

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, MD 21244-1850



State Demonstrations Group

December 12, 2025

Laura Phelan
Medicaid Administrator
Illinois Department of Healthcare and Family Services
201 South Grand Ave. East
Springfield, IL 62763-0001

Dear Director Phelan:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Reentry Demonstration Initiative Implementation Plan for Illinois' section 1115(a) demonstration, "Illinois Healthcare Transformation" (Project Number 11-W-00316/5). We have determined that the Reentry Demonstration Initiative Implementation Plan is consistent with the requirements outlined in the special terms and conditions (STCs) and are therefore approving it. A copy of the approved Reentry Demonstration Initiative Implementation Plan is enclosed and will be incorporated into the STCs as Attachment K. CMS will also incorporate the finalized Reentry Demonstration Initiative Service Definitions into the STCs as Attachment J. With this approval and the state's determination that participating facilities have demonstrated readiness, the state may begin claiming federal financial participation (FFP) for services provided through the reentry demonstration initiative.

We look forward to our continued partnership on the Healthcare Transformation section 1115 demonstration. If you have any questions, please contact your CMS project officer, Jonathan Morancy, at Jonathan.Morancy@cms.hhs.gov.

Sincerely,

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

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

Attachment J
Reentry Demonstration Initiative Services

The purpose of Attachment J is to provide descriptions of the reentry services listed in STC 4.4.

Covered Service	Definition
Pre-Release Case Management	<p>Case management to assess and address physical and behavioral health needs and social determinants of health needs. The purpose of case management in the context of the reentry demonstration component is to:</p> <ul style="list-style-type: none"> • Support the coordination of services delivered during the pre-release period and upon release; • Ensure linkages to community-based services, providers, and social supports; and • Facilitate the arrangement of appointments and access to healthcare services delivered in the community. <p>Pre-release case management services include the following required activities:</p> <ul style="list-style-type: none"> • Assessment and reassessment. • Development of a person-centered care plan. • Referral and related activities. • Monitoring and follow-up activities.
Medication Assisted Treatment (MAT)	<p>State Plan – MAT for opioid use disorders (OUD) (1905(a)(29))</p> <p>Medications covered under Prescription drug benefit (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)</p> <p>Counseling covered under Rehabilitation services benefit (1905(a)(13)(c), 42 CFR § 440.130(d))</p>
30-day Supply of Prescription Medications	<p>State Plan – Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)</p>
Prescribed Drugs and Medication Administration	<p>State Plan – Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)</p>
Physical and Behavioral Health Clinical Consultation Services, as clinically appropriate, to diagnose health conditions, provide treatment, and support pre-release case managers' development of a post-release	<p>As defined in the State Plan, primarily:</p> <ul style="list-style-type: none"> • Screening services (1905(a)(13), 42 CFR 440.130(b)) • Physician Services (1905(a)(5), 42 CFR 440.50) • Behavioral health rehabilitation services (1905(a)(13)(c), 42 CFR § 440.130(d)). <p>For the purpose of CAA section 5121 alignment, clinical consultation services will include necessary Early and</p>

treatment plan and discharge planning	Periodic Screening, Diagnostic and Treatment screenings for individuals under age 21.
Diagnostic services including laboratory and radiology services	State Plan Services that are medically necessary, appropriate for the unique setting, and that are in support of demonstration goals: <ul style="list-style-type: none"> • Physician services (1905(a)(5), 42 CFR § 440.50) • Diagnostic services (1905(a)(13), 42 CFR § 440.130(a)) • Laboratory and radiology services (1905(a)(3), 42 CFR § 440.30)
Treatment for Hepatitis C, HIV, TB, and Other Conditions	As defined in the State Plan, primarily: <ul style="list-style-type: none"> • Physician services (1905(a)(5), 42 CFR § 440.50) • Diagnostic services (1905(a)(13), 42 CFR § 440.130(a)) • Laboratory and radiology services (1905(a)(3), 42 CFR § 440.30) • Behavioral health rehabilitation services (1905(a)(13)(c), 42 CFR § 440.130(d)). • Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)
Family Planning Services and Supplies	State Plan – Family planning services (1905(a)(4)(C), 42 CFR 441.20)
Services Provided by Community Health Workers	SPA – pending submission CHW services are a preventive health service designed to prevent disease, illness and injury, prevent the progression of chronic conditions, and may include: <ul style="list-style-type: none"> • Health Promotion and Education • Health System Navigation and Resource Coordination • Screening and assessment to identify health-related social needs and barriers to accessing health care
Medical Equipment and Supplies	State Plan – Medical Equipment and Supplies (1905(a)(7), 42 CFR 440.70(b)(3))

ATTACHMENT K

REENTRY DEMONSTRATION INITIATIVE IMPLEMENTATION PLAN

On July 2, 2024, the Centers for Medicare & Medicaid (CMS) approved Illinois' request to extend and amend its section 1115(a) demonstration (Project Number 11-W-00316/5) to include expenditure authority for limited coverage for certain reentry services provided to certain incarcerated individuals for up to 90 days immediately prior to the individual's expected date of release.

In accordance with Special Terms and Condition (STC) 4.10, this Reentry Demonstration Initiative Implementation Plan outlines the approach to implementing the Reentry Demonstration Initiative. The Reentry Demonstration Initiative Implementation Plan is in alignment with the expectations within the State Medicaid Director Letter (#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated). The Implementation Plan is categorized into the following five Reentry Demonstration Initiative milestones:

- Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated
- Milestone 2: Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community
- Milestone 3: Promoting continuity of care
- Milestone 4: Connecting to services available post-release to meet the needs of the reentering population
- Milestone 5: Ensuring cross-system collaboration

Illinois is committed to improving care transitions for reentering individuals and designing an effective and equitable Reentry Demonstration Initiative. The state will continue to cultivate partnerships across the state and engage reentry stakeholders for purposes of planning and implementation of the initiative. For each milestone, the Reentry Demonstration Initiative Implementation Plan describes how Illinois is currently carrying out any elements of the milestone, key steps needed to support the successful implementation of the milestone with associated timelines and responsible entities, and plans for addressing identified challenges.

The state intends to implement the reentry waiver in all 30 state prisons, Cook County Jail, Cook County Juvenile Temporary Detention Center, and 6 state youth correctional facilities. over the course of the demonstration. Illinois also recognizes the statutory requirements of Section 5121 and 5122 of the Consolidated Appropriations Act 2023 (CAA, 2023), signed into law on December 29, 2022. Planning for the implementation of the Reentry Demonstration Initiative includes coordination of efforts to support correctional facilities as needed to meet the provisions of both this demonstration and those of the CAA. Pre-release requirements of section 5121 of the CAA, 2023 will be met through the 1115 reentry demonstration for youth incarcerated in Illinois Department of Juvenile Justice (IDJJ) facilities, Cook County Temporary Juvenile Detention Center, and for individuals ages 18-21 (or former foster youth up to age 26) who are incarcerated in Illinois Department of Corrections (IDOC) facilities or Cook County Jail. Illinois intends to use this 1115

Waiver Reentry Demonstration Implementation Plan as its internal operational plan for services delivered to youth incarcerated at facilities operated by the three carceral partners identified in this plan. The state plans to initially phase in 1115 Reentry Demonstration services with these three carceral system partners due to the vast differences in capacity of county jails and youth detention facilities throughout Illinois. In addition to capacity and resource needs, recent Illinois legislation (the Pre-Trial Fairness Act) has changed detention patterns throughout the state. Lengths of detention, especially for youth, are often less than 30 days. Most youth who are detained in Illinois are being released from jails and detention centers pre-adjudication. The number of post-adjudicated youth who are incarcerated in local facilities is relatively low. HFS has developed an operational plan to develop processes with local carceral facilities that are not participating in this 1115 Reentry Demonstration to implement the provisions mandated by Section 5121 of the CAA, 2023. This plan includes defining a standardized process for identifying post-adjudicated youth, establishing data sharing mechanisms, assuring provision of services, providing training and technical assistance, including leveraging existing providers and developing resource networks for carceral settings. The technical assistance between HFS and the local carceral facilities will be an important component to assure the provision of services to youth post-release.

Implementation Update (November 2025)

Milestone	Status
Waiver Milestones	
<p>Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated</p>	<ul style="list-style-type: none"> • Suspension strategy for incarcerated individuals in the state prison system already in place • Systems changes to support eligibility and enrollment changes needed for pre-release coverage expected to go live as early as Q3 of CY 2026 • Individuals already afforded opportunity to apply for Medicaid • HFS expects to finalize program guidance to participating facilities as early as Q2 of CY 2026 • Facilities will demonstrate compliance with all milestones activities as part of readiness assessment
<p>Milestone 2: Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community</p>	<ul style="list-style-type: none"> • Systems changes to support reentry provider enrollment and billing expected to be complete as early as Q3 of CY 2026 • HFS expects to finalize case management service requirements as early as Q1 of CY 2026 • Facilities will demonstrate ability to provide the full set of reentry services as part of readiness assessment
<p>Milestone 3: Promoting continuity of care</p>	<ul style="list-style-type: none"> • HFS expects to finalize case management service requirements as early as Q1 of CY 2026 • HFS expects to finalize managed care requirements to support transitions and meet all applicable milestone activities as early as Q2 of CY 2026

Milestone 4: Connecting to services available post-release to meet the needs of the reentering population
 Milestone 5: Ensuring cross-system collaboration

- HFS expects to finalize managed care requirements to support transitions and meet all applicable milestone activities as early as Q2 of CY 2026
- HFS expects to finalize program guidance to participating facilities as early as Q2 of CY 2026
- HFS expects to develop tools and processes for facility readiness assessment as early as Q2 of CY 2026
- HFS expects to assess readiness of facilities to allow for initial facilities to go live as early as Q3 of CY 2026

Expected Facility Phase-in Schedule by Demonstration Year

Demonstration Year	State Prisons	Youth Facilities	County Jail	County Juvenile Detention Center
DY1 (7/1/24-6/30/25)				
DY2 (7/1/25-6/30/26)				
DY3 (7/1/26-6/30/27)	7	6	1	1
DY4 (7/1/27-6/30/28)	23			
DY5 (7/1/28-6/30/29)				

Implementation Milestones

As a part of ongoing implementation planning, HFS, in partnership with IDOC, IDJJ, the entities at Cook County, and the Illinois Criminal Justice Information Authority (ICJIA), will identify non-service related needs¹ of facilities in order to comply with each of the following milestones. HFS will also establish a process for approving uses of non-services expenditures that will be eligible for federal match.

Milestone 1: Increasing Coverage and Ensuring Continuity of Coverage for Individuals who are Incarcerated

Illinois has taken steps to initiate Medicaid applications for those entering carceral settings (or those nearing release, as applicable) and to restrict rather than terminate Medicaid upon entry. Illinois will examine current policies and procedures to make sure consistent application of such policies are in place across all participating facilities and state agencies. HFS expects to meet this milestone fully as early as Quarter 3 of the 2026 calendar year (Q3 CY 2026).

Suspension Strategy for Incarceration (Milestone 1.a)

Action: Implement a State policy for a suspension strategy during incarceration (or implement an alternative proposal to ensure that only allowable benefits are covered and paid for during

¹ Non-service related needs may include: Technology and IT, hiring of staff and training, adoption of certified electronic health record technology, purchase of billing systems, development of protocols and procedures, additional activities to promote collaboration, planning focused on developing processes and information sharing protocols, and other activities to support a milieu of appropriate activities for the provision of pre-release services.

incarceration, while ensuring coverage and payment of full benefits as soon as possible upon release), with up to a two-year glide path to fully effectuate.

Current State

Illinois does not terminate Medicaid for members who become incarcerated in a state or county facility. For these members, Medicaid covered services are restricted to inpatient hospitalizations and professional medical services related to the hospital stay. Full Medicaid coverage is restored once someone transitions back into the community. This process is automated for individuals at an IDOC facility through a file transfer that indicates someone's date of incarceration and their date of release. The person's file is updated accordingly with a systems code that indicates their carceral status. The code is removed the day before their release date so that full Medicaid coverage resumes upon their release date.^{2,3} There is not a systematic way to get information from jails and IDJJ, and HFS is currently exploring electronic solutions for a systematic way to identify detained Medicaid members at these facilities, modeled after current IDOC process.

Future State: Planned Activities and Timeline

- As early as Q2 CY2026, Illinois will finalize solutions to assure data transfer between participating carceral settings and HFS.
- As early as Q3 CY2026, Illinois will establish a new systems code that will be assigned to all individuals eligible for the pre-release services outlined in this Pilot.
- As early as Q3 CY 2026, HFS will issue guidance to participating facilities on the process to notify HFS of a person's eligibility for the pre-release services so that the new systems code can be properly applied to the person's file.
- Continued planning efforts will include working with stakeholders, including IDOC, IDJJ, and the partners at Cook County, to evaluate the timing and effectiveness of current procedures to identify improvements that will best support individuals and promote continuity of care through an equity lens.

Identified Challenges and Plans to Address Each

- **Ensuring Seamless and Continuous Coverage Upon Reentry.** Sometimes, as a result of the process described above, or variability in release dates/times, there can be a lag time between the date of an individual's release from a carceral setting and the date that their Medicaid coverage becomes unrestricted. To continue to mitigate this issue, Illinois will follow current procedures that include a dedicated email for Medicaid members and providers if there are any issues with accessing a service due to a lag in updating a person's Medicaid status to unrestricted. This process ensures that no one is denied a needed service. Facilities will also be required to establish workflows that include communication with an individual's assigned managed care plan, if applicable, once the date of release is known, and then communication again to confirm reentry on the actual release date. If applicable, communication will be made by the person's pre-release case

² See Medicaid Release (MR) #20.03: Medical Coverage for IDOC Inmates & Misc. Updates: <https://www.dhs.state.il.us/page.aspx?item=97999>.

³ See MR #17.07: Automation of Medical Benefit Restriction for Incarcerated Individuals: <https://www.dhs.state.il.us/page.aspx?item=87793>.

manager. As a part of implementation planning, HFS will continue to work with partners on this process to identify timing and process improvements, as needed.

- **Challenges with Data, Technology, and Workforce Capacity.** HFS and the correctional partners anticipate a varying degree of challenges related to data/information sharing, technology/systems, and workforce capacity. Through ongoing implementation planning, HFS will continue to engage partners to identify specific challenges and create mitigation strategies that help promote quality data/information exchanges, effective technology solutions, and a supported workforce.

Connecting Individuals to Medicaid (Milestone 1.b)

Action: Ensure that any Medicaid-eligible person who is incarcerated at a participating facility but not yet enrolled is afforded the opportunity to apply for Medicaid in the most feasible and efficient manner and is offered assistance with the Medicaid application process in accordance with 42 CFR § 435.906 and § 435.908. This could include applications online, by telephone, in person, or via mail or common electronic means in accordance with 42 CFR § 435.907. All individuals enrolled in Medicaid during their incarceration must be provided notice of any Medicaid eligibility determinations and actions pursuant to 42 CFR § 435.917 and § 431.211.

To better connect individuals to the opportunity to apply for Medicaid coverage, all sites that participate in this pilot will ensure efficient and effective processes at intake, and at other times as appropriate such as during and just prior to the pre-release period, to assist with applications to benefits, including Medicaid and SNAP. Current processes and collaborative partnerships with local Illinois Department of Human Services (IDHS) offices, known as Family Community Resource Centers (FCRC), will be leveraged to further enhance the process followed by carceral facilities today.

Current State

ILLINOIS DEPARTMENT OF CORRECTIONS. Individuals incarcerated at an IDOC facility may apply for medical benefits in advance of their scheduled release date. Applications are processed by an IDHS FCRC or the HFS All Kids Unit.⁴ Currently, individuals are offered the opportunity to apply for Illinois Medicaid within 60 days of release from custody. The Re-Entry Counselor at the individual's IDOC facility assists with the process and provides education regarding the importance of health care coverage. Individuals apply for Medicaid pre-release with the address of the IDOC facility. Releasees are given instructions for reporting changes on their Medicaid account to update their permanent address upon release. If approved for Illinois Medicaid prior to release, the individual is provided their Recipient Identification Number (RIN). If an individual is an immediate release or is being turned over to the custody of another law enforcement entity, they are given the paper application for Illinois Medicaid to complete when appropriate.

Individuals are also offered the opportunity to apply for SNAP benefits at the same time as the Medicaid application. Currently the process for joint SNAP/Medicaid applications takes place within 5-10 days of release from custody due to time frame requirements as outlined by USDA Food

⁴ See MR #20.03: Medical Coverage for IDOC Inmates & Misc. Updates: <https://www.dhs.state.il.us/page.aspx?item=97999>.

and Nutrition Services SNAP rules. HFS is currently discussing options to assure Medicaid applications are adjusted for the 90-day pre-release period with IDOC and IDHS.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. In youth correctional facilities, designated case management staff (Youth & Family Specialists) have access to the Integrated Eligibility System (IES) that allows verification of current Medicaid enrollment. IDJJ staff verify enrollment prior to a youth's release from custody. Youth & Family Specialists are also trained in completing the online Application for Benefit Eligibility (ABE) for youth who are not currently enrolled in Medicaid. Enrollment occurs prior to release.

As the youth is preparing for release, their Aftercare Specialist (community case manager) inquires of the youth's parent/guardian about source of health coverage. The Aftercare Specialist records the parent/guardian report of health coverage in IDJJ's Aftercare data system. If the parent/guardian indicates that Medicaid is the coverage source, the Aftercare Specialist checks the Integrated Eligibility System (IES). The Aftercare Specialist completes a case note within the first 30 days of arrival to IDJJ or prior to the release review, whichever occurs first, and monthly thereafter to ensure medical coverage has not been terminated. In the event medical coverage has been terminated, the Aftercare Specialist contacts an IES administrator to request reactivation or reapplies using the ABE system.

COOK COUNTY. Cook County Health operates both a provider group and a managed care plan, both of which serve the residents in both the Cook County Department of Corrections (referred to as Cook County Jail throughout this document) and the Juvenile Temporary Detention Center (JTDC). The healthcare provider group at both sites is Cermak Health Services, a standalone, accredited correctional health facility operating under the umbrella of Cook County Health. Cook County Health provides Medicaid application and enrollment assistance during the intake process at the Cook County Jail. Individuals are screened for Medicaid eligibility at the point of intake and application submission processes are in place if Illinois eligibility criteria is met.

The JTDC does not have a formal process in place at this time to enroll juvenile residents into Medicaid, however all implementation plans for this demonstration at Cook County Jail will also apply to the JTDC.

Future State: Planned Activities and Timeline

- As early as Q1 CY 2026, HFS will provide a notice to all participating facilities outlining the expectations regarding application assistance, completion, and submission of Medicaid applications, including access to fair hearing procedures and activities for adverse actions related to Medicaid coverage or services. Application assistance may be provided by the carceral facilities or community-based partners (including HFS Application Agents or health insurance navigators) as appropriate. As part of their readiness reviews, facilities will have to have relevant policies and procedures in place. HFS will offer technical assistance as needed.
- As early as Q2 CY2026, IDOC facilities will update their process and workflows so that Medicaid application assistance is occurring prior to an individual's 90-day pre-release period, if that date is known.

- As early as Q3 CY 2026, HFS will have a listing of all existing data-sharing agreements and facilities with access to IES and ABE. As needed, IDOC, IDJJ, and the partners at Cook County will continue to execute data-sharing agreements so that all participating facilities have the appropriate access to the appropriate systems to fully meet this milestone as they join the pilot. For example, HFS is currently working on an enhancement request to add IDOC, IDJJ and county facilities as an option in the ABE Provider Portal. This will provide them the ability to apply for multiple individuals and track applications in a dashboard.

Identified Challenges and Plans to Address Each

- **Ensuring Access to Fair Hearings.** Individuals will be afforded the right to request a fair hearing regarding their Medicaid application or case and facilities already have capabilities in place to support telephone and virtual meetings. While HFS will monitor for compliance with fair hearing procedures, the State cannot guarantee these processes will be implemented in every instance given the unique nature of carceral settings, (e.g., unexpected lockdown protocols implemented). To address this, HFS, in partnership with IDHS, will monitor the number of fair hearing requests of individuals who were found ineligible for Medicaid and pre-release services, as well as fair hearing no-show rates, and will work with facilities to refine processes related to fair hearings to ensure that individuals have access to these procedures.
- **Brief Time in Custody.** In cases where an individual's stay is short, it may not be feasible to follow normal processes and timelines. In these instances, facilities will establish alternative protocols so that assistance to Medicaid applications will still occur. Individuals will be provided with assistance on how they can follow through with the process upon their release.

Medicaid Renewal or Redetermination Assistance (Milestone 1.c)

Action: Ensure that all individuals at a participating facility who were enrolled in Medicaid prior to their incarceration are offered assistance with the Medicaid renewal or redetermination process requirements in accordance with 42 CFR § 435.908 and § 435.916. All individuals enrolled in Medicaid during their incarceration must be provided notice of any Medicaid eligibility determinations and actions pursuant to 42 CFR § 435.917 and § 431.211.

In alignment with existing Medicaid application assistance, completion, and submission policies, facilities will also support the State's efforts to ensure continuous and uninterrupted coverage for qualifying Medicaid enrollees. The State will ensure that Medicaid renewal strategies are incorporated into all participating facilities' policies and procedures.

Current State

For most individuals in carceral settings, Medicaid eligibility is administratively renewed following an *ex parte* process, meaning that their Medicaid is renewed automatically. For those that do not fall into *ex parte* redetermination, a notice of redetermination is mailed to the individual at the mailing address on file.

ILLINOIS DEPARTMENT OF CORRECTIONS. IDOC facilities do not complete annual redeterminations or Medicaid renewals. As these individuals will be typically residing at the facility for an extended period of time, staff assist all individuals with Medicaid applications pre-release, as needed.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. In youth correctional facilities, the Youth & Family Specialists have access to the IES that allows verification of current Medicaid enrollment. If indicated, these specialists will assist youth and families in Medicaid renewals or redeterminations.

COOK COUNTY. Cook County Health has processes in place to assess for Medicaid coverage and to identify individuals who require redetermination or renewal of their Medicaid in the Cook County Jail. Cook County utilizes Financial Counselors to assist in the redetermination process. However, current processes are not formalized to include all populations entering the facility and is based on staff availability. Staff use the Financial Assistance Tracking System to track all applications for individuals screened for this need.

As with Medicaid application assistance, the JTDC does not have a formal process in place currently to assist with Medicaid redeterminations.

Future State: Planned Activities and Timeline

- As early as Q2 CY 2026, HFS will provide a notice to all participating facilities outlining the expectations regarding renewal and redetermination assistance. As part of their readiness reviews, facilities will assure that relevant policies and procedures are in place. HFS will provide technical assistance as needed or upon request.
- As early as Q1 CY2026, participating facilities will complete a self-audit as part of their readiness to determine if process improvements are needed to better support individuals in their custody to have continued Medicaid enrollment, as needed.⁵
- As early as Q1 CY 2026 , HFS will review current state redetermination procedures to determine if process improvements are needed to better ensure that Medicaid enrollees in custody receive timely notification about Medicaid redetermination/renewal requirements, (e.g., also sending redetermination notices to physical addresses on file, if they are a carceral setting).

Identified Challenges and Plans to Address Each

- The same challenges noted in milestone 1.a. and 1.b. above apply to milestone 1.c.

Providing Medicaid Coverage Information Upon Release (Milestone 1.d)

Action: Implement a state requirement to ensure that all Medicaid-enrolled individuals who are incarcerated at a participating facility have Medicaid and/or managed care plan cards or some other Medicaid and/or managed care Enrollment documentation (e.g., identification number, digital documentation, instructions on how to print a card, etc.) provided to the individual upon

⁵ There may be instances where this level of administrative effort may not be needed, for example, in instances of long-term incarcerations. In these instances, the facility will utilize their policies and procedures for Medication application assistance, when the timing is appropriate based on reentry timeframes.

release, along with information on how to use their coverage (coordinated with the requirements under milestone #3 below).

Illinois' strategy will encompass a transparent and simplified process for individuals transitioning to the community from carceral settings, including information and tools to assure that they know how to access their Medicaid benefits.

Current State

As part of the standard Medicaid eligibility process, applicants are notified of the outcome of their eligibility through a *Notice of Decision* letter. *Notice of Decision* letters include an explanation of the outcome or action being taken, a website where they can access more information, Rights of the individual, including appeal rights, how to apply for legal help, how to access their account online (*Manage My Case*), and information about approved representatives if applicable. Applicants may also choose to receive emails and text communications regarding their case.

ILLINOIS DEPARTMENT OF CORRECTIONS. For individuals incarcerated in an IDOC facility, the individual receives a *Notice of Decision* after application for Illinois Medicaid. The eligibility determination notice is sent back to the facility or to the individual's host site. It is only sent to the individual's host site if the individual also applies for SNAP benefits at the same time (which is the majority of cases), as those applications are submitted with the address where the individual will be residing. If the individual declines the SNAP application, the Medicaid eligibility determination notice comes back to IDOC within 45 days and is placed in the individual's medical file. Upon release, individuals are provided information on how to access their Medicaid benefits along with their user ID and security questions to access their online Medicaid case. They are also provided with reference materials, such as the *Medicaid Application Follow-Up* handout and *Instructions for Parolees* handout.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. Presently, formalized processes to meet this milestone are not occurring in IDJJ facilities, however, the person's Aftercare Specialist provides the person and their family with relevant Medicaid/health coverage information, as applicable. If the person is assigned to a managed care plan, the Aftercare Specialist provides an update to their care coordination team.

COOK COUNTY. Similar to individuals at an IDOC facility, individuals at Cook County Jail receive a *Notice of Decision* after application for Illinois Medicaid. Once the individual's Medicaid benefits are activated upon release and if eligible for managed care, the person is auto-assigned to a managed care plan. For these Medicaid beneficiaries, the current default auto-assignment is to CountyCare, a managed care plan operated by Cook County Health, if the person's county code is Cook County, with member choice remaining available, following normal Illinois Medicaid procedures. For those that are new Medicaid applicants and those that are already enrolled in CountyCare, an onsite CountyCare staff person connects with the individual to inform them of the CountyCare Justice-Involved program and CountyCare coverage and services. Individuals assigned to CountyCare receive contact information of the staff person, as well as the member service line information.

The JTDC does not have a formal process in place at this time to meet this milestone.

Future State: Planned Activities and Timeline

- As early as Q1 CY2026, HFS will provide written notice to all participating facilities outlining the expectations to provide Medicaid coverage information upon release, including RIN, phone numbers to call, and instructions for accessing information online, at a minimum. For those that have selected a managed care plan, health plan specific information, including care coordination contact information, member services contact information, and the crisis line information should also be provided, as available and provided by the managed care plan. As part of their readiness reviews, facilities will assure that relevant policies and procedures are in place. HFS will provide technical assistance as needed or upon request.
- HFS will continue to monitor compliance for providing Medicaid coverage information upon release on an ongoing basis, as needed, to provide technical assistance and ensure adherence to the policy.

Identified Challenges and Plans to Address Each

- **Timeliness and Format of Material Availability.** Carceral settings do not always allow individuals to receive certain formats of materials while within the institution, (e.g., printed materials, online materials) and an individual's Medicaid application may be in process, which can be a challenge to helping individuals understand their coverage. Illinois will leverage pre-release case managers and warm/hot hand-off procedures to assist with any challenges identified by individuals to help them obtain the information they need so they can understand how to access their healthcare coverage.

Accessing Medicaid Applications (Milestone 1.e)

Action: Establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid application, including providing information about where to complete the Medicaid application for another state, e.g., relevant state Medicaid agency website, if the individual will be moving to a different state upon release.

Illinois' strategy for Medicaid application assistance includes adapting facility processes to meet each individual's needs, (e.g., interpretation services, health literacy methods, connections to other State Medicaid application processes). The state intends to provide all individuals in need of medical assistance the option to complete a Medicaid application.

Current State

The processes outlined in milestone 1.b. (Connecting Individuals to Medicaid, beginning on page 3), include steps facilities take to assist individuals access Medicaid applications.

Future State Activities to be Completed and Timeline

- As early as Q1 CY 2026, HFS will provide written notice to all participating facilities outlining the expectations regarding application assistance, completion, and submission of Medicaid applications (including access to other State Medicaid applications, should a person be relocating out-of-state upon release). As part of their readiness reviews, facilities will have to have relevant policies and procedures in place. HFS will offer technical assistance as needed.

Identified Challenges and Plans to Address Each

- **Potential Confusion related to Other State’s Medicaid Application Processes for Incarcerated Individuals.** To help facilities have clear procedures in place for when an individual plans to leave Illinois upon release, HFS will maintain a state-by-state guide with websites, phone numbers, and current policies for incarcerated and recently incarcerated individuals applying for Medicaid.
- **Brief Time in Custody.** In cases where an individual’s stay is short, it may not be feasible to follow normal processes and timelines. In these instances, facilities will establish alternative protocols so that assistance to Medicaid applications will still occur. Individuals will be provided with assistance on how they can follow through with the process upon their release.

Milestone 2: Covering and Ensuring Access to the Minimum Set of Pre-release Services for Individuals who are Incarcerated to Improve Care Transitions Upon Return to the Community

Illinois is setting out to implement broad and inclusive parameters to provide pre-release services to individuals transitioning to the community from carceral settings and will follow the parameters as set by STC 4. The approach is intended to ensure access to high quality, comprehensive services and supports to successfully transition recently incarcerated people to a safe setting, with access to relevant services and supports thus reducing the likelihood of recidivism and promoting better health outcomes. HFS expects to meet this milestone fully as early as Q3 CY 2026

Identification Process (Milestone 2.a)

Action: Implement state processes to identify individuals who are incarcerated who qualify for pre-release services under the state’s proposed demonstration design (e.g., by chronic condition, incarceration in a participating facility, etc.).

Illinois’ approach to identifying individuals eligible for pre-release services will be embedded into participating carceral facility pre-release procedures and programs, as applicable, to promote timely identification and connection based on an individual’s needs.

Current State

While Illinois is not presently identifying individuals eligible for the reentry demonstration initiative’s set of pre-release services, the following outlines the process that HFS is exploring with IDOC, IDJJ, and the partners at Cook County. Modifications may be made, as implementation occurs, based on the needs of the individuals intended to benefit from this initiative, to ensure that equitable access to services is occurring.

The state is currently exploring potential identification processes to be adopted by participating facilities. The following steps are in draft form and are subject to revisions, based on continued discussions and collaboration with the reentry stakeholders:

- Step 1 – Identify release date:
 - Long-term stays – The person’s release date is set.

- The carceral facility will develop processes to track when an individual begins their 90-day pre-release period.
 - Short-term stays – The person’s release date is unknown.
 - When an individual is in custody at a facility with known release timeframes that average less than 90 days (e.g., Cook County Jail), the individual will be presumed to be within their 90-day pre-release period. Carceral facilities with short-term stays will be required to track and confirm the length of time that an individual has been in their 90-day pre-release period and will be prohibited from billing for pre-release services beyond the 90-day time frame.
- Step 2 – Verify Medicaid status: Person is identified as having Medicaid⁶
- Step 3 – Assign case manager: A pre-release case manager will be assigned to the individual (with the individuals’ consent). HFS will continue planning efforts with reentry partners to determine whether pre-release case managers are staff, contractors of carceral facilities, or community in-reach providers (which may vary by facility).
- Step 4 – Determination of need: The pre-release case manager completes a pre-release services review and determination. If the person is eligible for pre-release services (based on need), the facility will submit this information through the established notification process used currently to identify the person as being in or leaving a carceral setting. The pre-release services review will include a health assessment that will identify if any of the covered pre-release services are needed.
- Step 5 – Provision of services: Pre-release services will be covered through Medicaid Fee-for-Service, based on needs identified through the pre-release services review and determination process⁷
- Step 6 – Preparation for release: Facility discharge processes for this person will include a pre-release services screening as close to one week prior to their release date that will include:
 - A health assessment and file review to identify any medications, over-the-counter drugs, and durable medical equipment needed upon discharge

The above process can be modified by each facility site if determined by HFS to meet acceptable minimum criteria during readiness review activities. This will allow for flexibility to embed this process into their current workflows. Any physical and behavioral health assessment or screening tools used as part of the health assessment must be validated by HFS during the readiness review process and any previous or current medical treatment plans can be used as part of this assessment to determine needed pre-release services.

As one potential example for how this may be operationalized, IDOC performs an R&C (Receiving and Classification) physical on all people who transition to the prison system including a screening for acute and chronic conditions. Further, IDOC is currently working to implement an electronic

⁶ If a person’s Medicaid eligibility has not been determined/processed, the facility will either follow up to check on the status of the person’s notice of decision, or will assist in applying for Medicaid, if that has not already been offered.

⁷ Providers of pre-release services will need to validate that a person’s Medicaid file has been updated to reflect the affiliated aid code indicating the person’s eligibility for pre-release services.

health record for the prison system. In this instance, IDOC may implement a standardized process across sites that leverages their R&C, as well as the anticipated electronic health record.

As another example, both the Cook County Sheriff's Office and Cook County Health perform screening and assessments on individuals entering the Cook County Jail. Health information is documented in the electronic health record which has robust reporting and data management capability and interfaces with the Cook County Sheriff's Office jail management system. Currently these systems interface with bidirectional sharing of key data points. In this example, Cook County Jail may leverage its existing system capabilities and processes to embed a screening process that will be efficient and effective, but unique to their workflows.

Future State: Activities to Be Completed and Timeline

- As early as Q2 CY 2026, HFS will finalize the identification process outlined above.
- As early as Q2 CY 2026, HFS will provide guidance to facilities on the process for notifying IDHS FCRCs and the HFS All Kids Unit on individuals screened as needing pre-release services so that the appropriate systems code can be applied to the individual's file. HFS is in the process of outlining the system changes needed for the eligibility and payment system to ensure that coverage includes the authorized 90-day pre-release services, as applicable.
- Correctional facilities will be responsible for operationalizing the pre-release screening process to identify individuals eligible for pre-release services. HFS will review this process as part of readiness activities.
- As early as Q3 CY 2026, participating facilities will begin screening individuals for pre-release services, if they have completed their readiness review and have received clearance.
- HFS will monitor for implementation challenges, and make program changes, as needed to ensure appropriate identification of eligible Medicaid enrollees.
- As part of continued implementation planning and demonstration roll out, and with input from various reentry stakeholders, including correctional facilities, sister agencies, community-based providers, and managed care plans, HFS will evaluate and consider best-practice approaches to connecting individuals with managed care plans in their pre-release period and incorporating service delivery within managed care.

Identified Challenges and Plans to Address Each

- **Identifying Individuals with Short-Term Stays or Unpredictable Release Dates.** It is anticipated that the hardest group to screen for pre-release services will be those with short stays or unpredictable release dates. This is particularly true at the county jail level, but also occurs with incarcerated youth and some incarcerated adult populations, in particular incarcerated women. HFS will develop "short-term stay" best practices, in collaboration with stakeholders, and will disseminate this to facilities during readiness activities. As a best-practice, for facilities with populations that have average lengths-of-stay less than 90 days, the presumption will be that a person is within their 90-day window, thus service needs should be screened for and provided, if eligible.
- **Variation in Screening Practices and Procedures.** While the State has outlined pre-release screening steps that are to be adopted by facilities, flexibility will be needed to

ensure that current systems and workflows can be adapted. Prior to any facility deviating from the outlined steps, HFS must provide approval during readiness activities. HFS will monitor screening rates across sites and provide technical assistance as needed. If needed, HFS will develop a standardized tool to be used across sites.

Accessing the Pre-release Benefit Package (Milestone 2.b)

Action: Cover and ensure access to the minimum short-term, prerelease benefit package, including case management to assess and address physical and behavioral health needs and HRSN, MAT services for all types of SUD as clinically appropriate with accompanying counseling, and a 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release, to Medicaid eligible individuals identified as participating in the Reentry Section 1115 Demonstration Opportunity. In addition, the state should specify any additional services that the state proposes to cover for beneficiaries prerelease. The state should describe the Medicaid benefit category or authority for each proposed service.

Some pre-release services are currently being provided at correctional facilities in Illinois, although there is variation in application. HFS will ensure that the services outlined in the pre-release benefit package will be available at each participating facility during readiness review activities. If a facility will be phasing in services over time, this will be reviewed as a part of readiness activities (see milestone 5 for more information). Illinois will require participating facilities to select a Service Level for implementation. Service Level One consists of the expected minimum set of pre-release services as indicated in the State Medicaid Director Letter (SMDL) ([#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated](#)) and identified in STC 4.4(a), and must be the first Service Level category that is implemented. Service Level Two consists of the remaining reentry services authorized under the waiver. No facility may be a participating correctional facility that does not at least achieve and maintain provision of Service Level One. A facility must demonstrate to the state that it is prepared to implement all the services in Service Level One.

Facility Service Level Descriptions	
Pre-release service	Medicaid Benefit Category or Authority
Service Level 1	
Pre-Release Case Management	<p>1115 Reentry Demonstration Authority</p> <p>Case management to assess and address physical and behavioral health needs and social determinants of health needs. The purpose of case management in the context of the reentry demonstration component is to:</p> <ul style="list-style-type: none"> • Support the coordination of services delivered during the pre-release period and upon release;

	<ul style="list-style-type: none"> • Ensure linkages to community-based services, providers, and social supports; and • Facilitate the arrangement of appointments and access to healthcare services delivered in the community. <p>Pre-release case management services include the following required activities:</p> <ul style="list-style-type: none"> • Assessment and reassessment. • Development of a person-centered care plan. • Referral and related activities. • Monitoring and follow-up activities.
Medication Assisted Treatment (MAT)	<p>State Plan</p> <ul style="list-style-type: none"> • State Plan – MAT for opioid use disorders (OUD) (1905(a)(29)) • Medications covered under Prescription drug benefit (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25) • Counseling covered under Rehabilitation services benefit (1905(a)(13)(c), 42 CFR § 440.130(d))
30-day supply of all prescription medications and over-the-counter drugs (to be provided at time of release) Service Level 2	<p>State Plan – Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)</p>
Physical and Behavioral Health Clinical Consultation Services, as clinically appropriate, to diagnose health conditions, provide treatment, and support pre-release case managers’ development of a post-release treatment plan and discharge planning	<p>As defined in the State Plan, primarily:</p> <ul style="list-style-type: none"> • Screening services (1905(a)(13), 42 CFR 440.130(b)) • Physician Services (1905(a)(5), 42 CFR 440.50) • Behavioral health rehabilitation Services (1905(a)(13)(c), 42 CFR § 440.130(d)). <p>For the purpose of CAA section 5121 alignment, clinical consultation services will include necessary Early and Periodic Screening, Diagnostic and Treatment screenings for individuals under age 21.</p>

	As
Diagnostic services including laboratory and radiology services	<p>State Plan</p> <p>Services that are medically necessary, appropriate for the unique setting, and that are in support of demonstration goals:</p> <ul style="list-style-type: none"> • Physician services (1905(a)(5), 42 CFR § 440.50) • Diagnostic services (1905(a)(13), 42 CFR § 440.130(a)) • Laboratory and radiology services (1905(a)(3), 42 CFR § 440.30)
Treatment for Hepatitis C, HIV, TB, and Other Conditions	<p>As defined in the State Plan, primarily:</p> <ul style="list-style-type: none"> • Physician services (1905(a)(5), 42 CFR § 440.50) • Diagnostic services (1905(a)(13), 42 CFR § 440.130(a)) • Laboratory and radiology services (1905(a)(3), 42 CFR § 440.30) • Behavioral health rehabilitation services (1905(a)(13)(c), 42 CFR § 440.130(d)). • Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)
Prescribed drugs and medication administration	State Plan – Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)
Family Planning Services and Supplies Services provided by community health workers	<p>State Plan – Family planning services (1905(a)(4)(C), 42 CFR 441.20)</p> <p>SPA – pending submission</p> <p>CHW services are a preventive health service designed to prevent disease, illness and injury, prevent the progression of chronic conditions, and may include:</p> <ul style="list-style-type: none"> • Health Promotion and Education • Health System Navigation and Resource Coordination • Screening and assessment to identify health-related social needs and barriers to accessing health care
Medical equipment and supplies and/or medical equipment upon release	State Plan – Medical Equipment and Supplies (1905(a)(7), 42 CFR 440.70(b)(3))

Current State

ILLINOIS DEPARTMENT OF CORRECTIONS. IDOC currently provides case management, MAT, clinical consultation (physical and behavioral), medications and medication administration, community health workers, laboratory and radiology, and a 30-day supply of medications and/or durable medical equipment.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. Youth correctional facilities provide case management, clinical consultation (physical and behavioral), medications and medication administration, laboratory and radiology, and a 30-day supply of medications and/or durable medical equipment.

COOK COUNTY. Services available at Cook County Jail include case management, MAT, clinical consultation (physical and behavioral), medications and medication administration, community health workers, laboratory and radiology, and a 30-day supply of medications and/or durable medical equipment. Usually, the 30-day supply of medications is in the form of a prescription, which can be filled at the local public hospital.

Future State: Activities to be Completed and Timeline

- As early as Q2 CY 2026, HFS will issue guidance for providers regarding the approved pre-release services, which may include information on service provisions, highlighting any differences as a result of service setting, as well as reporting and billing requirements. HFS will develop service requirements for case management to ensure the service meets federal requirements and unique needs of individuals in Illinois. HFS will work with reentry partners to identify gaps between current service delivery and service requirements for pre-release case management and other reentry pre-release services.
- Correctional facilities, along with their identified partners, will be responsible for operationalizing the provision of pre-release services. Their procedures will be reviewed as part of readiness activities, to begin as early as Q2 CY 2026. A facility must complete all readiness activities prior to beginning any screening for pre-release services and rendering/facilitating the provision of any pre-release services, as early as Q3 CY 2026.
- Provider enrollment for pre-release services may begin as early as Q2 CY 2026.
- HFS will monitor for implementation challenges, and make program changes, as needed to ensure appropriate delivery of pre-release services to eligible Medicaid enrollees.

Identified Challenges and Plans to Address Each

In addition to the challenges outlined in milestone 1.a, Illinois has identified the following additional challenge for meeting milestone 2.b.

- **Providers that are New to Medicaid.** Illinois anticipates that some providers will be unfamiliar with Medicaid provider enrollment, and billing procedures. HFS will work with the Medicaid Technical Assistance Center (MTAC) to provide training and technical assistance as needed. Additionally, HFS will continue to explore ways to provide support to providers and to minimize administrative burden through potential solutions such as third-party administrators and community hubs.

Ensuring Care Managers Have Knowledge of Community Based Providers (Milestone 2.c)

Action: Develop a state process to ensure case managers have knowledge of community-based providers in communities where individuals will be returning upon release or have the skills and resources to inform themselves about such providers for communities with which they are unfamiliar.

Supporting care and case managers to ensure they have the tools they need to identify and connect members to community-based providers will be a key strategy to promoting a transition for individuals that is supportive of their needs to meet their unique reentry goals. Current reentry case management activities and processes vary across facilities. Part of the continuing implementation planning conversations with Illinois' reentry stakeholders will be to develop a clear understanding of current state by facility, as well as a co-designed approach to ensure that *pre-release case management services* will enhance and expand what is happening today.

Current State

ILLINOIS DEPARTMENT OF CORRECTIONS. IDOC staff and partners have deep local level knowledge needed to connect individuals with services in the communities they are returning to. The following are examples of case management programs that help support individuals make connections to community providers post-release:

- IDOC works with the University of Illinois at Chicago (UIC) who provides a case manager for individuals with HIV/AIDS, Diabetes, or individuals in need of transgender care. The case manager connects individuals to post-release community providers in order to assist in the transition of care.
- Individuals with high mental health needs and who are at risk of homelessness are connected to community mental health programs and case managers associated with permanent supportive housing, mental health providers, and wrap around services in order to assist with their transition of care.
- At two facilities (and expanding to four), IDOC has a collaborative partnership with the Safer Foundation. Through their Supportive Reentry Network Collaborative (SRNC), Safer Foundation connects with individuals at least once during pre-release and assists in coordinating the individuals' care and linkage to providers post-release. The SRNC also links individuals to MAT services post-release.
- Treatment Alternatives for Safe Communities (TASC) provides services including SUD assessments; clinical reentry management; and linkages to community-based SUD treatment, mental health treatment, and other supportive services necessary to assist individuals transition back into the community.
- Newly launched in October 2024, the GRO Community provides case management services in individual and group programs during the pre-release period along with post-release connections to ongoing program support and services, such as post-release case management and housing support.
- Heritage Behavioral Health uses a certified community recovery support specialist to provide case management in groups in pre-release, with connections to post-release case management and other supports as needed.

- IDOC’s Parole Re-Entry Group (PRG) is comprised of approximately 16 Casework Supervisors who work with the Field Services Representative at each IDOC facility to review the cases of individuals who are at risk of homelessness and help place them in appropriate housing (transitional housing, Recovery Home, high need mental health, nursing home placement, etc.) with appropriate services based on needs. Connections are made to individuals in their pre-release period, with services and connections continuing in their post-release period, mainly focused on housing security.
- IDOC contracts with other agencies that provide substance abuse treatment programming in some IDOC facilities. Case managers or contractual staff work to ensure post-release Recovery Home placement and/or continued treatment based on level of need for individuals releasing from those programs.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. The IDJJ Aftercare Specialist is the primary care manager for the reentry process. Incarcerated youth and families participate in a multi-disciplinary Youth and Family Team meeting once per month, including a release review meeting prior to the approval of release to the community. The staffing includes the Aftercare Specialist, who works with the rest of the team to identify Aftercare services and supports, including a wide range of community support programs and treatment providers. IDJJ currently has relationships with more than 50 community vendors who can provide services to youth in community. IDJJ is also engaged with in a geo-mapping project with Chapin Hall through the University of Chicago to identify locations of each partnership in relation to youth discharge addresses. The project is designed to be a tool for case managers to identify resources for youth upon release.

COOK COUNTY. The Cook County Sheriff’s Office and Cook County Health have a long-standing relationship with community providers. Cook County Health is also the largest safety net health system in Cook County, providing services that include behavioral health and crisis care, MAT, specialty care, and services to address HRSNs, such as housing and transportation. CountyCare, the managed care plan operated by Cook County Health, tracks and monitors the zip codes for all members who are auto-assigned from Cook County Jail. CountyCare then subsequently identifies community resources where the individual resides so that care coordinators can refer and connect members to these resources. In addition, CountyCare staff have access to various community resources (website, registries, etc.)

Future State: Activities to be Completed and Timeline

- As early as Q1 CY 2026, HFS will complete a landscape review of current case management programs providing pre-release and post-release services to assist in better defining providers of the pre-release case management services and expectations of pre-release case management services for this demonstration.
- As early as Q3 CY 2026, all managed care plans will identify a Reentry Liaison, and their contact information will be made available to all participating facilities. Participating facilities will also identify a point of contact for managed care plans. This will further bolster knowledge sharing and communication regarding the availability of community-based providers in the communities Medicaid members are returning to.

- Upon a facility’s initiation of providing the pre-release case management services, case management processes, at a minimum, will include warm hand-offs, (e.g., direct contact and linkage) to community-based providers.
- HFS will monitor for implementation challenges, and make program changes, as needed to ensure appropriate connections to community-based providers are occurring.

Identified Challenges and Plans to Address Each

- **Case Management Workforce Challenges.** It is possible that a case manager may be newer to their position, or unfamiliar with a particular community. This could cause them to be less familiar with available community-based providers in certain instances. By having each managed care plan have a point of contact (Reentry Liaison), they can provide support and facilitate connections as needed.
- **Changes in Providers and Programs.** Another challenge will be the ever-changing local landscape of community-based providers. In addition to the Reentry Liaison, HFS will work with the area 2-1-1s and other local service organizations to make sure case managers are able to access up-to-date information about local services.

Milestone 3: Promoting Continuity of Care

Robust case management and effective technology systems promote continuity of care during times of transition. Illinois’ demonstration expects to leverage both to address the health needs and HRSN of individuals transitioning from carceral settings, while centering practices on person-centered approaches. Through readiness and technical assistance activities, HFS will promote the best practice across these sites of promoting case managers and teams that include peers, which promotes trust among individuals leaving carceral settings. This will continue to be a key feature of the case management provided to these members. HFS expects to meet this milestone fully as early as Q3 CY 2025.

Person-Centered Care Planning (Milestone 3.a)

Action: Implement a state requirement that individuals who are incarcerated receive a person-centered care plan prior to release to address any physical and behavioral health needs, as well as HRSN and consideration for long term services and supports (LTSS) needs that should be coordinated post-release, that were identified as part of pre-release case management activities and the development of the person-centered care plan.

A person-centered care plan that covers one’s physical and behavioral health needs, as well as one’s HRSN and LTSS needs, and that is based on an individual’s personal goals, will be a roadmap for Medicaid members and their community-based providers to effectively support a successful transition back to the community. Currently, there is much variation across facilities on care/case planning.

Current State

ILLINOIS DEPARTMENT OF CORRECTIONS. IDOC currently utilizes the Ohio Risk Assessment System (ORAS) on all individuals, which assesses an individual’s risk to recidivate as well as their criminogenic needs that contribute to that risk. ORAS contains multiple assessments, and the main domains cover justice involvement, school problems and employment, family, substance use, and lifestyle. The Corrections Assessment Specialists (CAS) in each facility administer that

assessment and then work with individuals that score Moderate, High, or Very High risk to develop and implement an individualized case plan. This case plan aims to route individuals through clinical services programming, education, and re-entry-related goals during their incarceration. The case plan can be continued upon release with the Re-Entry CAS staff in our Parole Offices. This assessment identifies any medical or mental health issues and addresses potential barriers that could be present, as well as what needs to be done to address those; however, this plan is *not medical or mental health discharge planning*.

IDOC Mental Health, at the higher level of care units located in a few of IDOC's facilities, participate in the discharge planning process with individuals in custody pre-release. Those facility teams work with IDOC's Re-Entry Unit's high needs placement team to ascertain appropriate release plans to include placement and connection to post-release community services.

Individuals in a contracted substance abuse treatment program and individuals with medical needs who work with the UIC case manager also participate in this level of care planning.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. IDJJ's Aftercare Specialists link youth to community providers who provide physical and behavioral health needs. The Aftercare Specialist helps the youth and family identify health providers who are covered by Medicaid and support youth in obtaining and attending appointments. Through this demonstration, current activities will be evaluated, and improvement opportunities will be identified, including linkage to managed care post-release. As outlined in milestone 2.c, the Aftercare Specialist is the primary care manager and youth and families participate in a multi-disciplinary Youth and Family Team meeting once per month, including a release review meeting prior to the approval of release to the community. The staffing includes the Aftercare Specialist, who works with the rest of the team to identify Aftercare services and supports, including a wide range of community support programs and treatment providers. The medical and behavioral health team includes a Medical Doctor or Nurse Practitioner (primary care), a psychiatrist, a licensed mental health professional, and a licensed substance use disorders provider. Currently the staffing process includes:

- A discharge plan summary that includes:
 - Care provided
 - Care that is still need (inclusive of medications)
 - Appointment dates/times/and locations of any outstanding appointments or services needed

The summary is reviewed with the youth and a copy is sent with the youth.

- Parent/guardians contact regarding the discharge plan for youth under 18 (if possible).
- Youth are allowed to test for HIV if they have not had a test within 90 days.
- Upon release, youth are given a month supply of any medication that has been prescribed.
- Youth receive Narcan and education on its use.

COOK COUNTY. The Sheriff's Office conducts a voluntary assessment upon a person's entry into the Cook County Jail. This assessment provides recommendations for programming and services to individuals in custody while they are in the Cook County Jail and identifies probable needs for when they leave custody by providing connections to supportive resources. In addition, upon release, the

Sheriff's Office Community Resource Center offers each individual an opportunity to meet with a reentry care coordinator and connect them to services in the community based on their individualized needs.

Cook County Health assigns social workers to patients with mental health needs to assist residents with connecting to housing and medication resources in the community post release. The program focuses on the highest risk individuals with Serious Mental Illness. In addition, separate staffing resources perform case management and post release education for the SUD population while in jail to facilitate continuity of care. All CountyCare members and individuals who apply to Medicaid can connect with a CountyCare staff person who is onsite twice a week. A Social Determinants of Health (SDOH) screener is conducted to quickly assess the needs of these individuals and to refer them to community resources. While CountyCare has a delegated model for care management, all justice-involved members assigned to CountyCare receive care management and coordination to support continuity of care. With the SDOH screener within the member's file, a care coordinator is able to review and include within their individualized plan of care. CountyCare can also track members who were auto enrolled to CountyCare when applying to Medicaid while incarcerated. CountyCare monitors which members completed a Health Risk Screening (HRS) and the risk-level assigned to the member based on the HRS and engagement with their care coordinator. Care plans are completed for members who are assessed to be of higher risk (level 2 & 3). Once these members are released and integrated into the community, the care coordination team utilizes the individualized plan of care to connect members into the care coordination processes and workflows to ensure their healthcare needs are being met and they are effectively connected to community resources.

Future State: Activities to be Completed and Timeline

- As early as Q2 CY 2026, HFS will issue a policy requiring pre-release case managers to develop a person-centered care plan prior to release. The policy will include timeframes for the development and completion of the care plan, the components to be addressed, and the entities with which the care plan must be shared (e.g., treatment providers, post-release case managers, person's managed care plan, carceral facility, person's mandatory supervised release contact).
- As early as Q4 CY 2025, IDJJ (and other facilities as applicable) will evaluate their current Aftercare Specialist activities to identify opportunities to improve the way that individuals are connected to needed physical and behavioral health services upon reentry, including enhancements to the multidisciplinary team. Improvements will build on this milestone and the person-centered care planning process.
- Participating facilities, in partnership with the entity(ies) that will be providing pre-release case management, will submit a care plan template as part of readiness activities. At a minimum, the care plan is to include the following:
 - Goals and Actions to support one's physical and behavioral health needs
 - Goals and Actions to support one's HRSNs (e.g. access to nutritious food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social and familial connections, quality education, and opportunities for meaningful employment)
 - Goals and Actions to support one's LTSS needs

- Delineation of what needs to be done pre-release vs. post-release
- Before providing any services, participating facilities, community-based providers (if using an in-reach model), and managed care plans, will have executed data sharing agreements as applicable, to share the person-centered care plan, relevant assessment information, and clinical history. This will be in accordance with all applicable laws, including Section 1902(a)(7) of the Social Security Act; 42 CFR Part 431, Subpart F; 42 CFR Part 2; and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, Breach Notification, and Enforcement Rules (the HIPAA Rules). Facilities will update and maintain policies and procedures on obtaining signed releases of information. Part of the readiness assessment will also include a review of data sharing agreements that are executed and/or in process.
- Upon delivering pre-release case management services, case managers will use available assessments, as well as their own, comprehensive assessment to inform the development of the person-centered care plan. Case managers will ensure that signed releases of information are obtained as necessary and that all security and privacy laws are adhered to.

Identified Challenges and Plans to Address Each

- **Case Management Workforce Challenges.** Illinois anticipates that there could be challenges related to case/care management role delineation. To support facilities, community-based providers, and managed care plans, HFS will provide guidance regarding clear expectations on the role that the pre-release case manager will have, along with strategies for other care/case managers and programs to utilize to enhance coordination and collaboration with the pre-release case managers.
- **Individuals with Short-Term Stays or Unpredictable Release Dates.** It is anticipated that the hardest group to have a developed person-centered care plan developed prior to release will be those with short stays, quick turnarounds, or unpredictable release dates. HFS will develop “short-term stay” best practices, in collaboration with stakeholders, and will disseminate this to facilities during readiness activities.
- **Data and Information Sharing.** It may be a challenge to execute the needed data-sharing agreements between parties. Such agreements often require significant lead time given the legal review process necessary by all parties. HFS will develop guidance and templates to support the execution of such agreements, as needed.

Timely Access to Post-Release Health Care Items and Services (Milestone 3.b)

Action: Implement state policies to provide or facilitate timely access to any post-release health care items and services, including fills or refills of prescribed medications and medical supplies, equipment, appliances or additional exams, laboratory tests, diagnostic, family planning, or other services needed to address the physical and behavioral health care needs, as identified in the course of case management and the development of the person-centered care plan.

Timely access to care is critical to achieving one’s health- and HRSN-related goals and Illinois will establish policies that will ensure that these needs are met as individuals transition to the community.

Current State

ILLINOIS DEPARTMENT OF CORRECTIONS. Individuals are released from custody with a 30-day supply of prescribed medication and an additional 2-week prescription order to take to the pharmacy. Individuals at risk of homelessness are placed with community agencies that assist in connecting them to post-release care, especially those with high mental health and/or medical needs that result in placement in mental health centers or in nursing homes. Individuals with HIV/AIDS, Diabetes, or who need transgender care are able to work with a contracted case manager from UIC who connect to continued medical care post-release.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. IDJJ's Aftercare Specialists link youth to community providers who provide for physical and behavioral health needs. The Aftercare Specialist helps the youth and family identify health providers who are covered by Medicaid and support youth in obtaining and attending appointments.

COOK COUNTY. Currently, for individuals being released to the community, processes are in place for priority groups like SUD and Seriously Mentally Ill patients to ensure the receiving clinic/hospital knows the patient was discharged and is transitioning to their site for post-release care. Due to the implementation of the Illinois Pretrial Fairness Act (2023) which abolished cash bail, and the movement of individuals being detained and released quickly, Cook County Health has implemented a flexible approach to ensure members who complete the intake processes have an opportunity to receive health services while detained. Further, the Sheriff's Office provides direct case management to individuals leaving custody upon their release to link them with services. As part of this, many physical resources are offered to individuals upon release including weather appropriate clothing, books, Chicago Transit Authority (CTA) cards, non-perishable meals, Narcan kits, and fentanyl testing strips.

Additionally, all CountyCare members who have been released have access to care coordination. CountyCare has established various processes to help find members and engage them in care. CountyCare members detained at Cook County Jail meet with the Social Work Transitional Care Coordinator to complete a transition plan that includes demographic information and assessment of the needs of the member through an SDOH screener. Transition needs are identified and documented in the care management system for warm hand-off to the care coordinator. Presently, the goal is to contact the member within 14 days upon release from Cook County Jail. CountyCare leverages the care coordination model to connect with these members who have been recently released from Cook County Jail. CountyCare conducts home visits to support outreach efforts. Once members are engaged, they are connected to their care coordinator. Through care coordination, they are connected to any necessary healthcare services.

Future State: Activities to be Completed and Timeline

- As early as Q2 CY 2026, HFS will issue a policy that will require that a component of the pre-release case manager activities will include the facilitation of timely access to any post-release health care items and services, including fills or refills of prescribed medications and medical supplies, equipment, appliances or additional exams, laboratory tests, diagnostic, family planning, or other services needed to address the physical and behavioral health needs of the individual, as identified through the course of pre-release case management and the development of the person-centered care plan.

- The person-centered care plan described in milestone 3.a will include actions to be completed both pre- and post-release to facilitate timely access to any post-release health care items and services, including fills or refills of prescribed medications and medical supplies, equipment, appliances or additional exams, laboratory tests, diagnostic, family planning, or other services needed to address the physical and behavioral health needs of the individual.
- Providers of pre-release and post-release case management and facilities (and to the extent of involvement, managed care plans) will be required to work collaboratively to ensure that processes are complementary to each other which will promote the seamless facilitation of these services. At a minimum, they must have established processes that ensure that:
 - Prescribed medications are “in-hand” upon release
 - Durable medical equipment is either “in-hand” or that there is an established plan for connecting the member to the needed equipment upon release (same day if possible and within 48 hours if clinically appropriate)
 - Follow up visits for primary or specialty care are scheduled
 - Labs/diagnostics are ordered
 - Needed behavioral health services are scheduled/in place
 - A post-release case manager is identified (including warm/hot hand-off processes and timeframes)

Processes must include provisions on how case managers and individuals receiving services will be kept aware of prescriptions, appointments, authorizations, etc.

- HFS will work with reentry partners to identify the range of potential post-release case managers and develop processes for pre-release case managers to hand-off person-centered care plans and support transition of case management activities.
- HFS will monitor for implementation challenges and disparities in accessing services, and make program changes, as needed to ensure appropriate connections to services are occurring.

Identified Challenges and Plans to Address Each

- **Case Managers’ Ability to Ensure Timely Connections to Care.** While policies, procedures, and systems may be in place, case managers and individuals receiving these services may encounter barriers to accessing care or arranging for access to care for varying reasons. As one example, some community providers want to wait until the individual is released before scheduling an appointment. To support case management efforts, HFS will provide technical assistance to support case managers as they work to address barriers to needed care and services, as well as issue information to providers regarding the importance of timely service provision for this population.

Transferring Relevant Health Information (Milestone 3.c)

Action: Implement state processes to ensure, if applicable, that managed care plan contracts reflect clear requirements and processes for transfer of the member’s relevant health information for purposes of continuity of care (e.g., active prior authorizations, care management information or other information) to another managed care plan or, if applicable, state Medicaid agency (e.g., if the

beneficiary is moving to a region of the state served by a different managed care plan or to another state after release) to ensure continuity of coverage and care upon release (coordinated with the requirements under milestone #1 above).

Current State

Illinois does not currently have a process in place to transfer relevant health information from one managed care plan to another or to other state Medicaid agencies for this population. However, managed care plans do have contractual obligations and expectations around transitions of care for the purposes of continuity of care and quality transitions when a person is changing setting locations (e.g., institutional setting to a community setting) or changing coverage (e.g., managed care plan to managed care plan, managed care plan to FFS).

Future State: Activities to be Completed and Timeline

- HFS will continue to work with reentry stakeholders as they explore options and best practices for involving managed care plans in this demonstration. At a minimum, HFS expects managed care plans to be involved in a person's care coordination once the individual returns to the community and managed care plan enrollment is effective. HFS will continue to work with managed care plans to identify expectations around member engagement and connectivity to services and HRSNs post-release. Managed care contracts will be updated to include requirements for transferring health related information for HRSN services, including reentry services, as early as Q3 CY 2026.

Identified Challenges and Plans to Address Each

- **Timely and Effective Data Exchanges.** Facilities, community-based organizations, and managed care plans do not have an effective data exchange platform today. HFS will explore potential technology solutions to support timely and effective data exchanges between partners participating in the reentry demonstration initiative.

Ensuring Coordinated Care (Milestone 3.d)

Action: Implement state processes to ensure case managers coordinate with providers of pre-release services and community-based providers, if they are different providers. Implement a state policy to require case managers to facilitate connections to community-based providers pre-release for timely access to services upon reentry in order to provide continuity of care and seamless transitions without administratively burdening the beneficiary, e.g., identifying providers of post-release services, making appointments, having discussions with the post-release case manager, if different, to facilitate a warm handoff and continuity of services. A simple referral is not sufficient. Warm hand-offs to a post-release case manager and follow-up are expected, consistent with guidance language in the case management section.

Coordination of care is a foundational activity for the pre-release case managers and as such, Illinois will implement a process that will promote communication and collaboration throughout the transition process.

Current State

ILLINOIS DEPARTMENT OF CORRECTIONS. At the present time, this pre-release practice is not happening widely across IDOC. Individuals at risk of homelessness with high mental health needs

often engage in virtual or telephone interviews with community mental health agencies that are able to provide housing, mental health, community support and wrap around services in order to complete an assessment and placement interview.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. Youth Correctional Facilities leverage the Aftercare Specialist and the Youth and Family Team meeting process to promote coordinated care. This meeting, conducted one per month, serves as a staffing to identify needed Aftercare services and supports and to ensure that connections are being made.

COOK COUNTY. For individuals connected to CountyCare, using the care coordination process, connections are made to needed services, including connections based on the results of the SDOH screener. Cook County Health itself offers a large suite of services within its network that provides individuals with quick and seamless access. Presently, the goal is to connect with members within 14 days of release and complete a health-risk screen again within 60 days of release to identify any further needs. For some members, CountyCare works with organizations such as Safer Foundation and CARA via a warm hand-off process.

Future State: Activities to be Completed and Timeline

- As early as Q2 CY 2026, HFS will issue a policy that will require that a component of the pre-release case manager activities will include the facilitation of connections to community-based providers pre-release for timely access to services upon reentry. This will include requirements related to any warm/hot hand-offs to post-release case management services, as applicable. This policy will also detail the elements that are expected to be included in the warm/hot hand-off between the pre- and post-release case managers, the role of the managed care plan Reentry Liaison, and the timeframe expectations around activities to be completed related to the warm hand-off.
- As described in milestone 3.a, the person-centered care plan will include actions to be completed both pre- and post-release to facilitate timely access to any post-release health care items and services, and as also indicated in milestone 3.b, case managers will have responsibility for ensuring that follow up visits for primary or specialty are scheduled, labs/diagnostics are ordered, needed behavioral health services are scheduled/in place, and a post-release case manager is identified, as needed.

Identified Challenges and Plans to Address

- **Challenges with Provider Coordination.** Case managers may face challenges with identifying and effectively communicating with community-based providers to make appointments and other needed connections. HFS will work with managed care plans to develop and conduct provider awareness campaigns so that they are familiar with this initiative and how they can participate in the initiative to promote successful transitions to the community for these individuals. Further opportunities to help promote coordination among providers will be explored, including timely and effective data exchanges.
- **Challenges with the Warm Hand-off.** If unexpected release dates occur, or if releases out-of-county or out-of-state occur, case managers may experience a disconnect in timing or information. When a warm hand-off is not feasible pre-release, a post-release warm hand-off should occur within 48 hours, if a post-release case manager is identified. If a post-release case manager is not identified upon release, at a minimum, the pre-release case

manager will conduct a warm hand-off with the Reentry Liaison and/or assigned care coordinator affiliated with the individual's managed care plan, if it is known. HFS will partner with facilities to monitor for implementation challenges, and make program changes, as needed to ensure warm/hot hand-off activities are occurring.

Milestone 4: Connecting to Services Available Post-Release to Meet the Needs of the Reentering Population

A vital part of this demonstration will be to have a robust case management process that will provide support for members both pre- and post-release. This case management process will help keep members connected to needed services and supports throughout their transition to the community. To support these efforts, clear monitoring mechanisms and protocols will be established. HFS expects to meet this milestone fully as early as Q3 CY2026.

Ensuring Timely Post-Release Services (Milestone 4.a)

Action: Develop state systems to monitor individuals who are incarcerated and their person-centered care plans to ensure that post-release services are delivered within an appropriate timeframe. We expect this generally will include a scheduled contact between the reentering individual and the case managers that occurs within one to two days post-release and a second appointment that occurs within one week of release to ensure continuity of care and seamless transition to monitor progress and care plan implementation. These short-term follow-ups should include the pre-release and post-release (if different) case managers, as possible, to ensure longer term post-release case management is as seamless as possible. In keeping with the person-centered care plan and individual needs, CMS is providing these general timeframes as suggestions, but recognizes that depending on the beneficiary's individualized needs and risk factors, a case manager may determine that the first scheduled contact with the beneficiary should occur, for example, within the first 24 hours after release and on a more frequent cadence in order to advance the goals of this demonstration.

Current State

IDOC, IDJJ, and the Cook County sites have variation in the connectivity between pre-release and post-release services. Further, Illinois does not have a state system or systems in place currently to monitor individuals and their person-centered care plans to ensure that post-release services are being delivered as needed.

Future State: Activities to be Completed and Timeline

- Implementation steps included in milestone 3 are applicable for this milestone.
- HFS, through continued implementation planning and demonstration roll out, will work with reentry partners to ensure that clear roles and responsibilities are outlined regarding expectations for monitoring and communicating.
- HFS will monitor engagement levels and timeframes between interactions of members and case managers, as well as monitor encounter-level data for services received by members and will adjust requirements of case managers and managed care plans as needed to ensure that members are accessing needed services.

Identified Challenges and Plans to Address Each

- Member Contact Post-Release.** Post-release case managers may find it difficult to successfully contact members post-release, due to a member's variability in availability or access to a reliable contact method. To mitigate possible unable to reach/contact scenarios, pre-release case managers will include alternative contact numbers in the member's person-centered care plan. The pre-release case manager will also provide the member with the post-release case manager's contact information, if it will be a different case manager from the one providing pre-release case management. As applicable, a person's mandatory supervised release, probation, or Aftercare contact will also be included in this process. Additional mitigation strategies will be explored as a component of ongoing implementation planning and demonstration roll out.

Ensuring Ongoing Case Management (Milestone 4.b)

Action: Develop state processes to monitor and ensure ongoing case management to ensure successful transitions to the community and continuity of care post-release, to provide an assessment, monitor the person-centered care plan implementation and to adjust it, as needed, and to ensure scheduling and receipt of needed covered services.

Current State

Across IDOC, IDJJ, the Cook County sites, both dedicated facility staff and various, locally based, community partners provide case management in an individual's post-release period, although there is variation in the amount and scope of post-release case management, and utilization varies based on individual's needs (e.g., at risk of homelessness, SUD) and program capacity and resources. Managed care plans may also currently play a role in case/care management for these individuals.

ILLINOIS DEPARTMENT OF CORRECTIONS. IDOC's partnership with the Safer Foundation at two facilities (and expanding to four), as well as their partnerships with GRO and TASC are examples of successful programs that provide both pre- and post-release case management services.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. IDJJ partners with various organizations and vendors to help support juveniles in aftercare. Case management is a component of these services.

COOK COUNTY. Individuals connected to CountyCare currently receive care coordination. Members are tagged within its case management system so that these cases can be more readily pulled and tracked on a monthly basis. CountyCare tracks Health Risk Screening rates, care plan completion rates and engagement with care coordinators/managers. CountyCare also tracks demographic data from this particular cohort to best understand this population. CountyCare also examines claims data related to this cohort and tracks top health and mental health diagnosis to understand the overall needs of this population.

Future State: Activities to be Completed and Timeline

- As part of ongoing implementation planning and demonstration roll out, HFS will work with reentry stakeholders, including managed care plans, to build capacity of reentry case management providers, and develop a statewide process for monitoring the provision of needed post-release case management services.
- In addition to the items listed in Milestone 4.a, as early as Q3 CY 2026, HFS will issue guidance to the managed care plans outlining the process they must follow to monitor and

ensure ongoing case management is occurring post-release for members who received pre-release services.

- As early as Q2 CY 2026, HFS will issue best practices for case managers providing case management to members post-release that will include completing an assessment, monitoring and updating the person-centered care plan, and ensuring the scheduling and receipt of needed covered services.

Identified Challenges and Plans to Address Each

- **Post-release Case Management Workforce.** It is not known yet whether Illinois' landscape of reentry providers has a current level of case management workforce with capacity to provide the necessary, local-level and intensive case management services to these members. HFS will work with stakeholders and partners, including managed care plans and carceral facilities, to assess capacity building needs and develop a workforce development strategy for the delivery of post-release case management services.
- **Member Contact Post-Release.** As described in milestone 4.a, post-release case managers may find it difficult to successfully contact members post-release, due to a member's variability in availability or access to a reliable contact method. To mitigate possible unable to reach/contact scenarios, pre-release case managers will include alternative contact numbers in the member's person-centered care plan. The pre-release case manager will also provide the member with the post-release case manager's contact information, if it will be a different case manager from the one providing pre-release case management. As applicable, a person's mandatory supervised release, probation, or Aftercare contact will also be included in this process. Additional mitigation strategies will be explored as a component of ongoing implementation planning and demonstration roll out.

Ensuring Connections to Other Services (Milestone 4.c)

Action: Develop state processes to ensure that individuals who are receiving services through the Reentry Section 1115 Demonstration Opportunity are connected to other services needed to address LTSS and HRSN, such as housing, employment support, and other social supports as identified in the development of the person-centered care plan.

Current State

To the extent that these individuals are connected with a managed care plan post-release, processes are currently in place (e.g., the health risk screen/assessment process) to identify services needed, including those to address any needed long-term services and supports (LTSS) and health-related social needs (HRSN). Additionally, when a person is reentering the community from IDOC, IDJJ, and the Cook County sites, case management activities, as described within other sections of this implementation plan, include assistance to connecting individuals to needed services and supports, which may include LTSS and HRSN. With the concurrent implementation of HRSN services within this 1115 demonstration, connections to these services will be an expectation within this initiative.

Future State: Activities to be Completed and Timeline

The same activities described in milestones 4.a and 4.b will be used to connect members to needed LTSS and HRSN services. HFS will develop protocols for connecting individuals to the HRSN interventions within this demonstration and will leverage the use of the same screening and

referral tool/questions. HFS will also develop protocols for connecting individuals to Medicaid covered non-emergency medical transportation and non-medical transportation authorized within this demonstration.

Identified Challenges and Plans to Address Each

The same challenges identified in milestones 4.a. and 4.b are applicable to this milestone.

Ensuring Effective Response Times and Time Needed for Effective Transition Navigation (Milestone 4.d)

Action: Implement state policies to monitor and ensure that case managers have the necessary time needed to respond effectively to individuals who are incarcerated who will likely have a high need for assistance with navigating the transition into the community.

Current State

There is no current state process for monitoring and ensuring that case managers have the necessary time needed to respond effectively to individuals that are incarcerated.

Future State: Activities to be Completed and Timeline

- As early as Q2 CY 2026, HFS will issue a policy that details how the State will monitor pre-release case management to ensure that case managers have the necessary time needed to respond effectively to individuals who are incarcerated who will likely have a high need for assistance with navigating the transition into the community.
- As part of readiness activities, participating facilities, and any case management partners, will have to demonstrate how they will accurately monitor pre-release case management activities and make adjustments as needed to ensure that case managers have the necessary time needed to respond effectively to individuals who are incarcerated who will likely have a high need for assistance with navigating the transition into the community.

Identified Challenges and Plans to Address Each

- **Case Management Workforce Challenges.** It is not known yet whether the State of Illinois has a current case management workforce that is fully capable of providing the needed, local-level and intensive case management services to these members. The State will work with stakeholders and partners, including managed care plans and carceral facilities, to assess capacity building needs and develop a development strategy to ensure that case managers are able to respond effectively to those individuals with a high need for assistance with navigating the transition into the community.
- **Individuals with Short-Term Stays or Unpredictable Release Dates.** For individuals with short-term stays or unpredictable release dates, it may be a challenge to ensure that enough time is given to adequately plan for an effective transition to the community. HFS will develop “short-term stay” best practices, in collaboration with stakeholders, and will disseminate this to facilities during readiness activities. As mentioned under Milestone 2a, HFS will require facilities with short-term stays to track the length of time that an individual has been in their 90-day pre-release period, and providers will be prohibited from receiving Medicaid reimbursement for services outside of the 90-day pre-release period.

Milestone 5: Ensuring Cross-System Collaboration

HFS will engage stakeholders throughout the planning and implementation of pre-release services so that plans are well defined and promote clear communication, robust coordination, and meaningful engagement across partners. HFS expects to meet this milestone fully as early as Q3 CY 2026.

Readiness Assessment (Milestone 5.a)

Action: Establish an assessment outlining how the state's Medicaid agency and participating correctional system/s will confirm they are ready to ensure the provision of pre-release services to eligible beneficiaries, including but not limited to, how facilities participating in the Reentry Section 1115 Demonstration Opportunity will facilitate access into the correctional facilities for community health care providers, including case managers, in person and/or via telehealth, as appropriate. A state could phase in implementation of pre-release services based on the readiness of various participating facilities and/or systems.

Preparation and planning activities will be completed prior to covering any pre-release services. Participating correctional facilities and managed care plans will work closely with HFS to review (and test, as indicated) all activities that will be carried out by the facility, the managed care plan, and the case manager to ensure that coordinated and seamless processes are in place.

Current State

The State has not yet developed the readiness assessment tool and process.

Future State: Activities to be Completed and Timeline

- As early as Q1 CY 2026, HFS will develop Readiness Assessment that will include the following sections, in accordance with STC 4.9:
 - Pre-release Medicaid application and enrollment processes
 - Screening process for pre-release services
 - Provision and/or facilitation of pre-release services
 - Coordination amongst partners
 - Reentry planning, pre-release case management, and assistance with care transitions
 - Medicaid requirements
 - Data exchanges
 - Reporting
 - Staffing and project management
- As early as Q2 CY 2026, MTAC will develop and provide training and technical assistance to interested facilities related to Medicaid provider enrollment and billing/claiming processes and expectations.
- For this demonstration, facilities that may participate are IDOC facilities, IDJJ facilities, Cook County Jail, and the JTDC. These same facilities are eligible to participate and can request technical assistance from MTAC as they prepare for a Readiness Assessment review. HFS will use the monitoring and evaluation process from this demonstration to identify opportunities and best practices for jail sites and may include jails outside of Cook County as facilities that are able to participate in the pre-release services initiative through this demonstration in subsequent DYs. Additional county jails may be included in this

demonstration if they demonstrate capacity to assure that the reentry population may access the minimum required services of case management, MAT, and 30-day supply of prescriptions upon release.

- As early as Q2 CY 2026, a facility may submit a readiness assessment to HFS. The following must also occur once a readiness assessment is successfully completed and prior to any services being initiated under this reentry initiative:
 - Provider Eligibility:
 - Facilities must meet all readiness assessment components to be eligible to participate in the reentry initiative.
 - Facilities must identify which pre-release services that will be provided. If at the time of their readiness assessment review, a facility is not going to be providing the full complement of pre-release services approved in the reentry demonstration initiative, the facility must provide a plan and timeline for when they will be able to provide or facilitate the provision of all pre-release services approved in reentry demonstration initiative.
 - Provider Qualifications:
 - Providers of any clinical-related pre-release services must meet applicable licensure/certification requirements.
 - All providers must meet any additional provider qualification requirements, to be identified by HFS, as early as Q2 CY 2026.
 - Provider Enrollment Process:
 - All providers providing pre-release services to Medicaid members in the approved facility, must first be enrolled as a Medicaid provider prior to rendering services, following current Illinois provider enrollment processes.
- As early as Q3 CY 2026, pre-release services can be provided and covered by Illinois Medicaid FFS. Services can only be billed for after the facility completes a readiness assessment and is approved by HFS.

Identified Challenges and Plans to Address Each

- **Provider Enrollment.** It is anticipated that it could be administratively burdensome for correctional facilities and community-based providers to enroll as Medicaid providers. To assist, non-services funds, and technical assistance through MTAC may be available to facilities and community-based providers.
- **Billing and Claiming.** It is anticipated that Medicaid billing and claiming processes could also be administratively burdensome for correctional facilities and community-based providers. To assist, non-services funds⁸ and technical assistance through MTAC may be available to facilities and community-based providers.

⁸ Non-service related needs may include: Technology and IT, hiring of staff and training, adoption of certified electronic health record technology, purchase of billing systems, development of protocols and procedures, additional activities to promote collaboration, planning focused on developing processes and information sharing protocols, and other activities to support a milieu of appropriate activities for the provision of pre-release services

Organizational Level Engagement, Coordination, and Communication (Milestone 5.b)

Action: Develop a plan for organizational level engagement, coordination, and communication between the corrections systems, community supervision entities, health care providers and provider organizations, state Medicaid agencies, and supported employment and supported housing agencies or organizations.

Current State

At the foundation of reentry efforts, several comprehensive plans exist in Illinois to enhance the reentry ecosystem, including Illinois Department of Human Services' (DHS) Reimagine Public Safety Illinois, which is a result of Illinois' Reimagine Public Safety Act (430 ILCS 69) and the Illinois' Reentry Council Strategic Plan. Further, HFS, IDOC, IDJJ, the partners at Cook County, and ICJIA all have partnerships and initiatives with various organizations and sister agencies in Illinois to support the justice-involved population. At the onset of this demonstration initiative's application, HFS began convening stakeholder workgroups and these groups will continue to meet to inform the implementation and design of this Reentry Demonstration Initiative. HFS, along with its reentry stakeholders, will continue to seek ways to enhance coordination and communication among partners and will ensure alignment with the foundational plans in place in Illinois to enhance programs and services to wrap around individuals interfacing with the justice system and carceral settings.

ILLINOIS DEPARTMENT OF CORRECTIONS. As individuals served by the IDOC are also likely to be served by other organizations and state agencies, coordination, engagement, and communication between departments is a key part of reentry efforts. This includes monthly meetings with the Illinois Department of Human Services (DHS) and coordination with the DHS' Department of Mental Health as needed. IDOC also works collaboratively with the Illinois Department of Public Health (IDPH) for individuals needing a higher level of care and/or having a higher level of need, such as those needing to access state mental health facilities.

IDOC is currently working on several housing-related initiatives that require significant coordination and collaboration, including:

- Participating in the Illinois Housing Development Authority's (IHDA) reentry pilot to connect people to permanent supportive housing immediately upon release. That process begins pre-release, and if accepted/approved the individual is transitioned to their own apartment upon reentry.
- Working with community mental health providers that participate in DHS's Housing is Recovery Program. IDOC contracts with two community mental health agencies/providers for permanent supportive housing and services.
- Working with ICJIA on the Flexible Housing Pool Program in Cook County, which has contracted a case management provider that is versed in providing services to individuals with high mental health and medical needs. Individuals at risk of homelessness and with high mental health needs are connected to these organizations pre-release for referral, assessment, case planning, and are released to them for service provision and permanent supportive housing post-release.

- Partnering with the Division of Substance Use, Prevention and Recovery’s (SUPR) licensed Recovery Home providers for post-release transitional housing and case management for individuals at risk of homelessness and with substance abuse service needs.

IDOC also participates in the Summit of Hope, which is coordinated by IDPH. These reentry summits are hosted annually in different communities throughout the state and is geared toward individuals on supervision. This is a large collaborative effort that helps provide access to screenings and to services such as housing, state identification assistance, vaccinations, and access to hygiene products.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. Similar to IDOC, IDJJ has networks of providers to help connect individuals to needed services. These relationships consist of both formal contracts and informal referral partners.

COOK COUNTY. In addition to the partners already outlined in this plan, Cook County Health has developed a synergized strategy to help different teams (Cermak Health Services, CountyCare, Patient Access, etc.) work together. This includes establishing relationships with the financial counselors operating within Cook County Jail to ensure a smooth and warm handoff for all Medicaid applicants and CountyCare members. In addition, CountyCare has established data exchanges with adult probation. However, the data reporting optimization is still in development. The desired state is collaboration across entities to ensure that justice-involved members can be identified, found and engaged in healthcare services.

Future State: Activities to be Completed and Timeline

- As implementation planning progresses and roll out of the demonstration occurs, HFS will continue to convene various workgroups to strengthen communication and collaboration among partners. Additional forums and opportunities for engaging other stakeholders, including those with lived experience, will be explored.
- As early as Q1 CY 2026, HFS, in collaboration with sister agencies and other justice-involved partners, will develop a stakeholder engagement plan to assure organizational level engagement, coordination, and communication. Corrections systems, community supervision entities, health care providers and provider organizations, state Medicaid agencies, and supported employment and supported housing agencies or organizations will all be part of this plan and existing forums and workgroups will be leveraged.

Identified Challenges and Plans to Address Each

- **Potential for Competing Priorities and Resource Allocation Needs for Ongoing Implementation Planning and Collaboration.** HFS anticipates that an ongoing challenge will be competing priorities and resource allocation issues among reentry stakeholders, especially sister state agencies. Through frequent implementation meetings, HFS will work with the various stakeholders to facilitate the ongoing active participation and input needed for a successful implementation of the reentry demonstration initiative.

Awareness and Education about Medicaid Coverage and Health Care Access (Milestone 5.c)

Action: Develop strategies to improve awareness and education about Medicaid coverage and health care access among various stakeholders, including individuals who are incarcerated,

community supervision agencies, corrections institutions, health care providers, and relevant community organizations (including community organizations serving the reentering population).

Current State

Illinois leverages a robust strategy to ensure awareness of and education about Medicaid coverage and health care access. Illinoisians are encouraged to use a phone line or a website to connect to health care coverage options.

Future State: Activities to be Completed and Timeline

- As outlined in milestone 1, HFS will work with IDOC, IDJJ, and the partners at Cook County to ensure that enhancements are made to existing processes to help provide education about Medicaid coverage.
- HFS will leverage existing forums and workgroups described in milestone 5.b to also improve awareness and education to partners.
- HFS will explore additional opportunities to increase awareness and education, such as through provider communications, managed care plan member and provider resources and communications, and other public campaigns that are promoting health and access to health care coverage and services.

Identified Challenges and Plans to Address Each

- **Workforce Turnover.** A potential challenge in reaching and maintaining this milestone is knowledge deficit that can be caused by staff turnover. HFS, in collaboration with IDOC, IDJJ, and the partners at Cook County, will ensure that local processes account for and plan to address this by having clearly established workflows for staff to follow in educating and connecting individuals to coverage as needed.
- **Individual Health Literacy.** We know that not all individuals eligible for Medicaid will access Medicaid. To help better promote education and understanding about Medicaid, local facility strategies will utilize peers and those with lived experience to help build and share key messages and to translate program and promotional materials into plain language. For those served by DJJ, education will be provided to the family in addition to the youth.

Monitoring Health Care Needs and HRSN (Milestone 5.d)

Action: Develop systems or establish processes to monitor the health care needs and HRSN of individuals who are exiting carceral settings, as well as the services they received pre-release and the care received post-release. This includes identifying any anticipated data challenges and potential solutions, articulating the details of the data exchanges, and executing related data-sharing agreements to facilitate monitoring of the demonstration...

Current State

As described within this plan, systems and processes for monitoring the health care needs and HRSN of individuals exiting carceral settings are localized and vary by setting and an individual's needs.

Future State: Activities to be Completed and Timeline

- HFS will leverage existing systems and processes to the extent possible to establish a system or process for specifically monitoring the health care needs and HRSN of

individuals participating in the reentry demonstration initiative. HFS will work with partners, including IDOC, IDJJ, Cook County, case management organizations, other pre-release and post-release providers, and managed care plans to inform this system or process.

- As outlined in milestones 3 and 4, pre-release case management and post-release case management will be foundational for these processes.
- As applicable, tracking health care needs and HRSN will be incorporated into the monitoring protocol and evaluation design.

Identified Challenges and Plans to Address Each

- **Potential for Variation Needed.** It is possible, especially in the early stages of implementation, that manual processes will need to be operationalized first. This will be known at the time of a facility's readiness assessment and minimum reporting and tracking components will be established and clearly communicated. Another potential variation includes the connection to post-release case managers. Organizations and capacity vary by region in the state. HFS and its partners will develop plans to monitor capacity and outputs in the post-release period.