DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

July 2, 2024

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

Dear Director Cunningham:

The Centers for Medicare & Medicaid Services (CMS) is approving Illinois' (the "state") request for a five-year extension of the "Illinois Behavioral Health Transformation" section 1115(a) demonstration (Project Number 11-W-00316/5) (the "demonstration"), in accordance with section 1115(a) of the Social Security Act ("the Act"). The state requested to rename this demonstration the "Illinois Healthcare Transformation," and CMS is approving this request to rename the demonstration.

Approval of this request will extend three authorities from the original 2018 demonstration, including Substance Use Disorder (SUD) treatment for individuals residing in an Institution for Mental Diseases (IMD), SUD case management, and supported employment services. The extension also provides new authorities such as health-related social needs (HRSN) services and violence prevention and intervention services. With this extension, Illinois is also introducing a new initiative to provide pre-release services for eligible incarcerated individuals. The demonstration will provide expenditure authority for limited coverage for certain reentry services furnished to certain incarcerated individuals for up to 90 days immediately prior to the individual's expected date of release.

Overall, the goal of the demonstration is to provide medical assistance and improve the health of communities and populations. The initiative specific goals of the demonstration are to provide: 1) medical assistance to individuals with SUD; 2) SUD case management; 3) supported employment services; 4) targeted pre-release services to eligible individuals and improve the health of communities and populations in Illinois; 5) HRSN services; 6) violence prevention and intervention services; and 7) non-medical transportation. This approval is effective through June 30, 2029, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

CMS's approval is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent that those requirements have been specifically listed as waived or not applicable to expenditures under the demonstration.

Extent and Scope of the Demonstration Extension

With this extension, Illinois will continue to operationalize and refine its SUD demonstration initiatives. CMS is extending the state's current authority to receive federal financial participation (FFP) for clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an IMD, SUD case management, and supported employment services. The extension includes new authorities related to 1) HRSN, 2) violence prevention and intervention services, and 3) pre-release services.

1) HRSN Services

CMS is authorizing the state to increase coverage of certain services that address HRSN, as evidence indicates that these benefits are critical drivers of an individual's access to health services that keep them well.[1,2] Under this demonstration, eligible individuals will receive HRSN services including housing supports, such as pre- and post-tenancy sustaining supports and short-term post-hospitalization housing; and nutrition supports, such as home-delivered meals. Each of these services aligns with interventions outlined in the HRSN framework published in November 2023.[3]

HRSN services will be provided through the managed care delivery system, as managed care plans will provide referrals for HRSN services to otherwise eligible Medicaid managed care beneficiaries. HRSN services authorized in this demonstration must be clinically appropriate for the eligible beneficiary. Individuals eligible to receive HRSN services are Medicaid eligible with a documented medical need for the services. A comprehensive list of the populations that will be eligible to receive HRSN services will be described in the post-approval Protocol(s) for HRSN Services and Infrastructure, subject to CMS review and approval. Below are the target populations for whom the state expects to provide HRSN services, and the clinical and social criteria will be described in the post-approval protocol:

a. People who have been determined to be high-risk or high-cost based on service utilization or healthcare history. High-risk is defined as an individual with physical health condition(s) or symptom(s) that could lead to a complex physical health need if not treated (e.g., pre-diabetes, hypertension, high cholesterol). High-cost is based on an individual's service utilization or healthcare history;

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[1] As discussed in a letter to State Health Officials issued on January 7, 2021, https://www.medicaid.gov/federalpolicy-guidance/downloads/sho21001.pdf, addressing Social Determinants of Health can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid program. While "social determinants of health" is a broad term that relates to the health of all people, HRSN relates more specifically to an individual's adverse conditions reflecting needs that are unmet and contribute to poor health. See also https://www.healthaffairs.org/do/10.1377/forefront.20191025.776011/full/

[2] Bachrach, D., Pfister, H., Wallis, K., Lipson, M. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. The Commonwealth Fund; 2014; https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf.

[3] Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib11162023.pdf

b. People who have complex physical health needs such as persistent, disabling, or progressively life-threatening physical health conditions;

c. People with a behavioral health need, including SMI or SUD;

d. People with a high-risk pregnancy or complications arising from pregnancy; and/or

e. People with a chronic health condition, including but not limited to diabetes, cancer, human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS).

CMS also expects the state to maintain existing state funding and efforts for HRSN services, without this demonstration authority supplanting existing efforts, and to have in place partnerships with other state and local entities to coordinate possible pathways to permanency for services to be provided without demonstration authorities.

2) Violence Prevention and Intervention Services

CMS is authorizing the provision of violence prevention and intervention services to Medicaid beneficiaries who are enrolled in managed care and who: 1) have survived violence; 2) are currently experiencing violence; or 3) are at risk of experiencing violence. Violence prevention and intervention services are 1905(a) coverable services under the preventive services benefit category. The state requested using 1115 authority to test these services as a pilot for beneficiaries enrolled in managed care before seeking authority in the state plan.

Violence prevention services must be recommended by a physician or other licensed practitioner and include screening, assessment of needs, development of individualized service plans, trauma specific therapy (includes psychotherapy, individual, group and family therapy, grief counseling, mindfulness and relaxation-based treatments, art therapy and other evidence-based clinical and social interventions), mentoring, peer support services, life skills training, psychoeducation, conflict mediation, crisis intervention and care coordination services including linking beneficiaries to medical, social, educational, and other necessary services.

3) Pre-Release Services under Reentry Demonstration Initiative

Expenditure authority is being provided to Illinois to provide limited coverage for a targeted set of services furnished to certain incarcerated individuals for 90 days immediately prior to the individual's expected date of release. The state's proposed approach closely aligns with CMS's "Reentry Demonstration Opportunity" as described in the State Medicaid Director Letter (SMDL) released on April 17, 2023.

Eligible Individuals

Illinois will cover a set of pre-release benefits for certain individuals who are inmates residing in a state or local jail, prison, or youth correctional facility. To qualify for services covered under this demonstration approval, individuals residing in a correctional facility must have been

determined eligible for Medicaid pursuant to an application filed before or during incarceration, and must have an expected release date no later than 90-days after initiation of demonstration-covered services.

Medicaid Eligibility and Enrollment

CMS is requiring, as a condition of approval of this demonstration extension, that Illinois make pre-release outreach, along with eligibility and enrollment support, available to all individuals incarcerated in the facilities where the pre-release demonstration coverage services will be available.

For a Medicaid-covered individual entering a correctional facility, Illinois will not terminate Medicaid coverage, but will suspend the individual's coverage. For individuals not enrolled in Medicaid upon entering a correctional facility, Illinois will ensure the individual receives assistance with completing and submitting a Medicaid application sufficiently prior to their anticipated release date such that the individual can receive the full duration of pre-release services, unless the individual voluntarily refuses such assistance or chooses to decline enrollment.

Scope of Pre-Release Benefit Package

The pre-release benefit package is designed to improve care transitions of such individuals back to the community, including by promoting continuity of coverage, service receipt, and quality of care, as well as the proactive identification of both physical and behavioral health needs and HRSN. It is designed to address these overarching demonstration goals, while aiming to ensure that participating carceral facilities can feasibly provide all pre-release benefits to qualifying incarcerated individuals.

CMS is authorizing Illinois to provide coverage for the following services to be detailed in the Implementation Plan required by the demonstration STCs:

- Case management to assess and address physical and behavioral health needs and HRSN;
- Medication-assisted treatment (MAT) services for all types of SUD as clinically, including coverage for medications in combination with counseling/behavioral therapies;
- A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate) provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage and policy;
- Services provided by community health workers;
- Diagnostic and treatment services, including laboratory and radiology services;
- Prescribed drugs, in addition to MAT and the 30-day supply of prescription medications described above, and medication administration; and
- Medical equipment and supplies and/or medical equipment provided upon release.

CMS recognizes that many individuals exiting correctional facilities may not have received sufficient health care to address all of their physical and/or behavioral health care needs while incarcerated. This demonstration initiative will provide individuals leaving correctional facilities the opportunity to receive short-term Medicaid enrollment assistance and pre-release coverage

for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, while providing the state the opportunity to test whether these pre-release services improve uptake and continuity of MAT and other SUD and behavioral health treatment, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, and overdose-related death. Therefore, CMS is approving a demonstration benefit package in Illinois that is designed to improve identification of physical and behavioral health needs and HRSN, to facilitate connections to providers with the capacity to meet those needs in the community during the period immediately before an individual's expected release from a correctional facility. Once an individual is released, the coverage for which the individual is otherwise eligible must be provided consistent with all requirements applicable to such coverage.

Eligible Juveniles and This 1115 Reentry Demonstration Initiative

Section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) amends the Act and describes a mandatory population (eligible juveniles and targeted low-income children) and set of pre-release and post-release services, while section 5122 of the CAA, 2023 amends the Act and gives a state the option to receive federal financial participation for the full range of coverable services for eligible juveniles and targeted low-income children while pending disposition of charges. Every state is required to submit a Medicaid State Plan Amendment (SPA) attesting to meeting the requirements in Section 5121 beginning January 1, 2025. To the extent there is overlap between the services required to be covered under sections 1902(a)(84)(D) and 2102(d)(2) of the Act and coverage under this demonstration, we understand that it would be administratively burdensome for states to identify whether each individual service is furnished to a beneficiary under the state plan or demonstration authority. Accordingly, to eliminate unnecessary administrative burden and ease implementation of statutorily required coverage and this demonstration, we are approving waivers of the otherwise mandatory state plan coverage requirements to permit the state instead to cover at least the same services for the same beneficiaries under this demonstration. This approach will ease implementation, administration, and claiming, and provide a more coherent approach to monitoring and evaluation of the state's reentry coverage under the demonstration. The state will provide coverage under the reentry demonstration to eligible juveniles described in section 1902(nn)(2) in alignment with sections 1902(a)(84)(D) and 2102(d)(2) of the Act, at a level equal to or greater than otherwise would be covered under the state plan. Compliance and state plan submission requirements under Sections 5121 and 5122 of the CAA, 2023 will remain unchanged. Coverage of the population and benefits identified in sections 1902(a)(84)(D) and 2102(d)(2) of the Act, as applicable, would automatically revert to state plan coverage in the event that this demonstration ends or eliminates coverage of beneficiaries and/or services specified in those provisions. CMS will provide additional information in the future about these CAA, 2023 provisions.

Reentry Implementation and Reinvestment Plans

As described in the demonstration STCs, Illinois will be required to submit for CMS approval a Reentry Initiative Implementation Plan (Implementation Plan) and Reinvestment Plan documenting how the state will operationalize coverage and provision of pre-release services and

how existing state funding for carceral health services will continue to support access to necessary care and achievement of positive health outcomes for the justice-involved population.

The Reentry Implementation Plan, to be submitted to and reviewed by CMS consistent with the STCs, will describe the milestones and associated actions being addressed under this demonstration amendment and provide operational details not captured in the STCs regarding implementation of those demonstration policies. At a minimum, the Implementation Plan will include definitions and parameters related to the implementation of the reentry authorities, and describe the state's strategic approach for making significant improvements on the milestones and actions, as well as associated timelines for meeting them, for both program policy implementation and investments in transitional nonservice elements, as applicable. The Implementation Plan will also outline any potential operational challenges that the state anticipates and the state's intended approach to resolving these and other challenges the state may encounter in implementing the reentry demonstration initiative.

The reentry demonstration initiative is not intended to shift current carceral health care costs to the Medicaid program. Section 5032(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (Pub. L. No. 115-271) makes clear that the purpose of the demonstration opportunity contemplated under that statute is "to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX." Furthermore, demonstration projects under section 1115 of the Act must be likely to promote the objectives of title XIX, which includes the inmate payment exclusion and inmate eligibility exclusion, respectively, in recognition that the carceral authority generally bears the costs for health care furnished to incarcerated individuals. This demonstration does not absolve carceral authorities in Illinois of their constitutional obligation to ensure needed health care is furnished to inmates in their custody and is not intended as a means to transfer the financial burden of that obligation from a federal, state, or local carceral authority to the Medicaid program.

Illinois agrees to reinvest the total amount of new federal matching funds for the reentry demonstration initiative received under this demonstration amendment into activities and/or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for physical and behavioral health needs that may help prevent or reduce the likelihood of criminal justice system involvement. Consistent with this requirement, Illinois will develop and submit a Reinvestment Plan to CMS outlining how the federal matching funds under the demonstration will be reinvested. The Reinvestment Plan should align with the goals of the state's reentry demonstration initiative. It should detail the state's plans to increase access to or improve the quality of health care services for those who have recently been released, and those who may be at higher risk of future criminal justice system involvement, particularly due to untreated behavioral health conditions. The Reinvestment Plan should describe the activities and/or initiatives selected by Illinois for investment and a timeline for implementation. Any investment in carceral health care must add to and/or improve the quality of health care services and resources for individuals who are incarcerated and those who are soon to be released from carceral settings, and not supplant existing state or local spending on such

services and resources. The reinvestment plan may include the services provided to eligible juveniles under 1902(nn)(2) of the Act, which are covered under this demonstration.

Provider Rate Increase Condition

As a condition of approval for expenditure authority for HRSN services and related infrastructure (unless the amount of expenditure authority is under a *de minimis* amount)[4] the state will be required to increase and (at least) sustain Medicaid fee-for-service provider base payment rates and Medicaid managed care payment rates in primary care, behavioral health, and obstetrics care, should the state's Medicaid-to-Medicare provider rate ratio dip below 80 percent in any of these categories. At least a two-percentage point payment rate increase will be applied to each of the services in the one service category in each of Medicaid managed care and fee-for-service delivery systems that the state operates, if for that delivery system the ratio is both the lowest ratio among the three and below 80 percent. The state must attest that the rate increases will be implemented according to the STCs, and that it will not decrease provider payment rates for other Medicaid or demonstration-covered services for the purpose of making state funds available to finance these required provider rate increases (i.e., cost-shifting). The state also must sustain the increase for the remaining years of the demonstration.

Requests not Being Approved at this Time

CMS and Illinois are continuing discussions regarding some of the state's pending requests under the demonstration extension application submitted June 23, 2023. Over the course of the negotiations, CMS and the state prioritized the requests that are being approved today. The requests below continue to be under review:

1. Safety Net Hospital Health Equity and Access Leadership Grant Program which would provide funding to safety-net hospitals;

2. Cook County Disproportionate Share Hospital (DSH) which would have redirected DSH funding to create a pool of funding to fund strategies and interventions that tie to improving the health in underserved communities; and

3. Healthcare Transformation Collaboratives (HTC) which would include funding for social determinant of health assessments and training community health workers.

CMS encouraged the state to explore using the approved HRSN services and HRSN infrastructure to achieve the policy goals of the above-named programs.
Illinois also requested to authorize a new license type for groups serving beneficiaries with intellectual and developmental disabilities. As discussed with members of your staff, CMS cannot use 1115 authority to alter the licensing requirements for Intermediate Care Facilities for

[4] CMS developed the *de minimis* amount by arraying in order the requests we had from states for HRSN expenditures, as well as the likely costs for increasing provider rates, and examined the relationship between these ranges. CMS determined that applying the provider rate increase requirement if the annualized expenditure authority exceeds either the less of 0.5 percent of the state's annual Medicaid spending or $50 million in annual expenditures is a reasonable cut-off point under which a state would not be required to apply the HRSN rate increase policy.

Individuals with Intellectual Disabilities. We look forward to continuing to work with you on ensuring the highest quality of care for beneficiaries with intellectual disabilities/ developmental disabilities (ID/DD).

Budget Neutrality

Under section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that the demonstration is likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs).

CMS and states have generally been applying an approach to calculating budget neutrality that CMS described in the August 22, 2018 SMDL[5] entitled "Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects." Under this approval, CMS is departing from the budget neutrality approach described in the 2018 SMDL in a key way. CMS is making several changes including an updated approach to calculating the WOW baseline, which refers to the projected expenditures that could have occurred absent the demonstration and which, as described above, is the basis for the budget neutrality expenditure limit for each approval period. Under this approval, CMS calculated the WOW baseline by using a weighted average of the state's historical WOW per-member-per-month (PMPM) baseline and its recent actual PMPM costs, rather than taking the approach described in the 2018 SMDL, which was to adjust WOW PMPM cost estimates to reflect only the recent actual PMPM costs. This updated approach is expected to result in a slightly higher WOW baseline, while still primarily reflecting the state's most recent expenditures

In a second key change from the approach described in the 2018 SMDL, CMS is treating certain expenditures as "hypothetical" for the purposes of Illinois' budget neutrality calculation. As described in the 2018 SMDL, when calculating budget neutrality, CMS effectively treats a hypothetical expenditure like an expenditure that the state could have made absent the demonstration. As a result, hypothetical expenditures are included in both the WOW baseline and the estimate of the "with waiver" (WW) expenditures under the demonstration, and states do not have to find demonstration "savings" to offset hypothetical expenditures. However, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected

[5] August 22, 2018. SMD#18-009 Re: Budget Neutrality Policies for Section 1115(a) Demonstration Projects. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18009.pdf

or accrued "savings" from hypothetical expenditures. That is, "savings" are not generated from a hypothetical population or service if the state does not spend up to the hypothetical expenditure limit. To allow for hypothetical expenditures, while preventing them from resulting in "savings," CMS applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to predetermined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by finding "savings" elsewhere in the demonstration or to refund the federal matching funds to CMS.

In the 2018 SMDL, CMS explained that it historically considered demonstration expenditures to be "hypothetical" in the following circumstances: (1) when they are for populations or services that the state could otherwise have covered under its Medicaid state plan or other title XIX authority, such as a waiver under section 1915 of the Act; or (2) when a WOW spending baseline is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates (e.g., CMS has treated demonstration expenditures on the "adult group" described in section 1902(a)(10)(A)(i)(VIII) of the Act as hypothetical for this reason).

In a key change from the approach described in the 2018 SMDL, CMS is treating certain HRSN expenditures as "hypothetical" for purposes of Illinois' budget neutrality calculation. Under this approval, certain HRSN expenditures are considered "hypothetical" expenditures and are included in the budget neutrality WOW baseline. Some of these expenditures, as discussed above, are expenditures for services that the state could otherwise cover under other title XIX authority, such as tenancy and nutrition supports for beneficiaries. Treating those expenditures as hypothetical is consistent with how CMS has historically treated similar expenditures. While other approved HRSN expenditures could not otherwise be covered under title XIX authority, such as expenditures on section 1915(c) and 1915(i) services for beneficiaries who would not otherwise be eligible for them under section 1915, there are insufficient or inconsistent data to calculate a WOW baseline for at least some of these expenditures. Treating those expenditures as hypothetical also is consistent with how CMS has historically treated similar expenditures. As discussed above, based on robust academic-level research, it appears likely that these state expenditures could improve the quality and effectiveness of downstream services that can be provided under state plan authority.[6] Additionally, as discussed below, covering HRSN services might improve beneficiary health, reducing the future downstream costs of medical care for these beneficiaries. At the same time, predicting these downstream effects on overall Medicaid program costs of covering certain evidence-based HRSN services is extremely difficult, making it hard for CMS to pinpoint the estimated fiscal impact of these expenditures on demonstration budget neutrality or on the state's overall Medicaid program. Treating demonstration HRSN expenditures as hypothetical will give the state the flexibility to test these worthy innovations,

[6] Lipson, D. J. *Medicaid's Role in Improving the Social Determinants of Health: Opportunities for States*. National Academy of Social Insurance; 2017; https://www nasi.org/wp-content/uploads/2017/06/Opportunities-for-States web.pdf; Whitman, A., De Lew, N., Chappel, A., et al. *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*. Assistant Secretary for Planning and Evaluation; 2022; https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOHEvidence-Review.pdf.

especially as CMS anticipates that they might result in overall reductions in future Medicaid program costs.

Historically, CMS has often authorized expenditures through section 1115 demonstrations subject to expenditure limits. In this case, to ensure that treating certain HRSN expenditures as hypothetical will not have a significant negative impact on Medicaid fiscal program integrity, CMS is applying a budget neutrality spending cap to HRSN services expenditures and an additional sub-cap to HRSN infrastructure expenditures, and is referring to these expenditures as "capped hypothetical expenditures" in the STCs.

The caps on expenditures for these HRSN services and related infrastructure activities differ from the usual limits CMS places on hypothetical expenditures under the "supplemental test" discussed above in several respects. First, ordinarily, if a state exceeds the hypothetical expenditure limit, it can offset the additional costs with savings from the rest of the demonstration. That will not be permitted with the HRSN expenditures. However, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. Second, the expenditures subject to the cap are narrowly defined to reflect only expenditures associated with services that research indicates are likely to have certain positive downstream effects, as discussed above.

Third, the upper limit on the cap is based on a range of estimates of the likely cost of these expenditures over the course of the 5-year extension period and set at a mid-point in that range. While this cap deviates from the traditional approach to hypothetical expenditures, it is consistent with CMS' historical approach to maintaining budget neutrality in Medicaid demonstrations, and it does not alter the underlying financing structure of the Medicaid program. This cap will ensure that the state maintains its investment in the state plan benefits to which beneficiaries are entitled while testing the benefit of the HRSN services described above. This cap will not apply to any other benefits or services.

CMS is applying the traditional hypothetical approach to the state's reentry demonstration initiative. The Medicaid expenditures for pre-release services furnished to incarcerated beneficiaries under the reentry demonstration initiative include coverage of services that states can and do cover through Medicaid state plan or other title XIX authority, for beneficiaries who are not subject to the inmate payment exclusion. CMS considers these expenditures to be "hypothetical" because the pre-release services would be coverable under the Medicaid state plan or other title XIX authority if furnished to a beneficiary outside a carceral setting, similar to how CMS treats expenditures for services furnished to certain beneficiaries who are short-term residents in an IMD primarily to receive treatment for SUD, or serious mental illness (SMI) or serious emotional disturbance (SED), under the SUD and SMI/ SED section 1115 demonstration opportunities. Any population identified in section 1902(a)(84)(D) of the Act and covered instead under this demonstration will be included in the reentry Medicaid Eligibility Group (MEG).

The Medicaid expenditures for supported employment services and violence prevention and intervention services are also treated as hypothetical expenditures for purposes of budget neutrality approval of this demonstration extension.

Finally, CMS is revising the approach to adjusting the budget neutrality calculation in the middle of a demonstration approval period. Historically, CMS has limited its review of state requests for "mid-course" budget neutrality adjustments to situations that necessitate a corrective action plan, in which projected expenditure data indicated a state is likely to exceed its budget neutrality expenditure limit. CMS has updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Monitoring and Evaluation

Consistent with the demonstration STCs, the state submitted its Interim Evaluation Report for the prior demonstration approval period with the extension application. The evaluation found noticeable progress toward its demonstration goals. For example, compared to the pre-demonstration period, initiation and engagement in SUD treatment, adherence to and retention in SUD treatment, the continuity of pharmacotherapy for opioid use disorder (OUD), and access to preventive/ambulatory health services for adult Medicaid beneficiaries with SUD increased. Over the same period, there were decreases in the use of opioids at high doses, concurrent use of opioids and Benzodiazepines, emergency department utilization and inpatient stays for OUD. However, the COVID-19 public health emergency, which coincided with part of the evaluation period, may have confounded the trends in outcomes.

With this extension of the demonstration, the state is required to continue conducting systematic monitoring and robust evaluation of the demonstration, including the policies and initiatives approved through this extension, per applicable CMS guidance and technical assistance. In collaboration with CMS, the state must update its monitoring protocol, including relevant metrics data and narrative details describing progress with implementation of all components of the demonstration.

The state is required to conduct an evaluation of the demonstration to support a comprehensive assessment of whether the demonstration components, including components added to the demonstration through this extension, are effective in producing the desired outcomes for its beneficiaries and providers, as well as the state's overall Medicaid and CHIP program. The

demonstration evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components, as described in the STCs. Evaluation of the reentry demonstration initiative must align with the requirements detailed in the STCs, including examining impacts on Medicaid coverage, continuity of care, access to and quality and efficiency of care, utilization of services, health outcomes, and carceral and community coordination in service provision, among others.

In alignment with section 1902(a)(84)(D) and 2101(d)(2), eligible juveniles under 1902(nn)(2) of the Act are included under this 1115 reentry demonstration initiative and must be included in applicable monitoring and evaluation activities.

Consideration of Public Comments

The federal comment period opened on June 28, 2023, and closed on July 28, 2023. There were 21 public comments received during the federal comment period. Implementation of HRSN services was widely supported within the public comments. Many commenters expressed support for the housing support services and the food and nutrition services being offered through the extension. People also expressed support for justice-involved reentry, supported employment services, and violence prevention and intervention services. Some expressed support for the SUD components.

Numerous commenters also indicated that the state took seriously the comments offered during the state comment period, and adjusted its proposal in reaction to these comments. Many commenters also noted that the proposal addresses CMS's five equity priority areas.

Five commenters expressed concerns with the state's request regarding the Continuum of Care Facility Licensure provision which CMS is not approving as part of the extension. Commenters expressed a preference for individuals with disabilities to be served in home and community-based settings rather than in institutional settings.

After carefully reviewing the public comments submitted during the federal comment period and information received from the state public comment period, CMS has concluded that this extension is likely to assist in promoting the objectives of Medicaid.

Other Information

CMS's approval of this extension is conditioned upon compliance with the enclosed amended set of waiver authorities, expenditure authorities, and STCs defining the nature, character and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Jonathan Morancy. He is available to answer any questions concerning this extension. His contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Email: Jonathan.Morancy@cms.hhs.gov

If you have any questions regarding this approval, please contact Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services at (410) 786-9686.

Sincerely,

Chiquita Brooks-LaSure

Enclosure

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITIES

NUMBER: 11-W-00316/5

TITLE: Illinois Healthcare Transformation (IHT)

AWARDEE: Illinois Healthcare and Family Services

Under the authority of section 1115(a)(1) of the Social Security Act ("the Act"), the following waiver is granted to enable Illinois (referred to herein as the "state") to operate the Illinois Healthcare Transformation demonstration. This waiver shall be effective from July 2, 2024, through June 30, 2029, except as otherwise noted. This waiver may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

The following waiver authority shall enable Illinois to implement the approved STCs for the Illinois Healthcare Transformation (IHT) Medicaid section 1115 demonstration.

Coverage of Certain Screening, Diagnostic, Release and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release **Section 1902(a)(84)(D)**

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITIES

NUMBER: 11-W-00316/5

TITLE: Illinois Healthcare Transformation (IHT)

AWARDEE: Illinois Healthcare and Family Services

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by Illinois for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, until the ending date specified for each authority as listed below, be regarded as expenditures under the state's title XIX plan. These expenditure authorities shall be effective from July 2, 2024 through June 30, 2029, except as otherwise noted.

The following expenditure authorities shall enable Illinois to implement the approved special terms and conditions (STCs) for the Illinois Healthcare Transformation (IHT) Medicaid section 1115 demonstration.

1. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

2. **SUD Case Management Pilot.** Expenditures for SUD case management services as described in STCs 5.5 through 5.8.

3. **Supported Employment Services Pilot.** Expenditures for supported employment services as described in STC 7.

4. **Expenditures for Pre-Release Services.** Expenditures for pre-release services, as described in STC 4, provided to qualifying Medicaid individuals for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative under this demonstration.

5. **Expenditures for Pre-Release Administrative Costs.** Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure, and interventions, as is detailed in STC 4, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the Reentry Demonstration Initiative.

6. **Health-Related Social Needs (HRSN) Services**. Expenditures for HRSN services not otherwise covered that are furnished to individuals who meet the qualifying criteria as

described in Section 6. This expenditure authority is contingent upon compliance with Section 10, as well as all other applicable STC.

7. **Expenditures for HRSN Services Infrastructure.** Expenditures for payments for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized under in Section 6 of the STCs. This expenditure authority is contingent on compliance with Section 10 of the STC, as well as all other applicable STC.

8. **Expenditures for Violence Prevention and Intervention Services**. Expenditures for violence prevention and intervention services described in STC 8.

9. **Expenditures for Non-Medical Transportation.** Expenditures for non-medical transportation described in STC 9.1 and STC 9.2.

Title XIX Requirements Not Applicable to the HRSN Expenditure Authorities

Comparability; Amount, Duration, and Scope Section 1902(a)(10)(B), Section 1902(a)(17)

To the extent necessary to enable the state to provide a varying amount, duration, and scope of HRSN services to a subset of beneficiaries, depending on beneficiary needs.

Comparability; Provision of Medical Assistance and Reasonable Promptness **Sections 1902(a)(10)(B), 1902(a)(17), 1902(a)(8)**

To the extent necessary to allow the state to offer HRSN services to an individual who meets the qualifying criteria for HRSN services, including delivery system enrollment, as described in Section 6 of the STC.

To the extent necessary to allow the state to delay the application review process for HRSN services in the event the state does not have sufficient funding to support providing these services to eligible beneficiaries.

Title XIX Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services:

Statewideness **Section 1902(a)(1)**

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

Amount, Duration, and Scope of Services and Comparability **Section 1902(a)(10)(B)**

To enable the state to provide only a limited set of pre-release services, as specified in STC 4, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

Title XIX Requirement Not Applicable to the SUD Case Management Pilot Expenditure Authority

Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to require qualifying individuals to receive SUD Case Management Pilot Services, as authorized under this demonstration, through only certain providers.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00316/5

TITLE: Illinois Healthcare Transformation

AWARDEE: Illinois Healthcare and Family Services

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the "Illinois Healthcare Transformation" demonstration (hereinafter "demonstration"), to enable the Illinois Department of Health and Family Services (HFS) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted Illinois (referred to herein as the state) waivers of requirements under section 1902(a) of the Social Security Act ("the Act") and expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable and which are separately enumerated.

These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. These STCs neither grant additional waivers or expenditures, nor expand upon those separately granted. The demonstration is approved from July 2, 2024 through June 30, 2029.

The STCs have been arranged into the following sections:

1. Preface
2. Program Description and Objectives
3. General Program Requirements
4. Reentry Demonstration Initiative
5. Substance Use Disorder (SUD) Program and Benefits
6. Health-Related Social Needs (HRSN) Services
7. Supported Employment Services
8. Violence Prevention and Intervention Services
9. Non-Medical Transportation for HRSN Services and Supported Employment Services
10. Provider Payment Rate Increase Requirements
11. Monitoring and Reporting Requirements
12. General Financial Requirements
13. Monitoring Budget Neutrality
14. Evaluation of the Demonstration
15. Delivery System
16. Schedule of Deliverables for the Demonstration

Additional attachments have been included to provide supplementary information and for specific STCs.

Attachment A – Developing the Evaluation Design
Attachment B – Preparing the Interim and Summative Evaluation Reports
Attachment C – SUD Implementation Plan
Attachment D – SUD Monitoring Protocol [Reserved]
Attachment E – Evaluation Design [Reserved]
Attachment F – HRSN Implementation Plan [Reserved]
Attachment G – Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services Protocol [Reserved]
Attachment H – Monitoring Protocol [Reserved]
Attachment I – Provider Rate Increase Attestation Table [Reserved]
Attachment J – Reentry Demonstration Initiative Qualifying Conditions and Services [Reserved]
Attachment K – Reentry Demonstration Initiative Implementation Plan [Reserved]
Attachment L – Reentry Demonstration Initiative Reinvestment Plan [Reserved]

2. PROGRAM DESCRIPTION AND OBJECTIVES

The original Illinois section 1115 demonstration, Illinois Behavioral Health Transformation, was approved on May 7, 2018, and was entitled Behavioral Health Transformation. On June 23, 2023, the state submitted an extension application requesting that the demonstration be renamed Illinois Healthcare Transformation. Under the extension, the state will be continuing its two SUD programs from the original demonstration, along with the supported employment services pilot that was approved in 2018, but the state had not implemented. The SUD programs were SUD services provided in an institution for mental disease (IMD) and SUD case management. The goal of the Residential and Inpatient Treatment for Individuals with SUD Pilot is for the state to maintain critical access to opioid use disorder (OUD) and SUD services and continue delivery system improvements for these services to provide more coordinated and comprehensive OUD/SUD treatment for Medicaid beneficiaries. This demonstration will provide the state with authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an IMD. It will also build on the state's existing efforts to improve models of care focused on supporting individuals in the community and home, outside of institutions, and strengthen a continuum of SUD services based on the American Society of Addiction Medicine (ASAM) criteria or other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines.

During the extension approval period, the state will continue to test whether the SUD component of the demonstration described in these STCs is likely to assist in promoting the objectives of Medicaid by achieving the following results:

1. Increase rates of identification, initiation, and engagement in treatment for SUD;
2. Increase adherence to and retention in treatment;

3. Reduce overdose deaths, particularly those due to opioids;
4. Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6. Improve access to care for physical health conditions among beneficiaries with SUD.

As part of the extension, the state has received authority for additional initiatives. A full list of the approved initiatives is below:

1. Residential and Inpatient Treatment for Individuals with SUD;
2. SUD Case Management Pilot;
3. Supported Employment Services.
4. Justice-Involved Reentry;
5. Violence Prevention and Intervention Services Pilot;
6. HRSN Services; and
7. Non-medical transportation for HRSN Services and Supported Employment Services.

3. GENERAL PROGRAM REQUIREMENTS

3.1. Compliance with Federal Non-Discrimination Statutes. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy. All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. Changes in Medicaid and CHIP Law, Regulation, and Policy. The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. State Plan Amendments. The state will not be required to submit title XIX or XXI state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public

feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. Extension of the Demonstration. States that intend to request an extension of the demonstration must submit an application to CMS at least 12 months in advance from the Governor of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. **Transition and Phase-out Plan Requirements:** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected

beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. **Transition and Phase-out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. **Transition and Phase-out Procedures:** The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 35.916(f)(1), or for children in CHIP consider eligibility for other insurance affordability programs under 42 CFR 457.350. For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements for Medicaid found in 42 CFR, part 431 subpart E, including Sections 431.206 through 431.214 or for CHIP found at 42 CFR 457.340(e), including information about a right to review consistent with 42 CFR 457.1180. In addition, the state must assure all applicable Medicaid appeal and hearing rights are afforded to Medicaid beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including Sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain Medicaid benefits as required in 42 CFR § 431.230.

e. **Exemption from Public Notice Procedures 42 CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. **Enrollment Limitation during Demonstration Phase-Out.** If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.13. FFP. No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care organizations (MCO)s, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. Common Rule Exemption. The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. REENTRY DEMONSTRATION INITIATIVE

4.1. Overview of Pre-Release Services and Program Objectives. This component of the demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to qualifying Medicaid individuals, who are residing in a state or local jail, prison, or youth correctional facility (hereinafter "correctional facility") as specified in STC 4.5, the implementation timeline in STC 49, and the implementation plan in STC 4.10.

4.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The Reentry Demonstration Initiative provides short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other SUD and behavioral health treatments, as appropriate for the individual.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

c. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs and HRSN services;

f. Reduce all-cause deaths in the near-term post-release;

g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care; and

h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release.

4.3. Qualifying Criteria for Pre-Release Services. To qualify to receive services under this component of the demonstration, an individual must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 4.5; and

b. Have been found eligible for Medicaid.

4.4. Scope of Pre-Release Services. The pre-release services authorized under the Reentry Demonstration Initiative include the following services, which are further described in Attachment J titled "Reentry Demonstration Initiative Qualifying Conditions and Services." Contingent upon CMS's approval of the state's Reentry Demonstration Initiative, the state anticipates starting to make expenditures for such services no later than January 1, 2025.

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs and HRSN;

ii. Medication-assisted treatment (MAT) services for all types of SUD as clinically appropriate, including coverage for medications in combination with counseling/ behavioral therapies;

iii. A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon

release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy;

iv. Services provided by community health workers;

v. Diagnostic and treatment services, including laboratory and radiology services;

vi. Prescribed drugs, in addition to MAT and the 30-day supply of prescription medications described above, and medication administration; and

vii. Medical equipment and supplies and/or medical equipment provided upon release.

b. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the Reentry Demonstration Initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule, effective January 1, 2025, remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the Illinois Medicaid State Plan, as relevant, that are not included in the above-described pre-release services benefit for qualifying Medicaid individuals are not available to qualifying individuals through the Reentry Demonstration Initiative.

4.5. Participating Correctional Facilities. The pre-release services will be provided at correctional facilities, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to Illinois HFS' approval of a facility's readiness, according to the implementation timeline described in STC 4.9. Correctional facilities that are also IMDs are not allowed to participate in the Reentry Demonstration Initiative.

4.6. Participating Providers.

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under Illinois scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as a Medicaid provider.

b. Participating providers eligible to deliver services under the Reentry Demonstration Initiative may be either community-based or correctional facility-based providers.

c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the Reentry Demonstration Initiative.

d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise working with justice-involved individuals.

4.7. Suspension of Coverage. Upon entry of a Medicaid individual into a correctional facility, HFS must not terminate and generally shall suspend their Medicaid coverage.

a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medicaid and with submitting an application, unless the individual declines such assistance or wants to decline enrollment.

4.8. Interaction with Mandatory State Plan Benefits for Eligible Juveniles and Targeted Low-Income Children. To the extent Illinois' reentry demonstration initiative includes coverage otherwise required to be provided under section 1902(a)(84)(D) of the Act, and because this coverage is included in the base expenditures used to determine the budget neutrality expenditure limit, the state will claim for these expenditures and related transitional non-service expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

4.9. Reentry Demonstration Initiative Implementation Timeline. Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). HFS will determine that each applicable facility is ready to participate in the Reentry Demonstration Initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medicaid application and enrollment processes for individuals who are not enrolled in Medicaid prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 4.3;

c. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable;

d. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, social service departments, and managed care plans;

e. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the 90-day pre-release period, and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate) upon release, consistent with approved Medicaid state plan coverage authority and policy;

f. Operational approaches related to implementing certain Medicaid requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the Reentry Demonstration Initiative;

g. A data exchange process to support the care coordination and transition activities described in (d), (e), and (f) of this subsection subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

h. Reporting of data requested by HFS to support program monitoring, evaluation, and oversight; and

i. A staffing and project management approach for supporting all aspects of the facility's participation in the Reentry Demonstration Initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

4.10. Reentry Demonstration Initiative Implementation Plan. The state is required to submit a Reentry Demonstration Initiative Implementation Plan in alignment with the expectations outlined in 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). As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the Reentry Demonstration Initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60

calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment K titled "Reentry Demonstration Initiative Implementation Plan," and may be revised only with CMS approval.

CMS will provide the state with a template to support developing and obtaining approval of the Implementation Plan. Contingent upon CMS's approval of the state's Implementation Plan, the state may begin claiming FFP for services provided through the Reentry Demonstration Initiative starting from the date of inclusion of the Implementation Plan as an attachment to these STCs.

4.11. Reentry Demonstration Initiative Reinvestment Plan. To the extent that the Reentry Demonstration Initiative covers services that are the responsibility of and were previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan (Attachment L). The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the Reentry Demonstration Initiative, defined as services not previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals prior to the facility's implementation of the Reentry Demonstration Initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the Reentry Demonstration Initiative, with respect to the relevant increase in expenditures, as described in Attachment L the Reentry Demonstration Initiative Reinvestment Plan), is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to:

    i. The state share of funding associated with new services covered under the Reentry Demonstration Initiative, as specified in this STC;

    ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

    iii. Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the Reentry Demonstration Initiative opportunity;

iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and

vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. The reinvestment plan will describe whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

c. Within six months of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan (Attachment L) for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment L titled "Reentry Demonstration Initiative Reinvestment Plan."

4.12. Reentry Demonstration Initiative Planning and Implementation.

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid pre-release application and suspension/unsuspension planning and purchase of certified electronic health record (EHR) technology to support Medicaid pre-release applications In addition, Reentry Demonstration Initiative planning and implementation funds will provide funding over the course of the demonstration to support planning and IT investments that will enable implementation of the Reentry Demonstration Initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among HFS and Qualified Applicants listed in STC 4.12(d) below. The specific use of this funding will be proposed by the qualified applicant submitting the

application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the correctional facility) and must be properly cost-allocated to Medicaid. These allowable expenditures may include the following:

i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the Reentry Demonstration Initiative population with Medicaid application and enrollment for demonstration coverage. This includes the development of electronic interfaces for Qualified Applicants listed in STC 4.12(d). to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with Qualified Applicants listed in STC 4.12(d), in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

ii. **Hiring of Staff and Training.** Expenditures for Qualified Applicants listed in STC 4.12(d). to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

iii. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified EHR technology and training for the staff that will use the EHR.

iv. **Purchase of Billing Systems**. Expenditures for the purchase of billing systems for Qualified Applicants.

v. **Development of Protocols and Procedures**. Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid enrollment process, suspension/unsuspension process for eligible individuals, and provision of care coordination and reentry planning for a period for up to 90 days immediately prior to the expected date of release for individuals qualifying for Reentry Demonstration Initiative services.

vi. **Additional Activities to Promote Collaboration**. Expenditures for additional activities that will advance collaboration among Illinois' Qualified Applicants in STC 4.12(d). This may include conferences and

meetings convened with the agencies, organizations, and other stakeholders involved in the initiative.

vii. **Planning**. Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying individuals who are potentially eligible for Medicaid; (2) assisting with the completion of a Medicaid or CHIP application; (3) submitting the Medicaid or CHIP application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

viii. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction, or refurbishment of correctional facilities.

b. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 1. In the event that the state does not claim the full amount of FFP for a given demonstration year as defined in STC 4, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 1. Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

	DY 7	DY 8	DY 9	DY 10	DY 11
Total Computable Expenditures	$55,864,900	$8,798,722	$6,159,105	$3,233,530	$3,395,207

c. Reentry Demonstration Initiative Planning and Implementation funding will receive the applicable administrative match for the expenditure.

d. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include the state Medicaid/CHIP Agency, correctional facilities, other state agencies supporting carceral health, Probation Offices, and other entities as relevant to the needs of justice-involved individuals, including health care providers, as approved by the state Medicaid/CHIP agency.

5. SUD PROGRAM AND BENEFITS

5.1. SUD Program Benefits. The demonstration benefit package for Medicaid beneficiaries will include SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903(m)(7) of the Act. The state will be eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD. The state will aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to the Monitoring Protocol as outlined in STC 11.6, to ensure short-term residential stays.

Under this demonstration beneficiaries will have access to high quality, evidence-based OUD/SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing chronic care for these conditions in cost-effective community-based settings.

5.2. SUD Implementation Plan and Health Information Technology (HIT) Plan.

a. The state's SUD Implementation Plan, initially approved for the period from July 1, 2018 through June 30, 2023, remains in effect for the approval period from July 1, 2024 through June 30, 2029, and is affixed to the STCs as Attachment C. Any future modifications to the approved Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral. The approved SUD Implementation Plan describes the strategic approach and a detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD demonstration project:

b. *Access to Critical Levels of Care for OUD and other SUDs.* Coverage of SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; MAT (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state; intensive levels of care in residential and inpatient settings; and

medically supervised withdrawal management, within 12-24 months of demonstration approval;

c. *Use of Evidence-based SUD-specific Patient Placement Criteria.* Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the ASAM Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of demonstration approval;

d. *Patient Placement.* Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;

e. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities. Residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in the Illinois administrative code and the Division of Substance Use, Prevention and Recovery (SUPR) contractual provider manual. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

f. *Standards of Care.* Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

g. *Standards of Care.* Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;

h. *Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for OUD.* An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of demonstration approval;

i. *Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD.* Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

j. *Improved Care Coordination and Transition between Levels of Care.* Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of demonstration approval.

k. *SUD Health IT Plan.* Implementation of a Substance Use Disorder Health Information Technology Plan which describes technology that will support the aims of the demonstration. Further information which describes milestones and metrics as detailed in STC 5.3(b) and Attachment C; and

5.3. SUD Health Information Technology Plan ("HIT Plan"). The state has provided CMS with an assurance that it has a sufficient health IT infrastructure/ "ecosystem" at every appropriate level (i.e. state, delivery system, and individual provider) to achieve the goals of the demonstration – or it will submit to CMS a plan to develop the infrastructure/capabilities.

a. This "SUD Health IT Plan," or assurance, will be included as a section of the state's "Implementation Plan" (see STC 5.3), which will remain in effect for the approval period from July 1, 2024 through June 30, 2029, and is affixed to the STC as Attachment C. The SUD Health IT Plan does detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan also is used to identify areas of SUD health IT ecosystem improvement. The state must include in its Monitoring Protocol (see STC 11.5[a]) an approach to monitoring its SUD HIT Plan which will include performance metrics to be approved in advance by CMS.

b. The state must monitor progress, each demonstration year (DY), on the implementation of its SUD HIT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Report (see STC 11.6).

c. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD HIT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

d. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or accountable care organization (ACO) participation agreements)

to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally recognized standards.

e. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally recognized ISA standards.

f. Components of the HIT Plan include:

   i. The HIT Plan must describe the state's alignment with Section 5042 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act requiring Medicaid providers to query a Qualified Prescription Drug Monitoring Program (PDMP)[1].

   ii. The HIT Plan must address how the state's Qualified PDMP will enhance ease of use for prescribers and other state and federal stakeholders. States should favor procurement strategies that incorporate qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in RX Check for Interstate data sharing.

   iii. The HIT Plan will describe how technology will support substance use disorder prevention and treatment outcomes described by the demonstration.

   iv. In developing the HIT Plan, states should use the following resources:

      1. States may use federal resources available on HIT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and HIT" (https://www.healthit.gov/playbook/health-information-exchange/).

      2. States may also use the CMS 1115 HIT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, Health Information Exchange (HIE) and Interoperability" (https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html). States should review the "1115 HIT Toolkit" for HIT considerations in conducting an assessment and developing their HIT Plans.

      3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific HIT

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

4. States should review the Office of the National Coordinator's Interoperability Standards Advisory (https://www.healthit.giv/isa/) for information on appropriate standards which may not be required per 45 CFR part 170, subpart B for enhanced funding, but still should be considered industry standards per 42 CFR 433.112(b)(12).

5.4. Unallowable Expenditures Under the SUD Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

5.5. SUD Case Management Pilot. Under this pilot, the state will cover case management services under expenditure authority because the state aims to pilot the program and uses a limited provider network.

5.6. Description of Eligibility for SUD Case Management Pilot. Beneficiaries with an OUD/SUD diagnosis that qualify for diversion into treatment from the criminal justice system are eligible for this pilot. The state may not claim FFP for services provided to inmates of a public institution as defined in 42 CFR 435.1010.

5.7. Description of SUD Case Management Services. SUD case management services assist a beneficiary with accessing needed medical, social, educational, and other services. Case management services are individualized for beneficiaries in treatment, reflecting particular needs identified in the assessment process, and those developed within the treatment plan. SUD case management services include:

a. Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services;

b. Transition to a higher or lower level of SUD care;

c. Development ad periodic revision of a client plan that includes service activities;

d. Communication, coordination, referral and related activities;

e. Monitoring service delivery to ensure beneficiary access to services and the service delivery system;

f. Monitoring the beneficiary's progress; and

g. Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services.

Table 2 – SUD Case Management Provider Qualifications

Practitioner	Qualifications	Services
Case manager	High School diploma required; Must hold clinical certification as a Certified Alcohol and Drug Counselor (CADC) from the Illinois Alcoholism and Other Drug Abuse Professional Certification Association or work under the direct supervision of a CADC in a licensed substance use disorder treatment program; and completion of training program in motivational interviewing required.	All services identified above

5.8. SUD Case Management Delivery System. The state operates a limited provider network for the SUD Case Management Services Pilot.

6. HRSN SERVICES

6.1. HRSN Services. The state may claim FFP for expenditures for certain qualifying HRSN services identified in Attachment F and this STC, subject to the restrictions described below and outlined in any related CMS published guidance on HRSN[2,3]. Expenditures are limited to expenditures for items and services not otherwise covered under title XIX, but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care. All HRSN interventions must be evidence-based and medically appropriate for the population of focus based on clinical and social risk factors. The state is required to align clinical and health-related social criteria across services and with other non-Medicaid social support agencies, to the extent possible. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to the beneficiary through local, state, or federal programs. The HRSN services will be the choice of the beneficiary. The state must allow each beneficiary to opt out of HRSN services anytime; and the HRSN services do not absolve the state or its managed care plans of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances may the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on receipt of HRSN services. The state must submit additional details on covered services as outlined in STC 6.7 (Service Delivery) and Attachment F.

[2] "Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program," *CMCS Informational Bulletin*, published on November 16, 2023.
[3] "Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)," published on November 16, 2023.

6.2. Allowable HRSN Services. The state may cover the following HRSN services:

a. Housing Interventions, including:

i. Housing supports without room and board, including:

1. Housing transition and navigation services (e.g., finding and securing housing).

2. Pre-tenancy navigation services.

3. One-time transition and moving costs to assist with identifying, coordinating, securing, or funding one-time necessary items to help a person establish a basic household (e.g., security deposit, application and inspection fees, utilities activation fees, movers, relocation expenses, payment in arrears (capped at a total of six months of total arrear and prospective payments), pest eradication, and the purchase of household goods and furniture). Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services.

4. Tenancy and sustaining services and individualized case management (e.g., linkages to state and federal and state benefit programs, benefit program application assistance and fees, eviction prevention, tenant rights education).

ii. First month's rent, as a transitional service.

iii. Short-term pre-procedure, and/or post-hospitalization housing with room and board for up to 6 months per year, only where integrated, clinically oriented recuperative or rehabilitative services and supports are provided. Pre-procedure and post-hospitalization housing are limited to a clinically appropriate amount of time.

iv. Short-term post-transition housing with room and board for up to 6 months, where clinically oriented rehab services and supports may or may not be integrated, following allowable transitions, and limited to a clinically appropriate amount of time.

1. Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration. Utility assistance, capped at six months in total prospective/retrospective payments, including activation expenses and back payments to secure utilities, limited to individuals receiving housing supports, as described above. Allowable utilities include

water, garbage, sewage, recycling, gas, electric, internet, and phone services.

v. Home remediations, that are medically necessary, including, for example, air filtration devices, air conditioning, or ventilation improvements, humidifiers, refrigeration for medication, carpet replacement, mold and pest removal, and/or housing safety inspections.

1. Air conditioners, heaters, air filters, and generators in emergency/extreme climate situations, scoped only to individuals with a high-risk clinical condition.

vi. Home/environmental accessibility modifications, including, for example, wheelchair accessibility ramps, handrails, grab bars, repairing or improving ventilation systems, and/or mold/pest remediation.

b. Nutrition Interventions, considered standalone outside of joint room and board interventions:

i. Case management services for access to food/nutrition, including, for example outreach and education and/or linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees.

ii. Nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including guidance on selecting healthy food and meal preparation.

iii. Home delivered meals, medically tailored meals, or pantry stocking.

iv. Nutrition prescriptions, tailored to health risk, certain nutrition-sensitive health conditions and/or demonstrated outcome improvement, including, for example, fruit and vegetable prescriptions, protein box prescriptions, food pharmacies, and/or healthy food vouchers. Individuals who receive nutrition prescriptions cannot concurrently receive other nutritional HRSN services.

v. Grocery provisions, for high-risk individuals to avoid unnecessary acute care admission or institutionalization.

6.3. HRSN Infrastructure.

a. The state may claim FFP in infrastructure investments in order to support the development and implementation of HRSN services, subject to Section 10.1. This FFP will be available for the following activities:

i. Technology – e.g., electronic referral systems, shared data platforms, EHR modifications or integrations, screening tool and/or case management systems, databases/data warehouses, interoperability with the State Health Information Network for Illinois, information security, data analytics and reporting, data protections and privacy, accounting and billing systems.

ii. Development of business or operational practices – e.g., procurement and planning, screening and referral processes, capacity building for social service providers and network development, developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, member navigation.

iii. Workforce development – e.g., cultural competency training, trauma-informed training, traditional health worker certification, training staff on new policies and procedures.

iv. Outreach, education, and stakeholder convening – e.g., design and production of outreach and education materials, translation, obtaining community input, investments in stakeholder convening.

b. The state may claim FFP in HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 3. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 3. Annual Limits of Total Computable Expenditures for HRSN Infrastructure

	DY 7	DY 8	DY 9	DY 10	DY 11	Total
Total Computable Expenditures	$200,000,000	$275,000,000	$140,000,000	$100,000,000	$50,000,000	$765,000,000

c. Infrastructure investments will receive the applicable administrative match for the expenditure.

d. This infrastructure funding is separate and distinct from the payment to the applicable managed care plans for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures described in STC 6.4 are not factored into managed care capitation payments, and that there is no duplication of funds.

e. The state may not claim any FFP in HRSN infrastructure expenditures until the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualification is approved, as described in STC 6.6. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date.

f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

6.4. Excluded HRSN Services and Infrastructure. Excluded items, services, and activities that are not covered as HRSN services and infrastructure include, but are not limited to:

a. Construction costs (bricks and mortar) except as needed for approved medically necessary home modifications as described in STC 6.2(a)(vi).

b. Capital investments;

c. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months, except as specified in STC 6.2;

d. Research grants and expenditures not related to monitoring and evaluation;

e. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting except those HRSN related case management services provided as part of an approved reentry demonstration initiative;

f. Services provided to individuals who are not lawfully present in the United States or are undocumented;

g. Expenditures that supplant services and activities funded by other state and federal governmental entities;

h. School based programs for children that supplant Medicaid state plan programs, or that are funded under the Department of Education or state, and the local education agency;

i. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

j. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HRSN item or service under this demonstration.

6.5. Covered Populations. Expenditures for HRSN services may be made for the targeted populations specified in Attachment F, consistent with this STC. Individuals eligible to receive HRSN services are Medicaid eligible, enrolled in managed care, and have a

documented medical need for the services and the services must be determined medically appropriate, as described in the HRSN services in STC 6.2, for the documented need. Medical appropriateness must be based on clinical and health-related social risk factors. This determination must be documented in the beneficiary's care plan or medical record. Additional detail, including the clinical and other health related-social needs criteria, is outlined in Attachment F. The allowable covered populations are :

a. People who have been determined to be high-risk or high-cost based on service utilization or healthcare history. High-risk is defined as an individual with physical health condition(s) or symptom(s) that could lead to a complex physical health need if not treated (e.g., pre-diabetes, hypertension, high cholesterol). High-cost is based on an individual's service utilization or healthcare history

b. People who have complex physical health needs such as persistent, disabling, or progressively life-threatening physical health conditions;

c. People with a behavioral health need, including SMI or SUD;

d. People with a high-risk pregnancy or complications arising from pregnancy; and/or

e. People with a chronic health condition with nutritional needs, including but not limited to diabetes, cancer, human immunodeficiency virus (HIV)/ acquired immunodeficiency syndrome (AIDS).

6.6. Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services. The state must submit, for CMS approval, a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications to CMS no later than 90 days after approval of these authorities. The protocol(s) must include, as appropriate, a list of the HRSN services and service descriptions, the criteria for defining a medically appropriate population for each service, the process by which that criteria will be applied including care plan requirements or other documented processes, uses of HRSN infrastructure funds, and provider qualification criteria for each service. Each protocol may be submitted and approved separately. The state must resubmit an updated protocol, as required by CMS feedback on the initial submission. The protocol may be updated as details are changed or added. The state may not claim FFP in HRSN services or HRSN infrastructure expenditures until CMS approves the associated protocol, except as otherwise provided herein. Once the associated protocol is approved, the state can claim FFP in HRSN services and HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date. The approved protocol(s) will be appended to the STC as Attachment G.

Specifically, the protocol must include the following information:

a. Proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

b. A list of the covered HRSN services (not to exceed those allowed under STC 6.2), with associated service descriptions and service-specific provider qualification requirements.

c. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary eligibility, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

d. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may deem the service to be medically appropriate.

   i. Plan to identify medical appropriateness based on clinical and social risk factors.

   ii. Plan to publicly maintain these clinical/social risk criteria to ensure transparency for beneficiaries and stakeholders.

e. A description of the process for developing care plans based on assessment of need.

   i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.

   ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma informed.

f. Plan to avoid duplication/ displacement of existing food assistance/nutrition services including how the state will prioritize and wrap around Supplemental Nutrition Assistance Program (SNAP) and/or Women Infants and Children (WIC) enrollment, appropriately adjust Medicaid benefits for individuals also receiving SNAP and/or WIC services, and ensure eligible beneficiaries are enrolled to receive SNAP and/or WIC services.

g. An affirmation that the state agrees to meet the enhanced monitoring and evaluation requirements stipulated in STC 11.6.b.ii and STC 14.6.a which require the state to monitor and evaluate how the renewals of recurring nutrition services in STC 6.2(c) affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services. As required in STC 11.6 and STC 14.3, the monitoring protocol and evaluation design are subject to CMS approval.

6.7. Service Delivery: HRSN services will be provided in the managed care delivery system. As outlined in STC 6.1, HRSN services will be delivered by HRSN service providers. Terms applicable to all HRSN services:

a. When HRSN services are provided to beneficiaries enrolled in Medicaid managed care, the following terms will apply:

i. For a non-risk payment, the MCO is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR 447.362 and may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. For the purposes of this demonstration, fee-for-service as defined in 42 CFR 447.362 is the fee-for-service authorized in this demonstration for HRSN Services paid on a fee-for-service basis by the state. The managed care plan contracts must clearly document the process and methodology for non-risk payments.

ii. When the state incorporates the HRSN services into the risk-based capitation rates in Medicaid managed care, and must comply with all applicable federal requirements, including but not limited to 42 CFR 438.4, 438.5, 438.6, and 438.7, and the state may no longer utilize non-risk payments.

iii. Any applicable HRSN services that are delivered by managed care plans in a risk arrangement, must be included in the managed care contracts and rate certifications submitted to CMS for review and approval in accordance with 42 CFR 438.3(a) and 438.7(a). The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the inclusion of HRSN services in managed care programs.

iv. When HRSN services (i.e., HRSN services defined in STC 6.2 for the covered populations outlined in STC 6.5) are included in capitation rates paid to managed care plans under risk-based contracts, and only then, should HRSN services be reported in the medical loss ratio (MLR) reporting as incurred claims.

v. The state must develop an MLR monitoring and oversight process specific to HRSN services. This process must be submitted to CMS, for review and approval, no later than 6 months prior to the implementation of HRSN services in risk-based managed care contracts and capitation rates. The state should submit this process to CMS at DMCPMLR@cms.hhs.gov. This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure will be identified and reported in the MLR as non-claims costs.

b. In accordance with STC 6.13, CMS expects the state to have appropriate encounter data associated with each HRSN service. This is necessary to ensure appropriate fiscal oversight for HRSN services as well as monitoring and evaluation. This is also critical to ensure appropriate base data for Medicaid managed care rate development purposes as well as appropriate documentation for claims payment in managed care. Therefore, CMS requires that for HRSN services provided in a managed care delivery system, the state must include the name and definition of each HRSN service as well as the coding to be used on claims and encounter data in the managed care plan contracts. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology costs that identify each HRSN service. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 6.14.

c. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the inclusion of HRSN services in managed care programs.

6.8. Contracted Providers. Consistent with the managed care contract and applicable to all HRSN services:

a. Managed care plans will contract with providers to deliver the elected HRSN services authorized under the demonstration.

b. Managed care plans must establish a network of providers and ensure the Social Service Providers have sufficient experience and training in the provision of the HRSN services being offered. Social Service Providers do not need to be licensed, however, staff offering services through Social Service Providers must be licensed when appropriate and applicable.

c. The managed care plan and contracted providers will use rates set by the state for the provision of applicable HRSN services, consistent with state guidance for these services, and in compliance with all related federal requirements.

i. Any state direction of managed care plan expenditures under risk-based contract(s) and risk-based payments would only be considered a state directed payment subject to the requirements in 42 CFR 438.6(c).

6.9. Provider Network Capacity. Managed care plans must ensure the HRSN services authorized under the demonstration are provided to eligible beneficiaries in a timely manner and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid/operating agency guidance.

6.10. Compliance with Federal Requirements. The state shall ensure HRSN services are delivered in accordance with all applicable federal statute, regulation or guidance.

6.11. Person Centered Plan. The state shall ensure there is a person-centered service plan for each individual receiving HRSN services that identifies the member's needs and individualized strategies and interventions for meeting those needs. The plan must be developed in consultation with the member and the member's chosen support network as appropriate. The service plan must be reviewed and revised at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

6.12. Conflict of Interest. The state shall ensure appropriate protections against conflicts of interest in the service planning. The state must ensure that appropriate separation of service planning and service provision functions are incorporated into the state conflict of interest policies.

6.13. CMS Approval of Managed Care Contracts. As part of the state's submission of associated Medicaid managed care plan contracts to implement HRSN services through managed care, the state must include contract requirements including, but not limited to:

a. Beneficiary and plan protections, including but not limited to:

i. HRSN services must not be used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid covered services.

ii. Medicaid beneficiaries always retain their right to receive the Medicaid covered service on the same terms as would apply if HRSN services were not an option.

iii. Medicaid beneficiaries who are offered or utilized an HRSN service retain all rights and protections afforded under 42 CFR 438.

iv. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they are currently receiving HRSN services, have requested those services, or have previously received these services.

v. Managed care plans are prohibited from requiring a beneficiary to utilize HRSN services.

b. Managed care plans must timely submit data requested by the state or CMS, including, but not limited to:

i. Data to evaluate the utilization and effectiveness of the HRSN services.

ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identify), race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities.

iii. Any data necessary to monitor appeals and grievances for beneficiaries.

iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.

v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN initiatives.

c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:

i. The managed care plans must submit timely and accurate encounter data to the state for beneficiaries eligible for HRSN services. When possible, this encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts and subsequent efforts to mitigate health disparities undertaken by the state.

ii. Any additional information requested by CMS, the state or legally authorized oversight body to aid in on-going evaluation of the HRSN services or any independent assessment or analysis conducted by the state, CMS, or a legally authorized independent entity.

iii. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports its progress in building and sustaining its partnership with existing housing agencies and nutrition agencies to utilize their expertise and existing housing resources and avoid duplication of efforts.

iv. Any additional information determined reasonable, appropriate and necessary by CMS.

6.14. HRSN Rate Methodologies. All rate and/or payment methodologies for authorized HRSN services outlined in these STCs must be submitted to CMS for review and approval prior to implementation, including but not limited to FFS payment, as well as non-risk payments, state directed payment preprints, and capitation rates in managed care delivery systems, as part of the HRSN Implementation Plan (see STC 6.18) at least 60 days prior to

implementation. The state must submit all documentation requested by CMS, including but not limited to the payment rate methodology (or methodologies) as well as other documentation and supporting information (e.g., state responses to Medicaid non-federal share financing questions). The state must also notify CMS if it intends to direct its managed care plans on how to pay for HRSN services at least 60 days prior to implementation. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting FFS payment rates.

6.15. Maintenance of Effort (MOE). The state must maintain a baseline level of state funding for ongoing social services related to housing transition supports and nutrition supports for the duration of the demonstration, not including one time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the HRSN Implementation Plan that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 11.7, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-demonstration baseline.

6.16. Partnerships with State and Local Entities. The state must have in place partnerships with other state and local entities (e.g., Department of Housing and Urban Development (HUD) Continuum of Care Program, local housing authority, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the care plans as appropriate. The state must submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and nutrition supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 11.7, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.

6.17. Provider Payment Rate Increase. As a condition of the HRSN services and infrastructure expenditure authorities, Illinois must comply with the provider rate increase requirements in Section 10 of the STCs.

6.18. HRSN Implementation Plan

a. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding

implementation of demonstration policies that are outlined in the STCs. The Implementation Plan may be updated as initiatives are changed or added. CMS will provide a template to support this reporting that the state will be required to use to help structure the information provided and prompt the state for information CMS would find helpful in approving the Implementation Plan. The state must submit the MOE information required by STC 6.15 for CMS approval no later than 90 calendar days after approval of this demonstration. All other Implementation Plan requirements outlined in this STC must be submitted for CMS approval no later than 9 months after the approval of this demonstration. Once approved, the Implementation Plan will be appended as Attachment F and, once appended, may be altered only with CMS approval.

b. At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services; however, as applicable, the information provided in the two deliverables must be aligned and consistent with one another.

c. The Implementation Plan must include information on, but not limited to, the following:

    i. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation;

    ii. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries);

    iii. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision;

    iv. A plan for tracking and improving the share of Medicaid beneficiaries in the state who are eligible and enrolled in the SNAP, the Special Supplemental Nutrition Program for WIC, Temporary Assistance for Needy Families

(TANF), and federal and state housing assistance programs, relative to the number of total eligible beneficiaries in the state;

v. An implementation timeline and evaluation considerations impacted by the timeline, such as staged rollout, that can facilitate robust evaluation designs;

vi. Information as required per STC 6.14 (HRSN Rate Methodologies);

vii. Information as required per STC 6.15 (MOE); and

viii. Information as required per STC 6.16 (Partnerships with State and Local Entities).

d. Failure to submit the Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of authority for HRSN Infrastructure and HRSN Services, under this demonstration.

7. SUPPORTED EMPLOYMENT SERVICES PILOT

Under this pilot, the state will cover a set of home and community-based services (HCBS), specifically supported employment services that could be covered under a 1915(i) state plan amendment.

7.1. Description of Eligibility

The pilot serves Medicaid beneficiaries aged 18 or older who are enrolled in managed care. The state must ensure that the minimum needs-based criteria for the supported employment benefit is less stringent than for institutional care. The beneficiary must meet at least one of the following health needs-based criteria and the beneficiary is expected to benefit from supported employment services:

a. Serious and persistent mental health needs, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support), resulting from the presence of a mental illness;

b. Substance use needs, where an assessment using the ASAM criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient SUD treatment; or

c. Physical, intellectual, or developmental needs, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support), resulting from the presence of a physical, intellectual, or developmental disability.

Additionally, the beneficiary must also have at least one of the following risk factors:

a. Unable to be gainfully employed for at least 90 consecutive days due to a mental or substance use impairment, or due to physical, intellectual, or developmental needs;

b. More than one instance of inpatient substance use treatment in the past 2 years; or

c. At risk of deterioration from mental illness, SUD, or physical, intellectual, or developmental needs, including one or more of the following:

i. Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness.

ii. Care for mental illness and/or substance use disorder requires multiple provider types, including behavioral health, primary care, long-term services and supports, and/or other supportive services.

iii. Past psychiatric history, with no significant functional improvement that can be maintained without treatment and/or supports.

iv. Dysfunction in role performance, including one or more of the following:

1. Behaviors that disrupt employment or schooling, or put employment at risk of termination or schooling suspension.

2. A history of multiple terminations from work or suspensions/expulsions from school.

3. Cannot succeed in a structured work or school setting without additional support or accommodations.

4. Performance significantly below expectation for cognitive/ developmental level.

7.2. Description of Services. The supported employment services benefit package must be offered to eligible beneficiaries through a person-centered planning process whereby eligible services are identified in the plan of care. Supported employment services include services that would otherwise be allowable under section 1915(i), and are determined by the team working with the beneficiary, through the person-centered planning process, to be necessary for the beneficiary to obtain and maintain employment in the community. Supported employment services are individualized and may include any combination of the following services:

a. **Pre-employment services:**

i. Pre-vocational/job-related discovery or assessment;

ii. Person-centered employment planning;

iii. Individualized job development and placement (vocational analysis is a component of job development and placement);

iv. Job carving. Job carving is defined as working with client and employer to modify an existing job description containing one or more, but not all, of the tasks from the original job description when a potential applicant for a job is unable to perform all of the duties identified in the job description;

v. Benefits education and planning. Benefits education and planning is defined as counseling to assist the client in fully understanding the range of state and federal benefits they might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the client's options for returning to work; and

vi. Transportation (only in conjunction with the delivery of an authorized service).

b. **Employment sustaining services:**

i. Career advancement services**.** Career advancement services are defined as services that expand opportunities for professional growth, assist with enrollment in higher education or credentialing and certificate programs to expand job skills or enhance career development, and assist the individual in monitoring his/her satisfaction with employment, and determining level of interest and opportunities for advancement with current employer, and/or changing employers for career advancement.

ii. Assist the employee with negotiation with employers. Assist the employee with negotiation with employers is defined as services where a provider identifies and addresses job accommodations or assistive technology needs with the employer on behalf of the individual. Job accommodations can include the following: adjusting work schedule to reduce exposure to triggering events (i.e., heavy traffic triggering symptoms of agoraphobia); providing a private area for individuals to take breaks if they experience an increase in symptoms; access to telephone to contact support person if needed while at work; adjusting job schedule to accommodate scheduled appointments; and small, frequent breaks as opposed to one long one. Assistive Technology can include the following: bedside alarms, electronic medication reminders while at work or at home, and use of headset/iPod to block out internal or external distractions.

iii. Job analysis. Job analysis is defined as the gathering, evaluating, and recording of accurate, objective data about the characteristics of a particular

job to ensure the specific matching of skills and amelioration of maladaptive behaviors.

iv. Job coaching. Job coaching is defined as supporting the beneficiary to learn and complete employment-related skills and objectives such as learning specific work duties and how to perform job tasks.

v. Benefits education and planning. Benefits education and planning is defined as counseling to assist the client in fully understanding the range of state and federal benefits they might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the clients' options for returning to work.

vi. Transportation (only in conjunction with the delivery of an authorized service)

vii. Asset development. Asset development is defined as assisting the individual to identify resources and job positions in the workforce that will meet his or her express needs and desires.

viii. Follow-along supports. Follow-along supports are defined as on-going supports necessary to assist an eligible client to sustain competitive work in an integrated setting of their choice. This service is provided for, or on behalf of, a client, and can include communicating with the client's supervisor or manager, whether in the presence of the client or not (if authorized and appropriate). There is regular contact and follow-up with the client and employer to reinforce and stabilize job placement. Follow along support and/or accommodations are negotiated with an employer prior to client starting work or as circumstances arise.

c. The supported employment services benefit may not include:

i. Generalized employer contacts that are not connected to a specific enrolled individual or an authorized service;

ii. Employment support for individuals in sub-minimum wage, or sheltered workshop settings;

iii. Facility-based habilitation or personal care services;

iv. Wage or wage enhancements for individuals; or

v. Duplicative services from other state or federal programs.

d. Supported employment services defined in these STCs adhere to 42 CFR §§440.180(c)(2)(iii), 441.302(i) and 441.303(h) and shall not include habilitation

services such as facility-based day habilitation or personal care. Furthermore, services are to be provided in conjunction with a client's existing services and supports, and are therefore separate from special education or related services defined under sections 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16 and 17)) or as services under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. §730).

7.3. Provider Qualifications. Contracted providers must ensure staff providing supported employment services maintain appropriate qualifications. Below are the minimum provider qualifications; however, they may be substituted with appropriate combination of education, experience and skills, as determined by the provider contract.

Table 4 – Supported Employment Service Providers

Staff	Education (minimum)	Experience (minimum)	Skills (preferred)	Services
Supported Employment Service Providers	Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience.	1 year case management experience, or Bachelor's degree in a related field and field experience.	Knowledge of principles, methods, and procedures of services included under supported employment services– individual placement and support (as outlined above), or comparable services that support client ability to obtain and maintain employment.	Pre-employment services; employment sustaining services (as outlined above).

7.4. HCBS Beneficiary Protections.

a. **Person-Centered Service Planning**. The state assures there is a person–centered service plan for each beneficiary determined to be eligible for HCBS. The person–centered service plan is developed using a person–centered service planning process in accordance with 42 CFR 441.725(a) and the written person–centered service plan meets federal requirements at 42 CFR 441.725(b). The person–centered service plan is reviewed and revised upon reassessment of functional need as required by 42 CFR 441.725(c), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the beneficiary.

b. **HCBS Conflict of Interest.** The state assures compliance with the HCBS conflict of interest protections at 42 CFR 441.730(b). The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCBS services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

c. **HCBS Settings Requirements**. The state must assure compliance with the characteristics of HCBS settings as described in 42 CFR 441.710(a)(1) and (2) in accordance with implementation/effective dates as published in the Federal Register.

7.5. The state, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

7.6. Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan.

7.7. Each beneficiary eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care and person-centered service planning personnel will receive training on these options.

7.8. Quality Strategy for 1915(i)-like HCBS Service: For services that could have been authorized to individuals under a 1915(i) HCBS state plan amendment, the state must have an approved Quality Improvement Strategy that encompass LTSS specific measures set forth in regulations at 42 CFR 438.330 and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal requirements at 42 CFR 441.745(b) and is required to develop performance measures to address the following requirements:

7.9. Administrative Authority. The state must have performance measures to demonstrate that the State Medicaid Agency retains authority and responsibility for program operations and oversight.

7.10. Eligibility Based on Section 1115 Requirements. The state must have performance measures to demonstrate each of the following: a) that an evaluation for 1915(i)-like HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i)-like services may be needed in the future, b) the processes and instruments described in the approved program for determining 1915(i)-like eligibility are applied appropriately, and c) the 1915(i)-like benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved program.

7.11. Qualified Providers. The state must have performance measures to demonstrate that providers meet required qualifications.

7.12. Service Plan. The state must have performance measures to demonstrate that service plans: a) address assessed needs of 1915(i)-like participants; b) are updated annually; and c) document choice of services and providers.

7.13. Health and Welfare. The state must have performance measures to demonstrate that the state identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death, including the use of restraints.

7.14. Financial Accountability. The state must have performance measures to demonstrate that it maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i)-like participants by qualified providers.

7.15. HCBS Settings Requirements. The state must have performance measures to demonstrate that settings meet the home and community-based setting requirements in accordance with 42 CFR 441.710(a)(1) and (2).

7.16. Quality Improvement Strategy (QIS) and Performance Measures. The state must submit the QIS and performance measures to CMS for review and approval within 90 days following approval of the demonstration.

7.17. 1915(i)-like HCBS Reporting Requirements:

a. **Enrollment**. The state must annually report to CMS the projected number of individuals to be enrolled in the 1915(i)-like demonstration and the actual number of unduplicated individuals enrolled in the 1915(i)-like demonstration in the previous year. This report is due 90 days post the end of each Demonstration Year.

b. **Quality.** The state will submit a report to CMS, following receipt of an Evidence Request letter and report template from the Division of HCBS Operations and Oversight (DHCBSO), no later than 21 months prior to the end of the approved demonstration period, which includes evidence on the status of the approved HCBS quality performance measures and requirements that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community–Based Waivers. Following receipt of the state's evidence report, the DHCBSO will issue a draft report to the state and the state will have 90 days to respond. The DHCBSO will review and assess the evidentiary report to determine whether the performance measures and requirements have been met and will issue a final report to the state 60 days following receipt of the state's response to the draft report.

8. VIOLENCE PREVENTION AND INTERVENTION SERVICES PILOT

8.1. Description of Eligibility. This pilot services Medicaid beneficiaries who are enrolled in managed care and who: 1) have survived violence; 2) are currently experiencing violence; or 3) are at risk of experiencing violence.

8.2. Description of Services. Violence prevention services are recommended by a physician or other licensed practitioner and include screening, assessment of needs, development of individualized service plans, trauma specific therapy (includes psychotherapy, individual, group and family therapy, grief counseling, mindfulness and relaxation-based treatments, art therapy and other evidence-based clinical and social interventions), mentoring, peer support services, life skills training, psychoeducation, conflict mediation, crisis intervention and care coordination services including linking beneficiaries to medical, social, educational, and other necessary services. Services that are provided to parents, guardians and/or caregivers are provided for the direct benefit of the beneficiary.

8.3. Provider Qualifications. Medicaid-enrolled violence prevention community support teams must deliver the service and may include violence prevention professionals, case managers, victim services workers/advocates, and licensed practitioners (e.g. Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Therapists, Physicians, Nurse Practitioners). The requirements for each provider type is listed below.

Table 5 – Violence Prevention and Intervention Staff

Staff	Experience (minimum)	Skills	Services
Violence Prevention Professional	Previous experience working with at risk, gang involved or impacted youth and/or adults; Persons with personal experience in overcoming violence or gang involvement are preferred; Must complete a 40-hour Violence Prevention Training	Ability to effectively communicate and connect with individuals in violence prone situations; Conflict management; ability to remain calm in tense situations or emergencies; Knowledge of urban issues, violence and justice system	Outreach Peer Support

Case Managers	Previous experience working with vulnerable populations	Knowledge of local resources Ability to communicate effectively with clients Organizational Skills	Case Management
Victims Services workers/ Advocates	Volunteer or professional experience with violence victims; specialized training or certification may be accepted if no prior work experience	Knowledge of systems and resources Ability to manage cases effectively Ability to communicate and interact with victims, law enforcement, healthcare providers, and legal resources Ability to empathize with individuals	Case Management Connect individuals to appropriate services and supports in the community
Licensed Practitioners (Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Therapists, Physicians, Nurse Practitioners, etc.)	Must meet Illinois standard provider requirements associated with traditional standards of practice.	Must meet Illinois standard provider requirements associated with traditional standards of practice.	Trauma Specific Therapy

9. NON-MEDICAL TRANSPORTATION (NMT) FOR HRSN AND SUPPORTED EMPLOYMENT SERVICES

9.1. NMT for HRSN

a. NMT services may be provided to Medicaid beneficiaries to and from HRSN services authorized under this demonstration. The HRSN services must also be directly related to a goal on the beneficiary's service plan and be described in the beneficiary's service plan.
b. NMT services to HCBS may be provided to Medicaid beneficiaries receiving HRSN services if these individuals would otherwise be eligible for a 1915(c)

waiver or 1915(i) state plan authorities. The HCBS services must also be directly related to a goal on the beneficiary's service plan and be described in the beneficiary's service plan.

c. The state does not need to operate a 1915(c) waiver or 1915(i) state plan authority to provide NMT. The state will need to determine if the beneficiary meets an institutional level of care or would meet the needs-based criteria as defined under 42 CFR 441.710 for 1915(i) services.
d. All NMT must be provided in alignment with the technical specifications, and safeguards required for NMT authorized under 1915(c) waiver or under 1915(i) state plan authorities.

9.2. NMT for Supported Employment Services.

a. NMT services may be provided to Medicaid beneficiaries in conjunction with the beneficiary's receipt of Supported Employment services authorized under this demonstration. NMT for Supported Employment services must also be directly related to a goal on the beneficiary's service plan and be described in the beneficiary's service plan.
b. The state does not need to operate a 1915(c) waiver or 1915(i) state plan authority to provide NMT. The state will need to determine if the beneficiary meets an institutional level of care or would meet the targeting criteria as defined under 42 CFR 441.710 for 1915(i) services.
c. All NMT must be provided in alignment with the technical specifications, and safeguards required for NMT authorized under 1915(c) waiver or under 1915(i) state plan authorities.

10. PROVIDER RATE INCREASE REQUIREMENTS

10.1. The provider payment rate increase requirements described hereafter are a condition for the HRSN expenditure authorities, as referenced in expenditure authorities 6 and 10.

10.2. As a condition of approval and ongoing provision of FFP for the HRSN expenditures over this demonstration period of performance, DY 7 through DY 11, the state will, in accordance with these STC, increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in the ratio of Medicaid to Medicare provider rates for one of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent.

10.3. The state may not decrease provider payment rates for other Medicaid or demonstration covered services to make state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).

10.4. The state will, for the purpose of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increases as may be required under this STC 10, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.

10.5. No later than 90 days of the demonstration effective date, and if the state makes fee for service payments, the state must establish and report to CMS the state's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:

   i. for primary care and obstetric care services in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); AND

   ii. for behavioral health services (the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3)); OR

b. Provide to CMS for approval for any of the three services categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

   i. Service codes must be representative of each service category as defined in STC 10.4;

   ii. Medicaid and Medicare data must be from the same year and not older than 2019.

   iii. The state's methodology for selecting the year of data, determining Medicaid code-level utilization, the service codes within the category, geographic rate differentials for Medicaid and/or Medicare services and

their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

10.6. To establish the state's ratio for each service category identified in STC 10.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average fee-for-service ratio as provided in STC 10.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the State pay providers based on state plan fee-for-service payment rate schedules); OR

b. The data and methodology for any or all of the service categories as provided in STC 10.5(b) using Medicaid managed care provider payment rate and utilization data.

10.7. In determining the ratios required under STC 10.5 and 10.6, the state may not incorporate fee-for-service supplemental payments that the state made or plans through June 30, 2029, to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR 438.6(a) and 438.6(d).

10.8. If the state is required to increase provider payment rates for managed care plans per STC 10.2 and 10.6, the state must:

a. Comply with the requirements for state directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of a two-percentage point increase applied to the provider payments rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

10.9. For the entirety of DY 9 through DY 11, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY 7, and such rate will be in effect on the first day of DY 9. A required payment rate increase shall apply to all services in a service category as defined under STC 10.4.

10.10. If the state uses a managed care delivery system for any of the service categories defined in STC 10.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY 9 through DY 11, the managed care plans'

provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 7 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment increase shall apply to all services in a service category as defined under STC 10.4.

10.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of DY 9 (or, as applicable, the first day of the first rating period that starts in DY 9), the state will provide an alternative effective date and rationale for CMS review and approval.

10.12. Illinois will provide the information to document the payment rate ratio required under STC 10.5 and 10.6, via submission to the Performance Metrics Database and Analytics (PDMA) portal for CMS review and approval.

10.13. For demonstration years following the first year of provider payment rate increases, if any, Illinois will provide an annual attestation within the state's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, in the previous year.

10.14. No later than 90 days following the demonstration effective date, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 10.5 and 10.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment I:

Table 6 - Illinois HRSN Related Provider Payment Increase Assessment – Attestation Table

The reported data and attestations pertain to HRSN related provider payment increase requirements for the demonstration period of performance DY 7 through DY 11		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**
Primary Care Services	[*insert percent, or N/A if state does not make Medicaid fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories*]
	[*insert approach, either ratio derived under STC 10.5(a) or STC 10.5(b)*]	[*insert approach, either ratio derived under STC 10.6(a) or STC 10.6(b) insert data source and time period (e.g.,*

		applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
Obstetric Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers of covered service categories*]
	[*insert approach, either ratio derived under STC 10.5(a) or STC 10.5(b)*]	[*insert approach, either ratio derived under STC 10.6(a) or STC 10.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Behavioral Health Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]*
	[*insert approach, either ratio derived under STC 10.5(a) or STC 10.5(b)*]	[*insert approach, either ratio derived under STC 10.6(a) or STC 10.6(b)*]; insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]

In accordance with STC 10.1 through 10.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment increases for each service will be effective beginning on [*insert date*] and will not be lower than the highest rate for that service code in DY 7 plus a two-percentage point increase relative to the rate for the same or similar Medicare billing code through at least [*insert date*].

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers

types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 10.6 will be based on Medicaid managed care provider payment rate and utilization data.

[*Select the applicable effective date, must check either a. or b. below*]

☐a. The effective date of the rate increases is the first day of DY 9 (July 1, 2026), and will be at least sustained, if not higher, through DY 11 (June 30, 2029).

☐b. Illinois has a biennial legislative session that requires provider payment approval, and the timing of that session precludes the state from implementing the payment increase on the first day of DY 9 (July 1, 2026). Illinois will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY 11 (June 30, 2029)

Illinois [*insert does or does not*] make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, as necessary to comply with the HRSN STC, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*]

Illinois [*insert does or does not*] include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, as necessary to comply with the HRSN STC, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 10.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *[insert date*]

If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 10.8, I attest that necessary arrangements will be made to assure that

100 percent of the two-percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
Illinois further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 10.
I, *[insert name of SMD or CFO (or equivalent position)*] [*insert title*], attest that the above information is complete and accurate. [*Provide signature*_____] [*Provide date*_____] [*Provide printed name of signatory*]

11. MONITORING AND REPORTING REQUIREMENTS

11.1. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable(s) were due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable(s) were not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable(s) into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay, the steps the state has taken to address such issue(s), and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b) above, and the state fails to comply with the corrective action plan or, despite the

corrective action plan, still fails to submit the overdue deliverable(s) that meet the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

11.2. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in Implementation Plan and the required performance measures in the monitoring protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

11.3. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs. The state shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.

11.4. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115, Transformed Medicaid Statistical Information System (T-MSIS) and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

11.5. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration extension. The state must

submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment H. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the extension. Such amendment Monitoring Protocols are subject to same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, as applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., those described under the performance metrics section in STC 11.6), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS, as applicable. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography) and demonstration component.

The Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Disparities Sensitive Measure Set, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days after the receipt of the final Disparities Sensitive Measure Set from CMS. This set of measures consists of metrics known to be important for addressing disparities in Medicaid/CHIP (e.g., the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e., social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones including relevant transitional, non-service expenditures investments, as captured in these STCs, or other applicable implementation and operations protocols.

The state will also be expected to set up its HRSN service delivery system to allow screening of beneficiaries for identified needs, and to develop an appropriate closed-loop referral system or other feedback loop to ensure beneficiaries receive service referrals and provisions, and provide any applicable update on this process via the Monitoring Reports, in alignment with information provided in the Monitoring Protocol for Other Policies.

In addition, the state must describe in the Monitoring Protocol methods and the timeline to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include but are not limited to data related to carceral status, Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts to consult with relevant non-Medicaid agencies to collect and use data in ways that support analyses of data on demonstration beneficiaries and subgroups of beneficiaries, in accordance with all applicable requirements concerning privacy and the protection of personal information.

For the qualitative elements (e.g., operational updates as described in STC 11.6(a), CMS will provide the state with guidance on narrative and descriptive information, which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

11.6. Monitoring Reports. The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate Quarterly Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/ Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates – Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operation and other challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by individuals; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics – The demonstration's monitoring activities through quantitative data and narrative information must support tracking the state's

progress toward meeting the applicable program-specific goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments and transitional non-service expenditures, as applicable. Metrics in the state's Monitoring Reports must cover all key policies under this demonstration including, but not limited to, behavioral health, home and community-based services, s, HRSN, Reentry, and SUD components.

Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to individuals and the uninsured population, as well as on individuals' outcomes as well as outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The required monitoring and performance metrics must be included in the Monitoring Reports and must follow the framework provided by CMS to support federal tracking and analysis as applicable.

i. Specifically, the state must undertake standardized reporting on categories of metrics including, but not limited to: beneficiary participation in demonstration components, primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

ii. For HRSN components, in addition to reporting on the metrics described above, the state must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations, and the contracted providers of applicable services (e.g., managed care plans and their contracted HRSN providers). In alignment with STC 6.18, the state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing and nutrition agencies, leverage their expertise and existing housing and nutrition resources instead of duplicating services. Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track

progress via Monitoring Reports for the percent of Medicaid renewals completed *ex-parte* (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

iii. For the SUD component, the state's monitoring must cover metrics in alignment with the respective milestones as outlined in the State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMD #17–003).

iv. As applicable, if the state, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the state must use monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs and corresponding payment-related metrics; these metrics are specifically relevant for the state's HRSN initiatives.

v. The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the Reentry Demonstration Initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the Reentry Demonstration Initiative. CMS expects such metrics to include, but not be limited to, administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 4.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR § 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for

monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the Form CMS-64.

d. Evaluation Activities and Interim Findings – Per 42 CFR § 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

11.7. Reentry Demonstration Initiative Mid-Point Assessment. The state must contract with an independent entity to conduct a mid-point assessment of the Reentry Demonstration Initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment.

The Mid-Point Assessment must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the Reentry Demonstration Initiative. The report must be submitted to CMS by the end of the third year of the demonstration. In the event that the Reentry Demonstration Initiative is implemented at a timeline within the demonstration approval period, the state and CMS will agree to an alternative timeline for submission of the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any. If requested, the state must brief CMS on the report.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: provider participation in the state's Reentry Demonstration Initiative, eligible individuals, and other key partners in correctional facility and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state and CMS will collaborate to determine whether modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol are necessary for ameliorating these risks, with any modifications subject to CMS approval.

Elements of the Mid-Point Assessment must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and

toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets; and

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment.

11.8. SUD Mid-Point Assessment. The state must contract with an independent entity to conduct an independent Mid-Point Assessment by June 30, 2027. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning, and conduct of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to representatives of MCOs, health care providers (including SUD treatment providers), beneficiaries, community groups, and other key partners.

a. The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations. The state must provide a copy of the report to CMS no later than 60 calendar days after June 30, 2027, and the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

b. For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS proposed modifications to the SUD Implementation Plan and SUD Monitoring Protocol, for ameliorating these risks. Modifications to any of these plans or protocols are subject to CMS approval.

c. Elements of the Mid-Point Assessment must include at least:

i. An examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan, and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol;

ii. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

iv. For milestones or targets identified by the independent assessor as at medium to high risk of not being met, recommendations for adjustments in the state's SUD Plan or to other pertinent factors that the state can influence that will support improvement; and

v. An assessment of whether the state is on track to meet the budget neutrality requirements in these STCs.

11.9. Corrective Action Plan Related to Demonstration Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial, sustained directional change inconsistent with the state's demonstration goals , and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

11.10. Close-Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 14.7 and 14.8, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out Report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 11.1.

11.11. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, enrollment and access and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

11.12. Post Award Forum. Pursuant to 42 CFR 431.420(c), within 6 months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its Medicaid website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the year in which the forum was held, as well as in its compiled Annual Monitoring Report.

12. GENERAL FINANCIAL REQUIREMENTS

12.1. Allowable Expenditures. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

12.2. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total

expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

12.3. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

12.4. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the

demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

12.5. Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the

requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.8, 438.60 and 438.74.

12.6. Requirements for health care related taxes and provider donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

12.7. State Monitoring of Non-federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 11.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

12.8. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 13:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

12.9. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

12.10. Medicaid Eligibility Group (MEG). MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 7: Main MEG Chart

MEG	To Which BN Test Does This Apply?	Without waiver (WOW) Per Capita	WOW Aggregate	With Waiver (WW)	Brief Description

SUD IMD Pilot	**Hypo**	**X**		**X**	All expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment
SUD Case Management	**Hypo**	**X**		**X**	All expenditures for SUD case management services.
Reentry Services	**Hypo**	**X**		**X**	Expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to release from participating facilities.
Reentry Non-Services	**Hypo**		**X**	**X**	Expenditures for allowable planning and non-services for the reentry demonstration initiative.
Supported Employment Services	**Hypo**	**X**		**X**	Expenditures for Supported Employment Services.
Violence Prevention and Intervention	**Hypo**	**X**		**X**	Expenditures for Violence Prevention and Intervention Services.
Non-Medical Transportation	**Hypo**	**X**		**X**	Expenditures for non-medical transportation.
HRSN Services	**Capped Hypo**		**X**	**X**	All expenditures for certain HRSN initiatives.
HRSN Infrastructure	**Capped Hypo**		**X**	**X**	All allowable infrastructure expenditures for certain HRSN initiatives.

12.11. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00114/2). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the

budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with Dys. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 16, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in STC 11.6, the state must report the actual number of "eligible

member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 8: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
SUD IMD Pilot	Expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment as described in section 5.	See STC 5.4	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	Y	7/1/2018	6/30/2029
SUD Case Management	Expenditures for SUD Case Management as described in section 5.	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	Y	7/1/2018	6/30/2029
Reentry Services	Expenditures for allowable	None	Follow CMS-64.9 Base	Date of Service	MAP	Y	7/2/2024	6/30/29

	planning and non-services for the reentry demonstration initiative.		Category of Service Definitions					
Reentry Non-Services	Expenditures for allowable planning and non-services for the reentry demonstration initiative.	None	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	ADM	N	7/2/2024	6/30/29
Supported Employment Services	Expenditures for Supported Employment Services.	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	Y	7/2/2024	6/30/29
Violence Prevention and Intervention Services	Expenditures for Violence Prevention and Intervention Services	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	Y	7/2/2024	6/30/29
NMT	Expenditures for NMT	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	Y	7/22024	6/30/29

12.12. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the DY table below.

Table 9: Demonstration Years

Demonstration Year 7	July 1, 2024 to June 30, 2025	12 months
Demonstration Year 8	July 1, 2025 to June 30, 2026	12 months
Demonstration Year 9	July 1, 2026 to June 30, 2027	12 months
Demonstration Year 10	July 1, 2027 to June 30, 2028	12 months
Demonstration Year 11	July 1, 2028 to June 30, 2029	12 months

12.13. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the PMDA system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in section 16. CMS will provide technical assistance, upon request.[4]

12.14. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

12.15. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes

[4] 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STC requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

12.16. Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 13.3. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following:

mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High-cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

13. MONITORING BUDGET NEUTRALITY

13.1. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, one or more Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality Test, if applicable, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

13.2. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 7, Master MEG Chart and Table 8, MEG Detail for

Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

13.3. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver per member per month (PMPM) cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

13.4. Main Budget Neutrality Test. The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures inexcess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

13.5. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state

could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. However, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

13.6. Hypothetical Budget Neutrality Test 1: Reentry. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 10 - Hypothetical Budget Neutrality Test 1 – Reentry

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 7	DY 8	DY 9	DY 10	DY 11
Reentry Services	PC	Both	5.2%	$1,300.40	$1,368.02	$1,439.16	$1,513.99	$1,592.72
Reentry Non-Services	Agg	Both	N/A	$55,864,900	$8,798,722	$6,159,105	$3,233,530	$3,395,207

13.7. Hypothetical Budget Neutrality Test 2: SUD IMD. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality

Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11 - Hypothetical Budget Neutrality Test 2 – SUD IMD

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 7	DY 8	DY 9	DY 10	DY 11
SUD IMD	PC	Both	5.1%	$4,770.54	$5,013.84	$5,269.55	$5,538.30	$5,820.75

13.8. Hypothetical Budget Neutrality Test 3: SUD Case Management. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 12 - Hypothetical Budget Neutrality Test 3 – SUD Case Management

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 7	DY 8	DY 9	DY 10	DY 11
SUD Case Management	PC	Both	5.1%	$186.96	$196.49	$206.51	$217.04	$228.11

13.9. Hypothetical Budget Neutrality Test 4: Supported Employment Services. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit

from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 13 - Hypothetical Budget Neutrality Test 4 - Supported Employment Services

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 7	DY 8	DY 9	DY 10	DY 11
Supported Employment Services	PC	Both	5%	$483.25	$507.41	$532.78	$559.42	$587.39

13.10. Hypothetical Budget Neutrality Test 5: Non-Medical Transportation. The table below identifies the MEG that is used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 14 - Hypothetical Budget Neutrality Test 5 – Non-Medical Transportation

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 7	DY 8	DY 9	DY 10	DY 11
Non-Medical Transportation	PC	Both	5.2%	$266.99	$280.87	$295.48	$310.84	$327.01

13.11. Hypothetical Budget Neutrality Test 6: Violence Prevention and Intervention Services. The table below identifies the MEG that is used for Hypothetical Budget Neutrality Test 6. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 6 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 15 - Hypothetical Budget Neutrality Test 6 – Violence Prevention and Intervention Services

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 7	DY 8	DY 9	DY 10	DY 11
Violence Prevention and Intervention Services	PC	Both	5.2%	$216.66	$227.93	$239.78	$252.25	$265.36

13.12. Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives. When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in section 6), CMS considers these expenditures to be "capped hypothetical" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped Hypothetical Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.

13.13. Capped Hypothetical Budget Neutrality Test: HRSN. The table below identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 16: Capped Hypothetical BN Test

MEG	PC or Agg	WOW Only, WW Only, or	Trend Rate	DY 7	DY 8	DY 9	DY 10	DY 11
HRSN Services	Agg	Both	n/a	$450,000,000	$910,000,000	$950,000,000	$1,000,000,000	$1,200,000,000
HRSN Infrastructure	Agg	Both	n/a	$200,000,000	$275,000,000	$140,000,000	$100,000,000	$50,000,000

13.14. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBE/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

13.15. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from July 1, 2024 to June 30, 2029. If at the end of the demonstration approval period the Main Budget Neutrality Test or a Capped Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

13.16. Corrective Action Plan. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the table below as a guide for determining when corrective action is required.

Table 17- Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 7	Cumulative budget neutrality limit plus:	2.0 percent
DY 7 through DY 8	Cumulative budget neutrality limit plus:	1.5 percent
DY 7 through DY 9	Cumulative budget neutrality limit plus:	1.0 percent
DY 7 through DY 10	Cumulative budget neutrality limit plus:	0.5 percent
DY 7 through DY 11	Cumulative budget neutrality limit plus:	0.0 percent

14. EVALUATION OF THE DEMONSTRATION

14.1. Cooperation with Federal Evaluators and Learning Collaborative. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation—including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable—in a federal learning collaborative aimed at cross state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring, and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in Section 11.1.

14.2. Independent Evaluator. The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of

detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

14.3. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval date of the demonstration. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The draft Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs, and any applicable evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic)—as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STC 14.7 and 14.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment components. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

14.4. Evaluation Budget. A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation, such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design

or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

14.5. Evaluation Design Approval and Updates. The state must submit to CMS a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring Reports.

14.6. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by NQF.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to beneficiary experiences with access to and quality of care and the HRSN demonstration components, and housing related support services. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted

as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 90-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including**:** utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

a. Hypotheses must cover all policies and goals of the demonstration and should be crafted not only to evaluate whether overall demonstration goals were achieved but also the extent to which each component contributed to outcomes. Where demonstration components offer tailored service to specific populations, evaluation hypotheses must include an assessment of whether these programs improved quality of care outcomes and access to health care for the targeted population while also promoting the desired administrative and fiscal efficiencies.

The evaluation questions and hypotheses should address the impacts of the following demonstration initiatives, including but not be limited to:

i. Evaluation hypotheses for the HRSN demonstration components must focus on areas such as assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on prevalence and severity of beneficiaries' HRSNs and the provision of beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care; utilization of and costs associated with potentially avoidable, high-acuity health care; utilization of hospital and institutional care; and beneficiary physical and mental health outcomes.

ii. In addition, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys).

iii. Hypotheses must be designed to help understand, in particular, the impact of housing supports, case management, nutritional services, and transportation support toward accessing covered HRSN services and case management activities on beneficiary health outcomes and experience. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level.

iv. The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing supports and nutrition services change over time in concert with new Medicaid funding

toward those services. In addition, considering how the demonstration's HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. Evaluation of the HRSN initiative is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

v. Hypotheses for the SUD program must include an assessment of the objectives of the SUD component of this section 1115 demonstration. Examples include, but are not limited to, initiative and engagement; compliance with treatment, utilization of health services (e.g., emergency department and inpatient hospital settings), and a reduction in key outcomes, such as deaths due to overdose.

b. As part of its evaluation efforts, the state must conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. The state must analyze the budgetary effects of the HRSN services, and the overall medical assistance service expenditures and uncompensated care and associated costs for populations eligible for continuous eligibility, including in comparison to populations not eligible for such policies. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

c. Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

14.7. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension of the demonstration, the Interim Evaluation Report should be posted to the state's Medicaid website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, the Interim Evaluation

Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit revised Interim Evaluation Reports 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

f. Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

14.8. Summative Evaluation Report. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs, and in alignment with the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

14.9. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased

difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

14.10. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation reports, and/or the Summative Evaluation Report. Presentations may be conducted remotely.

14.11. Public Access. The state shall post the final documents (e.g., Implementation Plans, Monitoring Protocols, Monitoring Reports, Mid-Point Assessment, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

14.12. Additional Publications and Presentations. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration, over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

15. DELIVERY SYSTEM

15.1. Requirements for Risk-Based Managed Care Plans. This section outlines key deliverables and timelines to meet the requirements of STC 15.1 (a) through (e).

a. For risk-based plans, the state must submit the plan-generated reports detailed in 42 CFR 438.8(k) as well as any other documentation used to determine compliance with 42 CFR 438.8(k) to CMS at DMCPMLR@cms.hhs.gov.

i. For managed care plans that delegate risk to subcontractors, the state's review of compliance with 42 CFR 438.8(k) must consider MLR requirements related to such subcontractors; see: www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051519.pdf https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf The state must submit its plan to operationalize STC 15.1 (a) through (d) no later than six months after the demonstration approval. This plan must outline key deliverables and timelines to meet the requirements of STC 15.(a) through (d).

b. Effective January 1, 2026, the state must require risk-based plans contracted with the state to impose reporting requirements equivalent to the information required in 42 CFR 438.8(k) on their subcontractor plans or entities.

c. No later than January 1, 2027, the state must require risk-based plans contracted with the state to impose remittance requirements equivalent to 42 CFR 438.8(j) on their subcontractor plans or entities.

d. STC 15.1(a), 15.1 (b), and 15.1(c) must apply for all of the following entities:

   i. Risk-based plans for which the state receives federal financial participation for associated expenditures;

   ii. Full and partially delegated plans;

   iii. Other subcontractors, as applicable, that assume delegated risk from either the primary managed care plan contracted with the state, or plans referenced in STC 15.1.d.ii; and

   iv. Other subcontractors, as applicable, that assume delegated risk from entities referenced in STC 15.1.d.iii.

e. The state must work with CMS to effectuate an audit of the MLR data for all complete rating periods (i.e., MLR reporting periods) in this 1115 demonstration package. Final audit results and reporting must be provided to CMS no later than two years after the expiration of the current demonstration period.

16. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION

In general, all deliverables are subject to revisions upon CMS review and feedback. Revised deliverables are generally due to CMS 60 days after receipt of CMS feedback.

Table 18: Schedule of Demonstration Deliverables

STC Section	Demonstration Deliverable	Due Date	Frequency
6	Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services.	Due to CMS 90 calendar days after the approval of the extension	One-time
6	HRSN Implementation Plan	Within 9 months of the extension's approval	One-time

STC Section	Demonstration Deliverable	Due Date	Frequency
12	Monitoring Protocol	150 days after approval of the demonstration extension	One-time
12	SUD Mid-Point Assessments	No later than 60 calendar days after June 30, 2027	One-time
12	Reentry Mid-Point Assessment	By the end of the third year of the demonstration	One-time
16	Evaluation Design	Due to CMS 180 days after approval of the demonstration extension	One-time
16	Interim Evaluation Reports	One year prior to expiration date, June 30, 2028	One-time
16	Summative Evaluation Report	Due to CMS 18 months after the end of the demonstration approval period	One-time
12	Close-Out Report (applicable if demonstration or demonstration component expires)	Due to CMS 120 calendar days after the expiration of the demonstration	One-time
10	Provider Rate Increase Attestation Table and Supporting Information	Within 90 days of the extension approval	One-time
10	Annual Attestation of Provider Rate Increase	Annually, as part of demonstration annual report.	Ongoing
12	Quarterly Monitoring Report	Due to CMS 60 days after the end of each demonstration quarter	Ongoing
12	Quarterly Budget Neutrality Report	Due to CMS 60 days after the end of each demonstration quarter	Ongoing
12	Annual Monitoring Report	Due to CMS 90 days after the end of each demonstration year	Ongoing

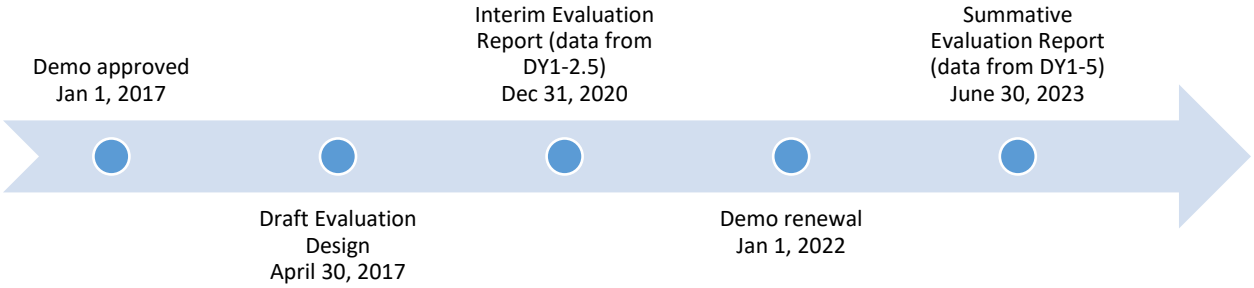
Attachment A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If

the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.

3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.
4. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure. Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.
2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3. *Evaluation Period* – Describe the time periods for which data will be included.
4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate. The state also should include the measure stewards

(i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.
6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.
7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).
2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:

a. Operating smoothly without administrative changes;
b. No or minimal appeals and grievances;
c. No state issues with CMS-64 reporting or budget neutrality; and
d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due

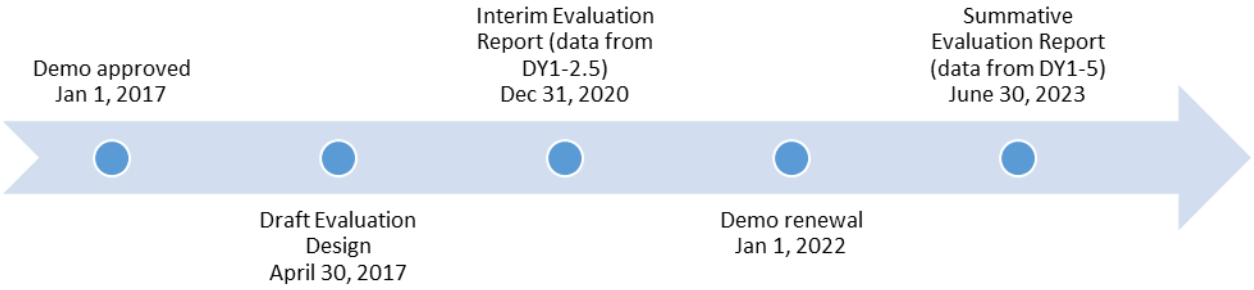
Attachment B
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow

the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When applying for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports
The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and,

J. Attachment(s).

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of titles XIX and XXI.
3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research,

(using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.
2. *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected.
4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.
6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. If the state did not fully achieve its intended goals, why not?
3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

Attachment C
SUD Implementation Plan
Approved: June 28, 2018

Introduction

On May 7, 2018, the Illinois Department of Healthcare and Family Services (IHFS) was notified that the *Better Care Illinois Behavioral Health Initiative* waiver application was approved and effective July 1, 2018 through June 30, 2023. This initiative includes four pilots that will provide authority for the Illinois Department of Human Services (IDHS), Division of Substance Use Prevention and Recovery (SUPR) to serve individuals with a substance use disorder (SUD) in a more comprehensive continuum of care. The continuum matches beneficiaries with the most appropriate services to meet their need, and provides an efficient use of resources grounded in evidence based practice. This includes a pilot for services provided in residential treatment settings that qualify as an Institution for Mental Diseases (IMD) consistent with key benchmarks from nationally recognized, SUD-specific program standards. Beneficiaries will have access to high quality, evidence based, SUD treatment on a continuum of services from outpatient to residential treatment including withdraw management. Case management services will be added for individuals with an SUD who have requested diversion from the criminal justice system. Peer recovery coaching that is delivered while an individual is receiving SUD treatment will also be piloted using a research model in a targeted geographic location.

Specifically, the four Illinois SUD pilots grant waiver authority to:

- Claim expenditures for services provided in an IMD for a statewide average length of stay of 30 days;
- Add clinically managed withdrawal management (American Society of Addiction Medicine (ASAM) Level 3.2) as a covered service;
- Deliver an evidence based peer recovery support service that will engage and support recovery for individuals in SUD treatment in a specified geographic area; and
- Add case management as a covered service for individuals with an SUD who are also involved with the Illinois criminal justice system and request diversion into SUD treatment as an alternative to incarceration.

As required by Standard Terms and Conditions (STC) #11W00316/5, this document serves as the Illinois 1115 Waiver SUD Implementation Plan and is referred to as the Implementation Plan here forth. The Implementation Plan establishes goals and required milestones to ensure that the four SUD pilots succeed in improving quality, accessibility, and outcomes for SUD treatment in the most cost-effective manner over the course of the waiver period. Additionally, the State of Illinois Opioid Action Plan (SOAP)

Implementation Report is included as Appendix A, Attachment 1. This report contains an overall strategy for addressing the opioid epidemic during the period of this waiver and contains several key activities for achievement of waiver milestones.

1115 Waiver Objectives

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

Waiver Achievement Milestones

The Implementation Plan includes identified staff and timetables designed to meet the following milestones:

1. Access to critical levels of care for OUD and other SUDs;
2. Use of Evidence-based SUD specific Patient Placement Criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications and establishment of a provider review process that includes a requirement that residential treatment providers offer Medication Assisted Treatment (MAT) on-site or facilitate access to MAT off-site;
4. Sufficient provider capacity at each level of care, including Medication Assisted Treatment for OUD;
5. Implementation of comprehensive treatment and prevention strategies to address opioid use disorders and an SUD Health IT Plan; and
6. Improved care coordination and transitions between levels of care.

Section I: Implementation Plan Milestones

To achieve the established objectives and milestones, IDHS/SUPR will work with its internal and external stakeholders to develop, design, and operationalize activities, as needed, and as so indicated on the following tables:

Milestone #1 – Access to Critical Levels of Care for OUD and other SUDS

To improve access to OUD and SUD treatment services for Medicaid beneficiaries it is important to offer a range of services at varying levels of intensity across a continuum of care since the effectiveness of the level of care may depend on the individual beneficiary. Coverage of outpatient, intensive outpatient, day treatment in a residential setting (Level 3.5) with 16 beds or less, psychiatric residential treatment facility (PRTF) (Level 3.5) for adolescents, medically monitored withdrawal management (Level 3.7) and medication assisted treatment are already in place and included in State Plan Services. Under this waiver authority, IMD services in Level 3.5 with a statewide average length of stay of 30 days and clinically managed based withdrawal management services (Level 3.2) will be covered upon approval within the proposed timeframes. In addition, Illinois will pilot the delivery of evidence based peer recovery support for patients receiving SUD treatment in a target geographic area. Case management services for beneficiaries with a SUD who are involved with the criminal justice system and request diversion into SUD treatment as an alternative to incarceration will also be added as part of the SUD continuum.

Milestone #1 Access to Critical Levels of Care for OUD and other SUD's.	Current Plan	Future State	Summary of Actions Needed/Timetable
Ensure access to OUD and SUD treatment services for Medicaid beneficiaries across a continuum of care.	Outpatient Care (Level 1) is currently covered in the Illinois State Medicaid Plan under Rehabilitative Services on page 13(A). Illinois has an administrative rule that authorizes licensure of outpatient substance use disorder services. Services authorized by this license average under nine hours weekly and include assessment, individual and group counseling, and psychiatric evaluation.	Continue to monitor and evaluate services and expenditures.	No Action needed
Ensure access to OUD and SUD treatment services for Medicaid beneficiaries across a continuum of care.	Intensive Outpatient Care (Level 2) is currently covered in the Illinois State Medicaid Plan under Rehabilitative Services on page 13(A), Appendix to Attachment 3.1.-A. Illinois has an administrative rule that authorizes licensure of intensive outpatient/partial hospitalization SUD treatment. Services authorized by this license average nine or more hours weekly and include assessment, individual and group counseling and psychiatric evaluation.	Continue to monitor and evaluate services and expenditures.	No Action needed

Milestone #1 Access to Critical Levels of Care for OUD and other SUD's.	Current Plan	Future State	Summary of Actions Needed/Timetable
Ensure access to OUD and SUD treatment services for Medicaid beneficiaries across a continuum of care.	MAT. Illinois SUPR allows any licensed level of care (outpatient through residential) to use Methadone as an adjunct to such treatment. Services include managing the medical plan of care, ordering and cost of the drug, nursing services related to administration and actual administration of the medication and coordination with other substance use disorder services. Medication Assisted Treatment is covered in the Illinois State Medicaid Plan under Rehabilitative Services on pages 14 and 39A. Illinois physicians, in accordance with their professional licensure and federal requirements, also utilize office-based MAT with buprenorphine and naltrexone.	Continue to monitor and evaluate services and expenditures.	No Action needed

Milestone #1 Access to Critical Levels of Care for OUD and other SUD's.	Current Plan	Future State	Summary of Actions Needed/Timetable
Ensure access to OUD and SUD treatment services for Medicaid beneficiaries across a continuum of care.	Day Treatment (Level 3.5). Illinois has an administrative rule that authorizes licensure of Level 3.5 residential treatment. Services authorized by this license must include a planned regimen of treatment averaging 25 hours or more per week. Services include individual and group counseling, discharge planning and general nursing and medical care, as needed. The current Illinois state plan covers this service as day treatment in programs with 16 beds or less and specifies that room and board is not covered. This service is covered in the Illinois State Medicaid Plan under Rehabilitative Services on page 14, Appendix to Attachment 3.1.-A treatment. Residential services for adolescents are delivered in PRTF, and are not subject to the IMD exclusion and are reimbursable as a full 24- hour rate. This service is covered in the Medicaid State Plan on Page 17, Appendix to 3.1-A.	Continue to monitor and evaluate services and expenditures.	No Action needed

Milestone #1 Access to Critical Levels of Care for OUD and other SUD's.	Current Plan	Future State	Summary of Actions Needed/Timetable
Ensure access to OUD and SUD treatment services for Medicaid beneficiaries across a continuum of care.	Medically Monitored Withdrawal Management (Level 3.7). Illinois has an administrative rule that authorizes licensure of medically monitored withdrawal management in a residential setting. Services are delivered under a defined set of physician-approved procedures with nursing staff in 24-hour inpatient care. The current Illinois state plan covers this service as day treatment in programs with 16 beds or less and specifies that room and board is not covered. This service is covered in the Medicaid State Plan on Page 14, Appendix to 3.1-B.	Continue to monitor and evaluate services and expenditures.	No action needed
Ensure access to OUD and SUD treatment services for Medicaid beneficiaries across a continuum of care.	Residential treatment (Level 3.5) and withdrawal management (Level 3.2 and 3.7) services in an IMD. These services are currently not covered in the State Plan but they are licensed and funded through Illinois general revenue funding (GRF).	Illinois will allow all currently licensed residential Level 3.2, 3.5 and 3.7 providers at current bed size capacity that are IMD's to receive reimbursement from Medicaid within 12-18 months of program demonstration approval.	Illinois SUPR staff will issue Medicaid certification and establish all billing procedure by September 2018. Illinois SUPR staff will amend administrative rules to reflect these changes to services delivered in an IMD by February 2019. Illinois SUPR staff, with input from HFS staff, will evaluate the possibility of increasing the number of providers and /or bed size by July 2020.

Milestone #1 Access to Critical Levels of Care for OUD and other SUD's.	Current Plan	Future State	Summary of Actions Needed/Timetable
Ensure access to OUD and SUD treatment services for Medicaid beneficiaries across a continuum of care.	Peer Recovery Support is not a covered service in the Medicaid State plan but some funding is provided with Illinois GRF.	Illinois will select a provider in a targeted geographic area with experience in delivering peer recovery support services to pilot delivery of these services while an individual is receiving SUD treatment. The selected provider will use individuals with Illinois certification as a Peer Recovery Support Specialist to deliver these services. Peer Recovery Support Specialists will engage families, help develop recovery plans and link participants to self-help, housing, vocational services, medical care and other services. They will also assist with the transition to additional recovery support upon discharge. Reimbursement rate for this service will be based on SUPR recovery support service rates.	Illinois SUPR staff will select the provider and have the service fully operational by September 2018. Illinois SUPR staff will amend administrative rules to include a section that includes recovery support requirements for all licensed providers by July 2019. Illinois SUPR staff, in coordination with IHFS staff, will explore the possibility of expanding providers to continue piloting peer recovery support during treatment by July 2020.

Milestone #1 Access to Critical Levels of Care for OUD and other SUD's.	Current Plan	Future State	Summary of Actions Needed/Timetable
Ensure access to OUD and SUD treatment services for Medicaid beneficiaries across a continuum of care.	Case Management for SUD is not a covered service in the Medicaid State plan. This service is funded with Illinois GRF.	The waiver will allow for the selection of providers who are SUPR licensed as "designated programs" to receive Medicaid reimbursement for case management services delivered on behalf of individuals who are involved in the Illinois criminal justice system and who requested diversion into SUD treatment as an alternative to incarceration. As specified in the STCs, individuals determined to meet the definition of an inmate of a public institution as defined in 42 CFR 435.1010 are not eligible to receive services through this pilot.	Illinois SUPR staff will work with designated program licensed providers to identify billing procedure and have the service fully operational by September 2018. Illinois SUPR staff will amend administrative rules to include a section that includes specification of case management requirements for all licensed providers by July 2019. Illinois SUPR staff, in coordination with IHFS staff, will explore the possibility of expanding providers to continue piloting case management for the individuals' diverted into SUD treatment by July 2020.
Ensure access to OUD and SUD treatment services for Medicaid beneficiaries across a continuum of care.	Clinically Managed Withdrawal Management (Level 3.2) is not covered service in the Medicaid State plan. This service is funded with Illinois GRF.	Any SUPR licensed Level 3.2 clinically managed withdrawal management program will be able to bill Medicaid for services provided to Medicaid beneficiaries.	Illinois SUPR staff will issue Medicaid certification to all Level 3.2 programs and have providers enrolled and billing by July 2019. Illinois SUPR staff will start the formal amendment process for administrative rules to reflect these changes by February 2019. Projected effective date of December 2019. Illinois SUPR staff, with input from IHFS staff, will evaluate the possibility of increasing the number of providers by July 2021.

Milestone #2-1 – Use of Evidence-Based SUD-Specific Patient Placement Criteria

Currently, Illinois SUPR licensed providers are required through administrative rule to utilize criteria

established by the ASAM for all patient assessment, initial placement in treatment and continuing stay reviews. These providers are also required to use the Diagnostic and Statistical Manual for Mental Disorders (DSM5) for diagnosis. SUPR staff conduct on- site monitoring and post-payment auditing to ensure compliance with these regulations.

Milestone #2-1 Use of Evidence-Based, SUD Specific Patient Placement Criteria.	Current Plan	Future State	Summary of Actions Needed/Timetable
Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines.	Illinois SUPR licensed providers have been required to use ASAM and the DSM5 since 1996 per Administrative Rule, Title 77, Chapter X, Subchapter d, Part 2060. Illinois currently, by policy is requiring use of the most recent version of ASAM (2013) and is offering free ASAM training for all providers that will be concluded in August of 2018. A training of trainers' event will also be offered in August to develop a cadre of trainers composed of SUPR staff and larger provider organizations to ensure that ASAM training is offered on a routine basis.	Continue to track and monitor the number of providers, total professional staff trained, and total trained staff currently available to provide treatment services.	No action needed.

Milestone #2-2 – Patient Placement

This milestone requires a utilization management approach so that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings. Illinois has several different strategies in place to meet this milestone. First, for Medicaid eligible individuals enrolled in a Managed Care Organization (MCO), the MCO conducts pre-authorization on many SUD services, including placement and continuing stay in residential settings. SUPR administrative rule also requires that each licensed provider have its own utilization management process. In addition, SUPR staff conduct post-payment audits annually and administrative rule monitoring at least once in a three-year licensure cycle. Both the audit and the on-site monitoring examine the assessment, identification of symptoms and need and how those translate to the diagnosis and treatment plan. Providers with non-compliance in these areas may face recoupment of reimbursement and/or sanctions against the provider license. These requirements help to ensure that beneficiaries have access to SUD

services at the appropriate level of care and that those services are appropriate for the diagnosis and treatment needs of the individual.

Milestone #2-2 Patient Placement	Current Plan	Future State	Summary of Actions Needed/Timetable
Utilization management approaches are implemented to ensure that beneficiaries have access to SUD services at the appropriate level of care and that interventions are appropriate for the diagnosis and level of care and there is an independent process for reviewing placement in residential treatment settings.	Most Medicaid beneficiaries receive pre-authorization of residential services by a MCO. For those beneficiaries that are not in an MCO, SUPR currently audits and inspects placement retrospectively. Additionally, all licensed providers are required to establish their own utilization management process, which can be conducted by the provider or through an independent contractor.	Illinois will propose regulatory amendment to strengthen the utilization management requirement to ensure its independence from the licensed provider. Illinois will also seek policy or rule amendment to initiate a pre- authorization process for residential treatment for those beneficiaries not enrolled in an MCO.	Illinois SUPR staff will start the formal amendment process for administrative rules to reflect these changes by February 2019. Projected effective date of December 2019.

Milestone #3-1 – Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications

The requirements for residential treatment providers are contained in administrative rule, Part 2060, and regulate administrative, facility, personnel and clinical standards. Residential treatment providers must deliver a planned regimen of clinical services for a minimum of 25 hours per week. All services must be delivered in accordance with the treatment criteria established by the American Society of Addiction Medicine. Non-hospital based residential SUD programs are required by legislation to obtain licensure from SUPR and are subject to inspection at least once in a three-year period. Illinois administrative rule, Part 2060, also requires that each licensed program have a Medical Director and at least one other professional staff who meet the credential requirements specified in the rule. At a minimum, professional staff must hold Illinois certification as an alcoholism and drug counselor. Other recognized credentials include licensed professional counselors, physicians, psychologists and licensed clinical social workers. All licensed residential providers that bill Medicaid are also subject to annual post-payment audit and funds will be recouped if qualified staff are not utilized to deliver services in accordance with administrative rule.

Milestone #3-1 Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	Current Plan	Future State	Summary of Actions Needed/Timetable
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualifications should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care, and credentials of staff for residential.	Illinois administrative rule, Part 2060, codifies the required regulations for residential treatment. Managed Care contracts also require that SUD providers have licensure and meet all requirements for professional staff.	Continue to monitor and enforce adherence to licensure requirements.	No action needed.

Milestone #3-2 – Standards of Care - Provider Review Process

Illinois currently has a provider review process for all licensed programs including residential treatment to monitor if providers deliver care consistent with the specifications of the ASAM criteria for the types of services, hours of clinical care and credentials for staff. As stated previously, all residential providers are monitored on-site at least once every three years or more often if complaints are received or problems are identified in some other manner. Non-compliance must have corrective action and can also result in a sanction against the license, more frequent inspection schedule or a finding of probation and/or revocation.

Milestone #3-2 Provider Review Process	Current Plan	Future State	Summary of Actions Needed/Timetable
A provider review process for all licensed programs including residential treatment to monitor if providers deliver care consistent with the specifications of the ASAM criteria for the types of services, hours of clinical care and credentials for staff.	Continue the monitoring schedule for all licensed residential providers.	Continue to monitor providers' adherence or fidelity to ASAM criteria, and the extent to which on-site monitoring is occurring.	No action needed

Milestone #3-3 – Standards of Care - Establishment of a Requirement that Residential Treatment Providers Offer MAT On-site or Facilitate Access to MAT Off-site

Illinois does not have a requirement that all residential treatment providers offer MAT on-site or facilitate access to MAT off-site. A few of our licensed residential providers do have MAT along with other residential services and some also offer MAT through linkage agreement with separately licensed Methadone programs or primary care physicians that can prescribe Buprenorphine, Vivitrol, etc.

Milestone #3-3 Implementation of a requirement that residential treatment offer MAT on-site or facilitate access off-site	**Current Plan**	**Future State**	**Summary of Actions Needed/Timetable**
Require all residential treatment providers to offer MAT on-site or facilitate MAT off- site	Very few residential programs offer MAT on-site and most do not have linkage agreements specifically for MAT off-site.	All residential treatment providers will be required to have MAT on-site or have linkage agreements for the MAT off-site.	SUPR will enact a policy change within 6 months that require all residential providers to have MAT on-site or a linkage agreement for MAT off-site. Illinois SUPR staff will start the formal amendment process for administrative rules to reflect these changes by February 2019. Projected effective date of December 2019.

Milestone #4 – Sufficient Provider Capacity at Each Level of Care Including Medication Assisted Treatment for OUD

Illinois has capacity information about providers that are subject to licensure by SUPR in all levels of care and uses this information to expand services and/or solicit new providers for funding opportunities in underserved areas. Illinois is also currently surveying active MAT providers to identify those accepting new patients and those with eligibility for Medicaid reimbursement and has received several federal grants to expand MAT services. The Illinois Department of Public Health (IDPH) is working on a qualitative study of active and inactive MAT providers to identify facilitators and barriers to office-based MAT. Many other activities to address the Opioid crisis are contained in SOAP, copy attached, and further explained in Milestone #5. Currently, with the exception of expanded MAT services, Illinois has sufficient provider capacity in the remaining levels of care as SUPR licenses approximately 1100 locations that provide SUD treatment statewide. This number does not include office-based MAT or other SUD treatment that is delivered directly by Illinois physicians or psychologists. Illinois will also ensure that a participant in any demonstration pilot authorized through the section 1115 demonstration population is eligible to receive the full array of Medicaid services offered by the State. When a pilot reaches its enrollment cap and/or the participant is no longer eligible to receive the pilot service, they will remain eligible for the broad Medicaid service package offered under the Medicaid State Plan.

Milestone #4 Sufficient Provider Capacity at Critical Levels of Care including Medication Assisted Treatment	Current Plan	Future State	Summary of Actions Needed/Timetable

Identify and expand, as needed, access to critical levels of care, including MAT for OUD.	Illinois is currently building capacity for OUD treatment in Illinois using a “hub and spoke” model where individuals with complex needs receive care through specialty treatment “hubs” responsible for coordinating care across health and SUD treatment systems, while individuals with less complex needs receive care through “spokes” comprising MAT-prescribing physicians and collaborating professionals who provide supportive services. Illinois is using federal State Targeted Response funds to pilot two Hub and Spoke projects in geographic areas of Illinois without access to MAT. SUPR is currently surveying active MAT providers to identify capacity. The IDPH is working on a qualitative study to identify active and inactive office based MAT. SUPR recently contracted with 12 new community based organizations to provide expanded OUD services. As of May 2018, nearly 2000 more patients have been admitted to these expanded services. Three new recovery homes for patients with OUD have also been added and 40 new individuals are receiving this service. Illinois will also ensure that a participant in any demonstration pilot authorized through the section 1115 demonstration population is eligible to receive the full array of Medicaid services offered by the State.	Illinois will evaluate the results of the Hub and Spoke pilots and replicate the model in future phases of implementation. Included in the capacity plan, Illinois will identify unmet needs and develop methods to address capacity insufficiency. IDPH, in cooperation with the SUPR Advisory Council, will compile targeted training activities for these MAT providers. Continue to monitor capacity for MAT and expand services as necessary. Continue to monitor capacity management to determine sufficient capacity for all levels of care.	Based upon the results of all SOAP activities in this area, study, Illinois will propose methods to address capacity insufficiency and include recommendations for re-distribution of services no later than July 2021.

Milestone #5 -1 – Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

On September 6, 2017, Illinois released its SOAP, along with an Executive Order, establishing the Governor's Opioid Prevention and Intervention Task Force. The SOAP forms the strategic framework for addressing the opioid epidemic in Illinois, setting a statewide goal of reducing opioid-related deaths by one-third in three years using a three-pillared approach of prevention, treatment and recovery and response. The Action Plan is a three-year plan with implementation in multiple phases. Contained within the plan are evidence-based strategies to achieve the overall goal and nine associated priorities, some of which address the milestone requirements in this implementation plan.

Milestone #5-1 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current Plan	Future State	Summary of Actions Needed/Timetable
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	The SOAP contains an overall priority of increasing the use of the Illinois Prescription Monitoring (PMP) program and reducing high-risk opioid prescribing through provider education and guidelines. Illinois law currently requires all prescribers with an Illinois controlled substance license to register with the PMP. The law also requires prescribers to document an attempt to access the PMP when providing an initial prescription for Schedule II narcotics, including opioids. The PMP currently identifies practitioners who are prescribing outside of Center for Disease Control and Prevention guidelines and sending letters informing them of how their practice compares to other providers in the same area of practice. PMP also sends providers of patients with a prescription history that might suggest “doctor shopping” behavior. Legislation was just passed that will require all health care professionals that hold a controlled substance license to take three of the mandated continuing education hours on proper opioid prescribing. l	Fully integrate the PMP into all electronic health record systems by 2021, prioritizing hospital systems in areas of high need for initial integration. Provide licensed delegates (e.g., registered nurses, physician assistants, certified nurse practitioners) and other non-licensed professionals access to the Illinois PMP. PMP will use identified high prescribers as the focus for dissemination of information about risk mitigation tools, prescribing guidelines, continuing medical education programs and academic detailing.	Continue implementation of the Electronic Health Records into the PMP DHS will implement technical infrastructure to enroll and give access to licensed delegates within 12 months The Department of Financial and Professional Regulation (DFPR) will adopt rules for the new continuing education requirement within 12 months. DFPR is currently in the process of implementing rules that will adopt the Federation of State Medical Boards’ Guidelines for the Chronic Use of Opioid Analgesics into the Medical Practice Act’s rules which govern al Illinois licensed physicians. This should be completed within 12 months.

Milestone #5-1 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current Plan	Future State	Summary of Actions Needed/Timetable
Facilitate naloxone access statewide and expand naloxone purchase, training and distribution services throughout Illinois Expand coverage of, and access to, naloxone for overdoes reversal	SUPR is currently supporting expanded naloxone purchase, training and/or distribution services in Illinois through its Drug Overdose Prevention Program (DOPP) including the use of funding provided through SAMHSA. To date, around 113,000 individuals have been trained in naloxone administration and around 1800 opioid reversals have been reported to the DOPP. In addition, over 17,000 naloxone kits have been distributed in Illinois. IDPH has released a statewide standing order for Naloxone and over 166 pharmacies and organizations have downloaded the standing order. IDPH has provided free naloxone and naloxone administration training to municipal and law enforcement agencies in 18 rural counties in south-central Illinois	Illinois will continue to utilize and expand training and use of naloxone to prevent overdose and to implement all other strategies contained within the SOAP.	Continue to maintain and expand training on the use of Naloxone and access to overdose prevention treatment and services.

Milestone #5-2 – SUD Health IT Plan

Illinois will provide CMS with assurance that it has sufficient health IT infrastructure/" ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. Specified below are strategies and activities already in place. HFS staff will complete any other required activities at a later date.

Milestone #5-2 SUD Health IT Plan	Current Plan	Future State	Summary of Actions Needed/Timetable
Infrastructure for SUPR Provider and Federal reporting	SUPR has an administrative data collections systems (DARTS) for patients who receive SUD treatment in Illinois that is reimbursed with state general revenue or other federal funding except for those recipients covered through a MCO. DARTS is used by all licensed, funded and or Medicaid certified providers in Illinois. DARTS collects demographic, substance use, financial, clinical and service information. DARTS also collects and produces the National Outcome Measures and generates the data needed for Provider Performance Reports. It is also used to fulfill the Federal Substance Abuse Prevention and Treatment Episode Data System reporting requirements. SUPR recently amended a data sharing agreement with IHFS to	Continue work with IHFS to ensure that all patient and service data is correct and linked appropriately and timely for state and federal reporting purposes	Ensure accuracy of shared data within 12 months
IT Plan for enhancing the Illinois Prescription Drug Monitoring Program (PDMP)	See Milestone #5 and the Attached SOAP, Strategy #5.	See Milestone #5	See Milestone #5

Milestone #6 – Improved Care Coordination and Transitions Between Levels of Care

This milestone requires that residential facilities ensure that beneficiaries are linked with community-based services and supports following stays in those facilities. Current administrative rules require linkage agreements with facilities for services not authorized by the licensed organization. Case management to

coordinate these linkages is reimbursed through state general revenue funds. A pilot to reimburse case management services for individuals who are involved in the Illinois criminal justice system and request diversion into SUD treatment as an alternative to incarceration is part of the 1115 Waiver for Illinois (see milestone #1). Illinois is in the process of transitioning all services to a Recovery Oriented System of Care that includes the projected expansion of recovery support services, pre- and post-treatment.

Milestone #6 Improved Care Coordination and Transitions between Levels of Care	Current Plan	Future State	Summary of Actions Needed/Timetable
Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community- based services and supports following stays in these facilities	Illinois has procedures in place to ensure residential and inpatient facilities link beneficiaries with community-based services. Current Licensing Regulations require Providers have linkage agreements with other community-based services.	Illinois will pursue administrative rule amendment to strengthen policies and linkage agreements relative to community-based services that cover other levels of SUD care and other primary care or mental health needs.	Illinois SUPR staff will start the formal amendment process for administrative rules to reflect these changes by February 2019. Projected effective date of December 2019.

Section II: Illinois Point of Contact for the Implementation Plan

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Section III: Relevant Documents

Appendix A, Attachment 1: SOAP Implementation Report

Attachment D
SUD Monitoring Protocol [Reserved]

Attachment E
Evaluation Design [Reserved]

Attachment F
HRSN Implementation Plan [Reserved]

Attachment G
Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services Protocol [Reserved]

Attachment H
Monitoring Protocol [Reserved]

Attachment I
Provider Rate Increase Attestation Table [Reserved]

Attachment J
Reentry Demonstration Initiative Qualifying Conditions and Services [Reserved]

Attachment K
Reentry Demonstration Initiative Implementation Plan [Reserved]

Attachment L
Reentry Demonstration Initiative Reinvestment Plan [Reserved]