DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FULL PUBLIC NOTICE
BEHAVIORAL HEALTH TRANSFORMATION SECTION 1115 DEMONSTRATION EXTENSION

The Illinois Department of Healthcare and Family Services (HFS) is seeking a five-year extension of the Behavioral Health Transformation Section 1115 Demonstration (Project Number 11-W-00316/5) approved by the Centers for Medicare & Medicaid Services (CMS). Pursuant to CMS federal rules for section 1115 demonstrations at 42 CFR 431.408, HFS is providing this full public notice to describe the key components of the proposed extension. The proposed draft extension application and other related materials are available for review and public input for a minimum 30-day period starting May 12, 2023, through June 12, 2023, as described in this notice. As described below, the demonstration will be renamed the "***Illinois Healthcare Transformation Section 1115 Demonstration***" to align with the new proposed design for the demonstration extension.

Demonstration Background:
This section 1115 demonstration was originally approved as the "Behavioral Health Transformation Section 1115 Demonstration" on May 7, 2018, to pilot the provision of certain 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 goal of the demonstration was to test how the provision of additional opioid use disorder/substance use disorder (OUD/SUD) services informed HFS 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, but experienced overall start-up and implementation delays with the demonstration pilots due to several circumstances (such as addressing challenges caused by the COVID-19 pandemic) and changes in the Medicaid behavioral health landscape in Illinois. As such, Illinois only implemented 4 of the 10 original pilots as listed in the below table:

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 otherwise 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. The services had to be recommended by a Physician or a Licensed Practitioner of the Healing Arts and must be delivered in accordance with an individualized plan of care.
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 a substance use disorder (peer recovery coach) who is certified to provide counseling support to help prevent relapse and promote recovery.

The COVID-19 pandemic and other early program implementation delays had lasting effects preventing the full implementation of the above four pilot programs and delayed care across the healthcare spectrum (for example, higher usage of telehealth services, increased emergency room visits due to the closure of some services, and potential delays in care post-shutdown due to closures and staffing shortages). Despite these challenges, preliminary data from the interim evaluation of the demonstration indicate that 39% of the performance metrics are progressing as expected, with several beginning to stabilize and having the potential to show change in the final two years of the current five-year demonstration period. The demonstration is currently set to end on June 30, 2023. With the proposed section 1115 demonstration extension application submitted to CMS after completion of the formal 30-day state public input period, HFS will seek a short-term temporary extension approval period to continue the current demonstration as approved while HFS works with CMS to negotiate the parameters for the formal approval of a five-year demonstration extension.

Demonstration Extension Proposal:
Illinois is proposing to extend the demonstration with 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 found healthcare disparities in Illinois' healthcare system. It is well documented that SDOH are major factors in addressing avoidable complications from undetected and undertreated chronic diseases which lead to poor health outcomes and higher medical costs. Section 1115(a) Medicaid demonstration authority is the best pathway to achieve these goals because the standard payment and programmatic constraints of the Medicaid statute do not fully provide the necessary levers to address the comprehensive set of goals of the state 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. Accordingly, the proposed new name for this demonstration program extension is the "**Illinois Healthcare Transformation Section 1115 Demonstration**."

Aligning to CMS's five health equity priority areas, the **goals and objectives** of the initiatives proposed for the section 1115 demonstration extension are as follows:

- 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 in health and improve healthcare access, quality, and outcomes.
- 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.
- Create and sustain capacity within healthcare organizations with a workforce skilled at meeting the unique needs of the communities of Illinois.
- Offer culturally and linguistically responsive care, providing communities with improved health care, patient safety, and experiences.
- Tailor programs to individuals and communities, resulting in improved access to care and services.

Program Design and Benefits
Through the implementation of nine pilot initiatives (i.e., 6 new; 3 currently approved; and 6 discontinued from the original five-year demonstration design) described in the below table, 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.

No.	Pilot Initiative	Status within this Extension Request	Medicaid Program Goal(s)	Supports the Primary 1115 Goal/Objective(s)
1	**Healthcare Transformation Collaboratives** (HTCs) that drive local, innovative approaches to deliver high-quality healthcare, with an intentional focus on addressing HRSN	New	Reorient the healthcare delivery system in Illinois around people and communities	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.
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.

No.	Pilot Initiative	Status within this Extension Request	Medicaid Program Goal(s)	Supports the Primary 1115 Goal/Objective(s)
5	**Community Health Worker (CHW) Training** that will create a workforce of CHWs 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 needs of the communities of Illinois.
6	**Safety Net Hospital Health Equity and Access Leadership (HEAL) Grant Program** that will 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 to short-term residents in facilities that meet the definition of an institution for mental diseases (IMD), including providing SUD case management services to assist beneficiaries with 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. 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

No.	Pilot Initiative	Status within this Extension Request	Medicaid Program Goal(s)	Supports the Primary 1115 Goal/Objective(s)
				access, quality, and outcomes.
9	**Supported Employment Services Pilot** that will authorize supported employment services to eligible beneficiaries through a person-centered planning process when eligible services are identified in the individuals' plan of care	Current and continuing with proposed changes	Promote an Illinois workforce that is sufficiently sized, diversified, culturally competent and trained	Create and sustain capacity within healthcare organizations with a workforce skilled at meeting the unique needs of the communities of Illinois.

Benefits and Eligibility

Through these nine pilot initiatives, the proposed demonstration extension will provide the HRSN services listed in the table below in accordance with the pilot eligibility criteria also defined in the table. The proposed demonstration benefits will be additional services not yet permissible for coverage under the state's Medicaid program or Children's Health Insurance Program (CHIP) in accordance with federal regulations.

The proposed HRSN benefit will be administered through the statewide Medicaid managed care program. Illinois Medicaid managed care enrollment is mandatory for all eligible state plan populations, except as follows:

- 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 are eligible for certain limited program benefits or are subject to Medicaid "spend down" requirements to become eligible for coverage. These populations are:
    - Individuals in a Spenddown Program
    - Individuals receiving temporary medical benefits
    - Individuals getting care in the Illinois Breast and Cervical Cancer Program
    - Individuals receiving private insurance that pays for hospital and doctor visits
    - Individuals getting care in the Medicaid Family Planning Program

All Medicaid state plan populations enrolled in full-scope Medicaid coverage will be eligible for this demonstration. Individuals who are eligible for voluntarily enrollment in a Medicaid managed care will be eligible to receive clinically appropriate HRSN services upon enrollment into a plan. Individuals only eligible for limited benefit Medicaid plans are not eligible for the demonstration.

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: • Have received care in EDs, hospitals, or crisis centers on multiple occasions (twice in six months or four times in 12 months); or • Have been determined to be high-risk or high cost based on service utilization or healthcare history; or • Have complex physical health needs (persistent, disabling, or progressively life-threatening physical health conditions that require improvement or stabilization to prevent deteriorated functioning); or • Have a behavioral or mental health need requiring improvement or stabilization to prevent deteriorated functioning; or • Are experiencing a high-risk pregnancy or complications associated with pregnancy, or are infants (up to one year old) born of such pregnancies; or • Is a young adult, aged 18 through 26 who has aged out of Foster Care; or • Are transitioning from institutions or carceral settings	<u>Pre-tenancy supports</u> • 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 • Housing navigation, including location assistance • Inspection fees for housing safety and quality • Application fees and fees to secure needed identification • 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 • Security deposit and rent/temporary housing up to six months (including arrears) • Utility deposits, activation fees, and back payments • Other one-time transition and moving costs, including movers, and essential home furnishings <u>Tenancy sustaining supports</u> • Intensive case management/care coordination to support housing stability, including tenant rights education and eviction prevention • Early identification of at-risk behaviors • Education and connection to resources

1115 Benefit	Eligible Medicaid Population(s)	Eligibility Needs Criteria	Benefit Description
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: • Are at risk for ED/hospitalization or institutional care; or • Currently in the ED or hospitalized; or • In institutional care	Recuperative care may be offered for up to six months and includes: • Specialized, onsite case management • Connections to other health related services • Transition support • Limited support for activities of daily living and/or instrumental activities of daily living • 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: • Have a chronic condition, such as diabetes or cancer; or • Have a behavioral or mental health condition; or • Are pregnant or up to 60 days postpartum	• Up to six months of: ○ Case management ○ Nutrition education, coaching, and skill development ○ Group nutrition classes • Assistance in identifying healthy foods and permanent food sources • Application assistance for SNAP and other available resources • Stocked refrigerator and pantry when transitioning out of institutional settings or a prolonged hospitalization • Medically tailored, home-delivered (or for pick-up) meals (up to three meals a day for up to six months) • Cooking supplies for meal prep and nutritional welfare, such as pots, pans, and utensils
Employment Assistance	Adults 18 years of age and older who are enrolled in Medicaid managed care who meet the needs criteria	Identified as needing employment assistance, and meet one of the following: • Have a physical, intellectual, or developmental disability; or • Have a behavioral or mental health condition; or	• Pre-vocational/job-related discovery or assessment • Person-centered employment planning • Job development and placement assistance, including job carving and vocational analysis • Benefits education and planning • Assessing and developing natural supports

1115 Benefit	Eligible Medicaid Population(s)	Eligibility Needs Criteria	Benefit Description
		• Are very low income (e.g., recipients of Temporary Assistance for Needy Families)	• Job training and coaching • Career advancement services • Employee/employer negotiations • Asset development • 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 • Violence intervention services • Evidence-based parenting curriculum • Home visitation services • 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 • Pharmacy trips • Trips to social services agencies for application assistance/support • Trips to Support Groups or similar meetings • 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,
			  • Re-entry case management services, including:
			  ▪ Obtaining identification
			  ▪ Connecting to the HRSN employment assistance services if needed as well as addressing the additional preparation needed to navigate employment for post-incarcerated individuals
			  ▪ Connecting to the HRSN housing support services if needed as well as

1115 Benefit	Eligible Medicaid Population(s)	Eligibility Needs Criteria	Benefit Description
			addressing the additional housing barriers for post-incarcerated individuals • Physical and behavioral health clinical consultation services provided in-person or via telehealth • Laboratory and radiology services • Medications and medication administration • MAT for all types of SUD with accompanying counseling • Services of community health workers 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
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 Colbert Consent Decrees	Individuals transitioning from institutional settings	• Linkages to various HRSN services including Housing Support, Food and Nutrition, Employment Assistance, and Non-Medical Transportation • Transition assistance and coaching, including peer-based outreach, engagement, and support pre- and post-transition • Individualized plan to address social isolation using person-centered goals • Linkages to social supports and recreation to mitigate impact or risk of health impacts from social isolation, including transportation to community and senior centers,

1115 Benefit	Eligible Medicaid Population(s)	Eligibility Needs Criteria	Benefit Description
			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 into treatment from the criminal justice system	• Comprehensive assessment and periodic reassessment 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 • 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 individual's progress • Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services
SUD Services in Institutions for Mental Diseases (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 for SUD while 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

Impact of Demonstration Extension on Traditional Medicaid Program Eligibility

The proposed demonstration extension does not propose any changes to Medicaid eligibility. Standards for eligibility remain 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 an SUD or HRSN benefit, who meet the state's eligibility needs criteria as defined in the above table will receive 1115 support services as described above.

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

Delivery System
The proposed 1115 benefits will be implemented statewide through managed care and HFS is engaging its provider community and managed care organizations (MCOs) on 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.

Other Program Modifications proposed for Demonstration Extension:

- *Repurposing Cook County Medicaid Disproportionate Share Hospital (DSH) payments to Create a New "Community Reinvestment Pool"* – Illinois requests expenditure authority to repurpose a portion or all of Cook County's annual DSH allotment (up to approximately $331 million) to be spent on HRSN initiatives in underserved communities as another tool to advance goals around equity. Cook County safety net patients and families experience significant system complexity and inequities that impact 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. The repurposed Cook County DSH allotment will create a pool to finance strategies that tie directly to improving health and health equity in underserved communities. This "pool" approach is expected to complement the goals and outcomes of the nine proposed pilot initiatives. All other aspects of the annual DSH allotment and hospital-specific DSH payments made to qualifying Illinois hospitals will remain the same.

- *Continuum of Care Facility Licensure* **–** The Illinois General Assembly enacted the *Continuum of Care Services for the Developmentally Disabled Act*[1] to authorize a new type of license for organizations providing 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 "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 continuum of residential care settings and supportive services in a manner that maximizes enrollee choice and satisfaction. The Act directs HFS to request from the government a "waiver pursuant to the federal Social Security Act" in order to define the requirements for a "continuum of care" facility licensure, to establish a process to receive and maintain such a license, and to establish an alternative budget-neutral reimbursement approach for adopting "continuum of care" facility licensure. The new "continuum

[1] See Illinois Compiled Statutes at https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=3741&ChapterID=21

of care" license will be implemented in compliance with the CMS home & community-based settings criteria.

- *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.

Enrollment and Expenditure Estimates for the Proposed Extension by Demonstration Year (DY):
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. HFS is similarly requesting hypothetical (i.e. "passthrough") expenditures to implement the legislatively directed "continuum of care" license and the DSH Community Reinvestment pool components of the proposal. The total estimated expenditures to implement all program initiatives under the 1115 extension are listed below. These expenditure estimates reflect total costs for the approximate 400,000 Medicaid eligibles that will be enrolled in each year of the proposed demonstration extension period. More detail on these annual, aggregate estimates are available in Section XII of the proposed extension application for public comment.

Demonstration Year (DY) (annual cycle = July 1 through June 30)	**Estimated 1115 Expenditures**
DY6	$1,338,697,241
DY7	$1,354,983,835
DY8	$1,560,924,469
DY9	$1,756,891,694
DY10	$1,905,817,045
Estimated 5-Year Total	**$7,917,314,284**

Budget Neutrality Assessment over the Current Five-year Demonstration Period:
The start-up and implementation delays of the original demonstration pilots additionally impacted the level of financial spending under the current demonstration period. As mentioned above, only 4 of the 10 original pilots were implemented to varying degree. As implementation of these four original pilots began to ramp up, HFS experienced another unforeseen complication caused by an internal system edit to the state's Medicaid eligibility system that impacted the ability to separately identify certain claims derived from the coverage authorized under the 1115 demonstration. Thereby expenditure data for the initial 5-year period is limited as described below. However, since identification of 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. While the current claiming system edit is still in effect, HFS utilized alternative approaches to extract available enrollment and expenditure data for the current, original demonstration approval period. Data was pulled from the HFS Enterprise Data Warehouse (EDW) using a known set of identifiers for applicable providers, the participants, and the service pilots. While the below enrollment and expenditure data does not lend to a traditional "without waiver" versus "with waiver" comparative approach to budget neutrality, we believe the data

does suggest that the four 1115 pilots implemented did not exceed the expected "without waiver" ceiling approved for the current 5-year demonstration period.

SUD Case Management Pilot

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 utilized in alignment with the benefit. That data is reflected in the below table.

Demonstration Year (DY)	Estimated 1115 Enrollees that Received SUD Case Management	Estimated 1115 Expenditures SUD Case Management
DY01	351	$1,067
DY02	1008	$3,645
DY03	911	$75,367
DY04	1054	$196,139
DY05	1054	$196,139

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 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). Due to the limited ability to fully implement this pilot as discussed, the total estimated 5-year cost of $472,357 (totaling the above annual estimated costs) is far less than the level of spending that was anticipated for the demonstration pilot. Thereby, while 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.

Peer Recovery Support Services Pilot

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. Thereby, no claims data or utilization data could be identified in the MCO data set examined for the initial 5-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 was also limited due to 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 below.

Demonstration Year (DY)	Estimated "Without Waiver" Enrollee Limit per STCs	Estimated 1115 Enrollees that Received Peer Recovery Support
DY01	160	23
DY02	240	38

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

Although the data does 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.

Clinically Managed Withdrawal Management Services Pilot

The current approved budget neutrality "without waiver" capped enrollment for each demonstration year. The limited implementation of this demonstration pilot was compounded by low beneficiary take-up of this 1115 service. 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." The expenditures reported on the MBES/CBES CMS 64 as reflected in the below table were too limited to produce a traditional PMPM assessment.

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 the data does 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 demonstration year one 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 does 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 expenditures in the below table are derived from HFS EDW fee-for-service and encounter claims that had certain procedure codes that aligned with the SUD criteria. There are expenditures reported on the MBES/CBES CMS 64 for the first three demonstration years, but these expenditures do not reflect full implementation of this service initiative based on the reporting issues. 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."

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

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 the total estimated cost of $69,274,684 did not exceed the expected "without waiver" expenditure levels approved for the current 5-year demonstration period.

Program Adjustments for the Extension

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 is 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; and,
- MCO reporting will include those recipients 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 currently foreseen.

Preliminary Evaluation Parameters for the Proposed Demonstration Extension:

In alignment with the new focus of the Illinois Healthcare Transformation Section 1115 Demonstration, the below table describes the proposed preliminary evaluation plan design framework for the demonstration extension, including the goals, hypotheses, and possible measures.

Initiative	Initiative-Specific Goals	Hypotheses	Possible Measures
Treatment for Individuals with Substance Use Disorder (SUD)	Increased rates of identification, initiation, and engagement in treatment	The demonstration will increase the percent of members referred to and engaging in SUD treatment The demonstration will increase the percent of	Process: • Initiation and engagement in SUD treatment • Initiation and engagement of SUD treatment

Initiative	Initiative-Specific Goals	Hypotheses	Possible Measures
	Increased adherence to and retention in treatment Reductions in overdose deaths, particularly those due to opioids 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 Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate Improved access to care for physical health and behavioral health conditions among beneficiaries	members adhering to SUD treatment The demonstration will result in decreased opioid-related overdose deaths The demonstration will result in fewer ED visits for SUD in the member population The demonstration will reduce readmissions to the same or higher levels of SUD care The demonstration will increase the percentage of members with SUD who access care for physical health conditions	• Access to preventive and ambulatory health services for adult Medicaid beneficiaries with SUD • Tobacco use screening and follow-up for people with alcohol or other drug dependence • Annual dental visits (SUD diagnosis) • Adolescent well-care visits (SUD diagnosis) • Prenatal and postpartum care timeliness (SUD diagnosis) • Prenatal and postpartum care (SUD diagnosis) Outcome (stratified by race/ethnicity): • Percentage of beneficiaries with an OUD/SUD diagnosis who used SUD services per month • Continuity of pharmacotherapy for OUD • Continuity of care after inpatient or residential treatment for SUD • Continuity of care after medically

Initiative	Initiative-Specific Goals	Hypotheses	Possible Measures
			managed withdrawal from alcohol and/or drugs • Opioid overdose deaths • Use of opioids at high dosage in people without cancer per 1,000 Medicaid beneficiaries • Concurrent use of opioids and benzodiazepines per 1,000 Medicaid beneficiaries • ED utilization for SUD per 1,000 Medicaid beneficiaries • ED utilization for OUD per 1,000 Medicaid beneficiaries • Inpatient stays for SUD per 1,000 Medicaid beneficiaries • Inpatient stays for OUD per 1,000 Medicaid beneficiaries • 30-day readmission for SUD treatment
Healthcare Transformation Collaboratives	Reorient the healthcare delivery system in Illinois around people and communities. Address SDOH, improve care delivery at the local level and address racist structures that create	HTCs 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: • Completed SDOH assessments • HRSN service use • CHW workforce trained and hired Outcome (stratified by race/ethnicity): • ED utilization

Initiative	Initiative-Specific Goals	Hypotheses	Possible Measures
	disparate health outcomes		• Hospital utilization and length of stay • HEDIS measures such as: use of preventive services (e.g., PCP visits) and use of SUD and/or BH services Health Outcomes (stratified by race/ethnicity): • Control and prevalence of chronic conditions such as asthma, diabetes, COPD, heart disease • 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: • Numbers of individuals auto enrolled • HRSN service use Outcome: • Recidivism rates • ED utilization • Employment rates • HEDIS measures such as: use of preventive services (e.g., PCP visits) and use of SUD and/or BH services
Violence Prevention and Intervention	Prevent violence, including gun violence, as well as reduce the health impacts of prolonged and	Community-led violence prevention initiatives, coupled with person-centered and trauma-	Process: • Violence Prevention Community

Initiative	Initiative-Specific Goals	Hypotheses	Possible Measures
	chronic stress and trauma resulting from violence	informed case management and other services will reduce violence, including gun violence, and will reduce health effects of prolonged and chronic stress and trauma	Support team service use • HRSN service utilization Outcome: • Violence rates • 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 services, decrease avoidable ED use and hospitalizations, and improve health and quality of life.	Process: • Service utilization • Patient hub utilization Outcome (stratified by race/ethnicity): • ED utilization • Hospital utilization and length of stay • HEDIS measures such as: use of preventive services (e.g., PCP visits) and usage of SUD and/or BH services Health Outcomes (stratified by race/ethnicity): • Control and prevalence of chronic conditions such as asthma, diabetes, COPD, heart disease • Maternal and infant morbidity and mortality
Community Health Worker Training	To identify, recruit, train, and certify a workforce of community health workers who serve in the communities where they live	Investments in CHW training and certification will: • Increase access to services through the HTCs, thus reducing	Process: • Number of CHWs trained and certified in the state

Initiative	Initiative-Specific Goals	Hypotheses	Possible Measures
		avoidable ED use and hospitalizations, improve maternal and infant health outcomes, other health outcomes, and enhance quality of life • Promote a pathway for employment and career development, which will increase job satisfaction and retention • Bridge the gap between health-related social and medical needs, which will increase use of preventive care	• Number of trained and certified CHWs working in the HTCs • CHW retention and turnover rates within HTCs Outcome: • CHW caseloads and ED utilization and hospitalization rates • CHW caseloads and maternal and infant outcomes Health Outcomes (stratified by race/ethnicity): • Control and prevalence of chronic conditions such as asthma, diabetes, COPD, heart disease • 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: • Hospital quality indicators Outcome (stratified by race/ethnicity): • ED utilization • Hospitalization and length of stay • HEDIS measures such as: use of preventive services (e.g., PCP visits) and SUD and/or BH services

Initiative	Initiative-Specific Goals	Hypotheses	Possible Measures
			Health Outcomes (stratified by race/ethnicity): • Control and prevalence of chronic conditions such as asthma, diabetes, COPD, heart disease • 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: • HRSN service use Outcome: • Report of stable housing • Control and prevalence of chronic conditions such as asthma, diabetes, COPD, heart disease • ED utilization • Hospital utilization and length of stay
Supported Employment Services	To promote an Illinois workforce that is sufficiently sized, diversified, culturally competent and trained	Coordinated and comprehensive employment support services will improve quality of life, mental health, and global functioning	Process: • HRSN service use Outcome: • Employment rates • Service utilization for mental health related issues • 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	• Promote disability inclusion by addressing SDOH to increase the health and well-being of these	Process: • Employment Support Services usage • Transitions between locations

Initiative	Initiative-Specific Goals	Hypotheses	Possible Measures
	timely manner across the continuum.	Medicaid beneficiaries There will be a decrease in resident and family report of administrative burden related to any transition as a result in a change in level of care need	Outcome: Resident/family report of administrative burden

Section 1115 Waiver and Expenditure Authorities proposed for Demonstration Extension:
Waiver Authority – The state is requesting the below list of waivers pursuant to section 1115(a)(1) of the Social Security Act to enable Illinois to implement the demonstration extension:

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 – The state is requesting the below expenditure authorities pursuant to section 1115(a)(2) 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 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

Public Notice and Comment Process

As announced in the abbreviated public notice issued by HFS on May 12, 2023 via notice in the Illinois Register, the draft section 1115 demonstration extension and related materials, along with this the full public notice, are posted for a minimum 30-day public comment period starting May 12, 2023 through June 12, 2023, on the 1115 Demonstration Waiver Home page located on the HFS website: https://hfs.illinois.gov/medicalproviders/cc/1115demonstrationwaiverhome.html. Three public hearings will be held to solicit input on the proposed extension. The date, time, and location of public hearings are listed below:

Public Hearing One:
May 19, 2023
1:00 pm to 3:00 pm
Illinois Department of Transportation
Hanley Building Conference Center – Auditorium
2300 S. Dirksen Parkway
Springfield, IL 62764

Parking information for the Hanley Building: Please refer to the Hanley Building Parking and Traffic Circulation Map at **https://public.powerdms.com/IDOT/documents/2081507**. Attendees may use any of the non-restricted parking spaces on the Hanley Building Campus. Violators are subject to towing. The department does not guarantee parking or assume responsibility for damage to any vehicles.

Public Hearing Two:
May 22, 2023
10:00 am to 12:00 pm
University of Illinois Chicago - College of Pharmacy
833 South Wood Street - Room 134-1
Chicago, IL 60612

Paid parking is available on the UIC campus at the Wood Street Parking Structure, 1100 South Wood Street, or at the Paulina Street Parking Structure, 915 South Paulina Street. For map and additional details, visit https://pharmacy.uic.edu/programs/pharmd/maps-and-directions/

The first two public hearings will be held in-person only. The third public hearing will be held via audio conference only.

Public Hearing Three:
May 25, 2023
10:00 am to 12:00 pm via WebEx
Please Register at the following link:
https://illinois.webex.com/weblink/register/rd11246f9d640a2caabbf0cf3c3881cae

Other Pertinent Hearing Information:

- Attendees must sign in at the registration desk outside of the public hearing location.
- People who want to provide oral testimony should indicate their intentions during registration and are encouraged to submit a written copy of the testimony at that time.
- Written testimony from individuals choosing not to speak also will be accepted during the registration period.
- Speakers will be heard on a first come, first serve basis.
- Individuals giving oral testimony should limit their comments to three minutes.
- Organizations are asked to select one spokesperson to present oral testimony on their behalf and will be asked to limit their comments to five minutes.
- To assist the orderly conduct of the hearing and ensure that the opinions of all interested individuals and/or groups are considered, the department may impose other rules of procedure as necessary, including, but not limited to, adjusting the time limit or the order of presentation.

Submission of Public Comments: Any interested party may direct comments, data, views, or arguments concerning this proposal. Comments not provided at the hearing must be submitted and received by June 12, 2023, through the following methods:

- Email to HFS.BBPC@Illinois.gov; or
- Mail to:
  Kelly Cunningham
  Medicaid Administrator
  Division of Medical Programs
  Department of Healthcare and Family Services
  201 South Grand Avenue East, 3rd Floor
  Springfield, IL 62763

Individuals who wish to obtain a copy of the demonstration application and related materials for review and comment during the 30-day public comment period, may obtain a copy from the above address.

Individuals needing special accommodation, please contact Mary Doran at (217)-524-7436. Each public hearing will have an American Sign Language Interpreter present and the WebEx will have closed captioning.

This notice is provided in accordance with the federal requirements in 42 CFR 431.408.