condition as defined by the Healthcare Cost and Utilization Project (HCUP)

**Data sources-Treatment and Comparison Groups**

Table C-1 summarized the treatment and comparison groups used in the individual pilot evaluations. We present information on the pilot, the outcome variables, the treatment and comparison groups, and the potential limitations of using propensity score matching to make the comparisons. Additional detail about the outcomes appears in Tables B6- B8.

| Table C-1. Summary of Treatment and Control Populations for Propensity Score Matching Analyses | | | | | |
|---|---|---|---|---|---|
| Hypotheses: Relative to matched controls, participants in the pilots will have better outcomes. | | | | | |
| Pilot | Outcomes | Treatment Group | Matched Controls | Data sources | Potential Limitations |

| Clinically Managed Withdrawal | ED visits | Members receiving residential services under waiver | Members with a diagnosis of substance intoxication receiving ED services | State Medicaid Claims Data | Too low a ratio of potential matches to waiver recipients<br><br>Unobserved variables |
|---|---|---|---|---|---|
| Case Management | Number of Arrests<br><br>Continuity of Care | Members receiving case management under waiver | Members with similar history of criminal involvement not receiving case management under waiver | SUPR DARTS | Too low a ratio of potential matches to waiver recipients<br><br>Unobserved variables |
| Peer Recovery Support Services | Continuity of Care<br><br>ED visits | Members receiving case management under waiver | Members receiving residential but not PRSS | MCO-<br><br>Residential data; Comparison State Data | Too low a ratio of potential matches to waiver recipients<br><br>Unobserved variables |

**Potential limitations**

Although a one-to-one matching of participants to non-participants based on every single observable variable would be favorable, this may require a large ratio of available comparison subjects. Potential solutions involve use of K:1 matching with replacement, where comparison subjects (i.e., good matches) can be matched multiple times to treatment participants (e.g., beneficiary receiving Peer Recovery Support under the waiver). Additionally, purchasing other state's claims data may result in a much larger pool of potential control subjects that would enable the analysis.

Bias could still occur if participants and non-participants remain different on dimensions which are unobservable to the researcher but, nevertheless, contribute to the measured outcomes.

## Timeline

| Task | Projected Dates |
|---|---|
| Evaluation Contractor (CPRD) Data Processing | |
| Determine required variables, timeline of variables (monthly, quarterly), and dates needed for overall evaluation and individual pilot evaluations. | July 2021 |
| CPRD requests and receives access to Illinois Medicaid Claims Data | July 2021 |
| CPRD receives data and examines for accuracy and feasibility | July 2021 – August 2021 |
| CPRD processes data – cleaning and merging of data files received | August 2021 - October 2021 |
| Initial Data Analysis and Interim Report Writing | |
| Descriptive Statistics<br>Primary Driver 1 – Descriptive statistics for 2 measures<br>Primary Driver 2 – Descriptive statistics for one measure | September 2021 |

| | |
|---|---|
| Primary Driver 3 – Descriptive statistics for 3 measures<br>Primary Driver 4 – Descriptive statistics for 4 measures<br>Primary Driver 5 – Descriptive statistics for 1 measure<br>Primary Driver 6 – Descriptive statistics for 7 measures | |
| Chi-Square Analyses<br>Primary Driver 2 – Chi-square for 2 measures<br>Primary Driver 3 – Chi-square for 2 measures<br>Primary Driver 6 – Chi-square for 2 measures | September 2021 |
| CPRD team works to develop interim report update to CMS | September 2021 |
| Interim Report Due | October 2021 |
| Accessing Comparison State Data | |
| Investigate state data sets and waiver status to determine a suitable comparison state dataset | June 2021-July 2021 |
| Determine required variables, number of cases, timeline, dates, and other required information to include in the request | August 2021 |
| Develop a Security Plan for data transfer and data sharing between the University of Illinois and the comparison state's data custodian | October 2021 |
| Submit a request and process payment to access the 2017-most current comparison state data. | October 2021 |
| Estimated date of receipt for comparison state dataset | October 2022 |
| Additional data requests for subsequent year(s) of data | October 2022 |
| Estimated date of receipt for comparison state dataset | October 2023 |
| Overall Evaluation Analysis | |
| Interrupted Time Series (ITS) Analysis<br>Primary Driver 1 – ITS for 2 measures<br>Primary Driver 3 – ITS for 1 measure<br>Primary Driver 4 – ITS for 4 measures<br>Primary Driver 5 – ITS for 1 measure<br>Primary Driver 6 – ITS for 5 measures | September 2022 – June 2023 |
| Propensity Score Matching (PSM) Analysis<br>Primary Driver 2 – PSM for 2 measures | September 2022 – June 2023 |
| Summarize analysis findings for overall demonstration evaluation | July 2023 – September 2023 |
| Individual Pilot Demonstration Analyses | |
| Descriptive Statistics and/or Chi-Square Analyses<br>Crisis Intervention Pilot Evaluation, All Cause Readmission | October 2023 – April 2024 |
| Propensity Score Matching (PSM) Analysis and/or Logistic Regression and/or difference-in-differences approach<br>Clinically Managed Withdrawal – 1 measure<br>SUD Case Management – 1 measure under hypothesis one and 1 measure under hypothesis two<br>Peer Recovery Support Specialists – 2 measures<br>Crisis Intervention – 1 measure | October 2023 – April 2024 |
| Summarize analysis findings for pilot demonstration evaluations | May 2024 – July 2024 |
| Compile Analysis Summaries and Develop Final Summative Evaluation Report | July 2024 – December 2024 |
| Summative Evaluation Report Due | December 2024 |

Evaluation Budget

| Table D-1. Evaluation Budget FY21-23 | | | |
|---|---|---|---|
| Hypotheses: Relative to Matched controls, participants in the pilots will have better outcomes. | | | |
| Description | Percent Effort | Role/Description | Budgeted Amount |
| Personnel | | | |
| Evaluator | .15 | Oversee entire evaluation<br>Lead evaluation reports | Salary: $552,853<br>Fringe: $259,342<br><br>Total: $812,195 |
| Project Manager | .4 | Assist with evaluation reports | |
| Data Analysts | 2.20 | Analyze data | |
| Graduate Assistant | .625 | Clean data<br>Assist with data analyses<br>Assist with writing reports | |
| Supplies | | | |
| Computers | | Two computers, one each for 2.0 FTE data analysts | $3,200 |
| Travel | | | |
| National Travel | N/A | Presentation of findings at national conferences (3 staff members at one conference annually) | $12,240 |
| Other | | | |
| Comparison claims data/ Telecom | N/A | Purchase of other state's beneficiary data ($120,000)<br>Telecom costs ($7,233) | $127,233 |
| CPRD Lease | | Lease expense prorated per FTE | $22,386 |
| Consultant | | Christina Andrews-five days of consulting per year | $15,608 |
| ICR | | ICR (Charged at 21.7% of MTDC) | $233,138 |
| Total Budgeted Amount<br><br>(Estimated at for full three years, from July 1, 2020 through June 30th, 2023) | | | $1,329,891 |

CPRD | Center for Prevention
Research & Development
SCHOOL OF SOCIAL WORK

March 9, 2020

To Whom It May Concern,

This purpose of this letter is to provide a statement about my status as an Independent Evaluator for the State of Illinois' Behavioral Health Transformation 1115 demonstration. Currently, I serve as the director of the Center for Prevention Research and Development (CPRD) at the University of Illinois in Urbana-Champaign. Our agency agrees to do this evaluation under contract with the Office of Medicaid Innovation and the Illinois Department of Healthcare and Family Services.

I was involved in developing the initial evaluation plan in collaboration with other professors at a separate campus in the Illinois system. They have since left the project. I have worked with OMI and IL DHFS to revise the original evaluation plan. Below please find a description of my evaluation team, as well as a detailed response to the reviewer comments on the original evaluation plan.

My experience and that of my staff at CPRD are well suited to conduct a fair and impartial evaluation and ensure that there are no conflicts of interest. We look forward to preparing an objective Evaluation Report for this project.

Sincerely,

Douglas C. Smith, Ph.D. Professor, School of Social Work

University of Illinois at Urbana-Champaign (UIUC)-Personnel

Douglas C. Smith, PhD (Evaluator), is an Associate Professor of Social Work and Director of the Center for Prevention Research and Development (CPRD) at the University of Illinois at Urbana-Champaign. He has prior direct practice experience working in residential substance use disorder (SUD) treatment and providing case management services in state-funded facilities serving individuals from low-income backgrounds. His research focuses on substance use disorder treatment outcomes among adolescents and emerging adults (ages 18-29). The latter comprise an especially at-risk population that account for approximately 25% of all opiate users in the United States, have poorer retention and engagement in treatment, are of childbearing age, and may need developmentally appropriate case management services focused on occupational functioning. Dr. Smith has previously been funded to complete substance use disorder (SUD) treatment evaluations by the National Institutes of Health (NIH), the Substance Abuse and Mental Health Administration (SAMHSA), and the United States Department of Justice (DOJ). His nearly 50 peer-reviewed publications largely focus on substance use disorder treatment outcomes. Among those most relative to this evaluation are articles or chapters on 1) how the presence of DSM- 5 diagnosed withdrawal syndromes predict a return to substance use (Davis, Smith et al., 2017), 2) the limited work on peer recovery support specialists (Smith, Schwebel, and Larimer, 2017) in SUD treatment, 3) the use of case management services in family-based adolescent substance use disorder treatment (Smith et al., 2006), and 4) the use of propensity score matching in evaluating SUD treatment outcomes (Smith et al., 2011).

Crystal Reinhart, PhD, (Project Manager) Dr. Crystal Reinhart is a Research Scientist at the Center for Prevention Research and Development (CPRD) at the University of Illinois in Urbana-Champaign. She currently works on the Illinois Youth Survey project, which collects data from middle and high school students in Illinois. This data has contributed to several peer-reviewed publications and collaborations with researchers around the state to further understanding of substance use, perceptions about substance use, and a variety of other health and safety issues among youth. She is passionate about addressing the opioid crisis in Illinois, is a member of the Illinois Opioid Advisory Council, and recently developed a comprehensive epidemiological profile on opioid use in Illinois. In addition to her work on the survey, Dr. Reinhart is contracted with the Leukemia & Lymphoma Society and Tufts University Medical Center to study cancer survivorship among adolescents and young adults. She received her PhD in Community Psychology from Wichita State University in 2010.

Alex Lee, (PhD Student), is a PhD student supervised by Dr. Smith. He will assist with data cleaning, report writing, and analyses.

Data Analysts (TBA). CPRD currently employs one full time Master's and one full-time PhD level data analysts who have experience working on very large substance use prevention (Illinois Youth Survey, IYS, n=230,000) and home visitation datasets (i.e., MIECHV). We will hire two full-time analysts to work on this project to join our data analysis unit at CPRD. Additionally, Shahana Begum will allocate .25 effort on this project. Thus, we will have 2.25 data analysts dedicated to this project.

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## Appendix B: Citations


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