



Administrator
Washington, DC 20201

MAY - 7 2018

Felicia F. Norwood
Director
Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763-0002

Dear Ms. Norwood:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving Illinois' request for a new 1115 demonstration, the Illinois Behavioral Health Transformation (Project Number 11W00316/5). This approval is effective from July 1, 2018 through June 30, 2023.

CMS applauds your efforts and those of your team in designing this demonstration, as well as your ongoing commitment to improving the health and well-being of Medicaid beneficiaries in Illinois. At CMS, we are dedicated to empowering states to better serve their beneficiaries through state-led reforms to improve health outcomes. Under the demonstration, Illinois will implement 10 pilots that are currently not available to Illinois Medicaid beneficiaries. These additional services are expected to transform the behavioral health system in Illinois because beneficiaries will have access to less costly community-based services, which are expected to help beneficiaries improve their health and avoid costlier services in an institution.

CMS's approval of this section 1115 demonstration is subject to the limitations specified in the approved expenditure authorities as well as the enclosed special terms and conditions (STCs) defining the nature, character, and extent of federal involvement in this project. Illinois (the state) may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as not applicable to the expenditure authority.

This approval authorizes the state to receive federal financial participation (FFP) for the continuum of services to treat addictions to opioids and other substances, including services provided to Medicaid enrollees with a substance use disorder (SUD) who are short-term residents in residential and inpatient treatment facilities that meet the definition of an Institution for Mental Diseases (IMD). At this time, CMS is not providing authority for Illinois to receive FFP for the costs of services for individuals residing in an IMD who are in an IMD only to receive mental health treatment. It is CMS's current policy, as reflected in the November 1, 2017 State Medicaid Director's Letter #17-003, not to authorize costs of services for individuals residing in an IMD who are in an IMD only to receive mental health treatment. CMS will continue to work with the state to support the state's efforts to provide comprehensive mental health services for Medicaid beneficiaries.

Implementation of this demonstration is likely to assist in promoting the objectives of the Medicaid program as it is expected to improve health outcomes for Medicaid beneficiaries by increasing access to high quality opioid use disorder/substance use disorder (OUD/SUD) care. Specifically, the demonstration is expected to assist the state in increasing the identification, initiation, and engagement in treatment; increased adherence to and retention in treatment; reductions in overdose deaths, particularly those due to opioids; and reduced inappropriate or preventable utilization of emergency departments and inpatient hospital settings through improved access to other continuum of care services.

This approval authorizes the state to implement 10 pilots. The state is electing to use expenditure authority so that it can implement these pilots less than statewide and so that it may institute annual enrollment limits in nine of the ten pilots, which is not allowable under the Medicaid state plan. The pilots are:

1. Residential and Inpatient Treatment for Individuals with SUD Pilot (will be statewide and will have no annual enrollment limits);
2. Clinically Managed Withdrawal Management Services Pilot;
3. SUD Case Management Pilot;
4. Peer Recovery Support Services Pilot;
5. Crisis Intervention Services Pilot;
6. Evidence-based Home Visiting Services Pilot;
7. Assistance in Community Integration Services Pilot;
8. Supported Employment Services Pilot;
9. Intensive In-Home Services Pilot; and
10. Respite Services Pilot.

As we have discussed, at this time, CMS is not approving the state's request for FFP for 30 days of services prior to release for individuals who are incarcerated due to the inmate exclusion. CMS is also not approving the proposed infant/early childhood mental health consultation pilot at this time because the consultation services proposed are not for the direct benefit of the beneficiary. Finally, CMS is not approving the First Episode Psychosis training and infrastructure pilot or workforce development pilot because the training and infrastructure costs are not for the direct benefit of Medicaid beneficiaries. However, CMS will continue to work with the state to identify appropriate funding alternatives for these initiatives.

Both Illinois and CMS received comments during the state and federal public comment periods. Consistent with federal transparency requirements, CMS reviewed all of the materials submitted by the state, as well as all of the comments it received, when evaluating whether the demonstration project as a whole was likely to assist in promoting the objectives of the Medicaid program.

The vast majority of comments expressed support for the additional SUD and other pilot services proposed under the demonstration. Some commenters shared views on aspects of the proposal that CMS is not approving at this time, including on services prior to release for individuals who are incarcerated.

The award is subject to your written acknowledgement of the award and acceptance of the STCs within 30 calendar days of the date of this letter. Please send your written acceptance to your project officer, Mr. Felix Milburn. He is available to answer any questions concerning your section 1115 demonstration. His contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-03-17
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-1315
E-mail: Felix.Milburn@cms.hhs.gov

Official communication regarding official matters should be simultaneously sent to Mr. Felix Milburn and Ms. Ruth Hughes, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in our Chicago Regional Office. Ms. Ruth Hughes' contact information is as follows:

Ms. Ruth Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519
Telephone: (312) 353-1670
E-mail: Ruth.Hughes@cms.hhs.gov

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

Congratulations and we look forward to our continued partnership through the implementation of these important reforms.

Sincerely,

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Seema Verma

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11W00316/5

TITLE: Illinois Behavioral Health Transformation Demonstration

AWARDEE: Illinois Department of Healthcare and Family Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Illinois (the state) for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from July 1, 2018 through June 30, 2023, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable the state to operate the above-identified section 1115 demonstration.

- 1. Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD) Pilot.** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD) as described in STC 20. This pilot will operate statewide and there are no annual enrollment limits.
- 2. Clinically Managed Withdrawal Management Services Pilot.** Expenditures for clinically managed withdrawal management services as described in STC 28. The state may implement this pilot less than statewide and may institute annual enrollment limits.
- 3. SUD Case Management Pilot.** Expenditures for SUD case management services as described in STC 29. The state may implement this pilot less than statewide and may institute annual enrollment limits.
- 4. Peer Recovery Support Services Pilot.** Expenditures for peer recovery support services as described in STC 30. The state may implement this pilot less than statewide and may institute annual enrollment limits.
- 5. Crisis Intervention Services Pilot.** Expenditures for crisis intervention services as described in STC 31. The state may implement this pilot less than statewide and may institute annual enrollment limits.
- 6. Evidence-based Home Visiting Services Pilot.** Expenditures for evidence-based home visiting services as described in STC 32. The state may implement this pilot less than statewide and may institute annual enrollment limits.

- 7. Assistance in Community Integration Services Pilot.** Expenditures for home and community-based services (HCBS) and related services as described in STC 34. The state may implement this pilot less than statewide and may institute annual enrollment limits.
- 8. Supported Employment Services Pilot.** Expenditures for HCBS and related services as described in STC 35. The state may implement this pilot less than statewide and may institute annual enrollment limits.
- 9. Intensive In-Home Services Pilot.** Expenditures for HCBS and related services as described in STC 36. The state may implement this pilot less than statewide and may institute annual enrollment limits.
- 10. Respite Services Pilot.** Expenditures for HCBS and related services as described in STC 37. The state may implement this pilot less than statewide and may institute annual enrollment limits.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)**

NUMBER: 11W00316/5

TITLE: Illinois Behavioral Health Transformation Section 1115(a) Demonstration

AWARDEE: Illinois Department of Healthcare and Family Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Illinois Behavioral Health Transformation section 1115(a) Medicaid demonstration project (demonstration), to enable the State of Illinois Department of Healthcare and Family Services (state), to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable under Section 1903 of the Social Security Act (“the Act”), which are separately enumerated. These STCs set forth conditions and limitations on those expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. These STCs neither grant waivers nor additional expenditure authorities, nor expand upon those separately granted. These STCs are effective as of the date of the approval letter, unless otherwise specified, for the period beginning July 1, 2018 through June 30, 2023 (the approval period).

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility and Enrollment
- V. Demonstration Programs and Benefits
- VI. Cost Sharing
- VII. Delivery System
- VIII. General Reporting Requirements
- IX. Monitoring
- X. Evaluation of the Demonstration
- XI. General Financial Requirements Under Title XIX
- XII. Monitoring Budget Neutrality for the Demonstration
- XIII. Schedule of Deliverables for the Demonstration Approval Period

Attachments have been included to provide supplementary information and guidance for specific STCs.

- Attachment A: Developing the Evaluation Design
- Attachment B: Preparing the Interim and Summative Evaluation Reports

- Attachment C: Reserved for Evaluation Design
- Attachment D: Reserved Substance Use Disorder (SUD) Implementation Protocol
- Attachment E: Reserved for SUD Monitoring Protocol

II. PROGRAM DESCRIPTION AND OBJECTIVES

The demonstration provides authority for the state to operate 10 pilots.

The goal of the Residential and Inpatient Treatment for Individuals with Substance Use Disorder (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 Institution for Mental Diseases (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.

The state will implement the following pilots under the demonstration:

1. Residential and Inpatient Treatment for Individuals with SUD Pilot (will be statewide and will have no annual enrollment limits);
2. Clinically Managed Withdrawal Management Services Pilot;
3. SUD Case Management Pilot;
4. Peer Recovery Support Services Pilot;
5. Crisis Intervention Services Pilot;
6. Evidence-based Home Visiting Services Pilot;
7. Assistance in Community Integration Services Pilot;
8. Supported Employment Services Pilot;
9. Intensive In-Home Services Pilot; and
10. Respite Services Pilot.

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

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

III. GENERAL PROGRAM REQUIREMENTS

- 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, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program, or the Children's Health Insurance Program (CHIP) for the separate CHIP population, expressed in 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. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal 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 and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 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.
- 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. 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 subparagraph.
 - b. If mandated changes in the federal law require state legislation, 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.
- 5. State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments 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 state plan governs.

- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, 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. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.
- 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 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 15. 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 data analysis which identifies the specific “with waiver” impact of the proposed 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 proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. An up-to-date CHIP allotment worksheet, if necessary;
 - d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
 - 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.
- 8. Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, if the state intends to request a demonstration extension under section 1115(a) of the Act, the state must submit the extension application no later than 12 months prior to the expiration

date of the demonstration. The Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at CFR section 431.412(c) or a phase-out plan consistent with the requirements of STC 10.

9. Compliance with Transparency Requirements 42 CFR Section 431.412. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in STC 15, as well as include the following supporting documentation:

- a. Demonstration Summary and Objectives: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.
- b. Special Terms and Conditions: The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
- c. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
- d. Quality: The state must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) reports; state quality assurance monitoring; and any other documentation that validates the quality of care provided or corrective action taken under the demonstration.
- e. Compliance with Budget Neutrality Cap: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.
- f. Evaluation Report: The state must provide an evaluation report reflecting the hypotheses being tested and any results available. For the proposed extension period, the state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period.

- g. Documentation of Public Notice 42 CFR section 431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

10. 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 phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment, and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 calendar days after CMS approval of the phase-out plan.

- b. 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 eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- d. 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 terminating the demonstration including services and administrative costs of disenrolling participants.

- 11. CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
- 12. Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.
- 13. Withdrawal of 1115(a) Authority.** CMS reserves the right to withdraw waiver 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. 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 and administrative costs of disenrolling participants.
- 14. Adequacy of Infrastructure.** The state will 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.
- 15. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 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 section 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 section 431.408(b), State Medicaid Director Letter #01-024, and contained in the state's approved Medicaid State plan, when any program changes to the demonstration, either through amendment as set out in STC 6 and STC 7 or extension as referred to in STC 8, are proposed by the state.

- 16. Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or a later date if so identified elsewhere in these STCs or in the list of waiver or expenditure authorities.

17. 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, MCOs and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

18. Common Rule Exemption. The state must ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and which are designed to study, evaluate, or otherwise examine the Medicaid program – including public benefit or service programs; procedures for obtaining Medicaid benefits or services; possible changes in or alternatives to those programs or procedures; or possible changes in methods or level of payment for benefits or services under those programs. 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 46.101(b)(5).

IV. ELIGIBILITY AND ENROLLMENT

19. Eligibility Groups Affected by the Demonstration. Under the demonstration, there is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan. All affected groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable.

V. DEMONSTRATION PROGRAMS AND BENEFITS

20. Opioid Use Disorder/Substance Use Disorder Program. Effective upon CMS' approval of the OUD/SUD Implementation Protocol the demonstration benefit package for beneficiaries will include OUD/SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD), which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Illinois Medicaid recipients who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits, which would otherwise be matchable if the beneficiary were not residing in an IMD. Illinois will aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in Section VIII below, to ensure short-term residential treatment stays. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

The coverage of OUD/SUD treatment services, withdrawal management, SUD case management, and recovery coaching during short term residential and inpatient stays in IMDs will expand the state’s current OUD/SUD benefit package available to all Illinois Medicaid beneficiaries as outlined in Table 1. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 1: Illinois OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Expenditure Authority
Outpatient Services	State plan (Individual services covered)	
Intensive Outpatient Services	State plan (Individual services covered)	
Residential Treatment	State plan (Individual services covered)	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	State plan	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	State plan	Services provided to individuals in IMDs
Clinically Managed Withdrawal Management	1115 Expenditure Authority	Services provided to individuals in IMDs
SUD Case Management	1115 Expenditure Authority	Services provided to individuals in IMDs
Peer Recovery Support Services	1115 Expenditure Authority	Services provided to individuals in IMDs

21. SUD Implementation Protocol. The state must submit a SUD Implementation Protocol within 90 calendar days after approval of this demonstration. The state may not claim FFP for services provided in IMDs until CMS has approved the SUD Implementation Protocol. Once approved, the SUD Implementation Protocol will be incorporated into the STCs, as Attachment D, and once incorporated, may be altered only with CMS approval. The state must explain how the enrollment limits that apply to each of the pilots) will affect access to services and the state’s strategy to ensure individuals have adequate access to needed services in the implementation protocol. The state is not imposing enrollment limits on any service covered under the Medicaid state plan. In addition, the state is not imposing any enrollment limits on the residential treatment services delivered in an IMD. The state must also explain how the state will manage

enrollment, including the enrollment limits, for all of the pilots in this SUD Implementation Protocol. After approval of the Implementation Protocol, FFP will be available prospectively, not retrospectively. Failure to submit an Implementation Protocol 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 the OUD/SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral. At a minimum, the SUD Implementation Protocol must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD component of this demonstration program:

- a. Access to Critical Levels of Care for OUD and other SUDs: Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;
- b. 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 American Society of Addiction Medicine (ASAM) criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;
- c. 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 SUD program demonstration approval;
- d. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities: Currently, 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 Alcoholism and Substance Abuse (DASA) contractual provider manual. The state will 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 OUD/SUD program demonstration approval;
- e. 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 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 SUD program demonstration approval;
- f. 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 SUD program demonstration approval;
- g. Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for OUD: An assessment of the availability of providers in the key 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 SUD program demonstration approval;
 - h. 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;
 - i. SUD Health IT Plan: Implementation of the milestones and metrics as detailed in STC 27; and
 - j. Improved Care Coordination and Transitions 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 SUD program demonstration approval.

22. SUD Monitoring Protocol. The state must submit a SUD Monitoring Protocol within 150 calendar days after approval of SUD program under this demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment E. At a minimum, the SUD Monitoring Plan Protocol will include reporting relevant to each of the program implementation areas listed in STC 21. The protocol will also describe the data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion. The SUD Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 40 of the demonstration. In addition, for each performance measure, the SUD Monitoring Protocol will identify a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points.

Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements. Progress on the performance measures identified in the Monitoring Protocol will be reported via the quarterly and annual monitoring reports.

23. Mid-Point Assessment. The state must conduct an independent mid-point assessment by December 31, 2020 of the demonstration. The assessor must collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-

point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The mid-point assessment will also provide a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor will provide a 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. A copy of the report will be provided to CMS. CMS will be briefed on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the SUD Implementation Protocol and SUD Monitoring Protocol for ameliorating these risks subject to CMS approval.

24. Deferral for Insufficient Progress Towards Milestones and Failure to Report

Measurement Data. If the state does not demonstrate sufficient progress on milestones, as specified in the SUD Implementation Protocol, as determined by CMS, or fails to report data as approved in the SUD Monitoring Protocol, CMS will defer funds in the amounts specified in STC 41 and STC 42 for each incident of insufficient progress or failure to report in each reporting quarter.

25. SUD Evaluation. The OUD/SUD Evaluation will be subject to the requirements listed in sections VIII General Reporting Requirements and X Evaluation of the Demonstration of the STCs.

26. SUD Evaluation Design. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than 180 days after the effective date of these STCs. 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 state must use an independent evaluator to develop the draft Evaluation Design.

- a. Evaluation Design Approval and Updates: The state must submit a revised draft Evaluation Design within 60 days after receipt of CMS' comments. 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 within 30 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 Reports and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs. 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.

- b. Evaluation Questions and Hypotheses Specific to OUD/SUD Program: Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets 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 (NQF).

27. SUD Health Information Technology (Health IT). The state will provide CMS with an assurance that it has a 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—or it will submit to CMS a plan to develop the infrastructure/capabilities. This “SUD Health IT Plan,” or assurance will be included as a section of the state’s SUD Implementation Protocol (see STC 21) to be approved by CMS. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

- a. The SUD Health IT section of the SUD Implementation Protocol will include implementation milestones and dates for achieving the milestones.
- b. The SUD Health IT Plan must be aligned with the state’s broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state’s Behavioral Health (BH) “Health IT” Plan.
- c. The SUD Health IT Plan will describe the state’s goals, each DY, to enhance the state’s prescription drug monitoring program’s (PDMP).¹

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.

- d. The SUD Health IT Plan will address how the state’s PDMP will enhance ease of use for prescribers and other state and federal stakeholders.² This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients’ history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
- e. The SUD Health IT Plan will, as applicable, describe the state’s capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state’s ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.
- f. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.³
- g. In developing the Health IT Plan, states should use the following resources:
 - i. States may use resources at Health IT.Gov (<https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/>) in “Section 4: Opioid Epidemic and Health IT.”
 - ii. States may also use the CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” at <https://www.medicare.gov/medicaid/data-and-systems/hie/index.html>. States should review the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.
 - iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration
- h. The state will include in its SUD Monitoring Plan (see STC 22) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.
- i. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (see STC 44).
- j. As applicable, the state should advance the standards identified in the ‘Interoperability Standards Advisory—Best Available Standards and Implementation

² *Ibid.*

³ Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

Specifications’ (ISA) in developing and implementing the state’s SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

- i. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or 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, barring another compelling state interest.
- ii. 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, barring no other compelling state interest.

28. Clinically Managed Residential Withdrawal Management Pilot. Under this pilot, the state will cover clinically managed withdrawal management services under expenditure authority because the state may implement this pilot less than statewide and may institute annual enrollment limits.

Description of Eligibility

Beneficiaries are eligible for this pilot if a Physician or Licensed Practitioner of the Healing Arts determines the beneficiary demonstrates moderate withdrawal signs and symptoms, has a primary diagnosis of OUD/SUD, and requires 24-hour structure and support to complete withdrawal management and increase the likelihood of continuing treatment and recovery.

The state may institute annual enrollment limits in this pilot as specified in the table below:

Demonstration Year (DY)	Enrollment Limit (beneficiaries)
DY 1	3,875
DY 2	7,529
DY 3	11,072
DY 4	11,072
DY 5	11,072

Description of Services

Withdrawal management services must be recommended by a Physician or a Licensed Practitioner of the Healing Arts and must be delivered in accordance with an individualized plan of care.

The components of withdrawal management services are:

- a. Intake: The process of admitting a beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment

- needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
- b. **Observation:** The process of monitoring the beneficiary’s course of withdrawal. To be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary’s health status.
 - c. **Medication Services:** The prescription or administration related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by staff lawfully authorized to provide such services within their scope of practice or license.
 - d. **Discharge Services:** The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment.

Provider Qualifications

Services provided are administered by a qualified treatment professional in a DASA-licensed residential facility.

Practitioner	Qualifications	Services
Qualified treatment professional	<p>Hold a clinical certification as a Certified Alcohol and Drug Counselor from the Illinois Alcoholism and Other Drug Abuse Professional Certification Association (IAODAPCA); or</p> <p>be a licensed professional counselor or licensed clinical professional counselor pursuant to the <i>Professional Counselor and Clinical Professional Counselor Licensing Act</i>; or</p> <p>be a physician licensed to practice medicine in all its branches pursuant to the <i>Medical Practice Act of 1987</i>; be licensed as a psychologist pursuant to the <i>Clinical Psychology Practice Act</i>; or</p> <p>be licensed as a social worker or licensed clinical social worker pursuant to the <i>Clinical Social Work and Social Work Practice Act</i>.</p>	Intake, observation, medication services and discharge services

29. SUD Case Management Pilot. Under this pilot, the state will cover case management services under expenditure authority because the state may implement this pilot less than statewide and may institute annual enrollment limits.

Description of Eligibility

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.

The state may institute annual enrollment limits in this pilot as specified in the table below:

Demonstration Year (DY)	Enrollment Limit (beneficiaries)
DY 1	2,040
DY 2	2,440
DY 3	2,835
DY 4	2,835
DY 5	2,835

Description of 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:

- i. Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services;
- ii. Transition to a higher or lower level SUD of care;
- iii. Development and periodic revision of a client plan that includes service activities;
- iv. Communication, coordination, referral and related activities;
- v. Monitoring service delivery to ensure beneficiary access to services and the service delivery system;
- vi. Monitoring the beneficiary’s progress; and
- vii. Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services.

Provider Qualifications

Practitioner	Qualifications	Services
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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
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30. Peer Recovery Support Services Pilot. Under this pilot, the state will cover peer recovery support services under expenditure authority because the state may implement this pilot less than statewide and may institute annual enrollment limits.

Description of Eligibility

Beneficiaries receiving SUD treatment, have a primary diagnosis of OUD/SUD, and have an assessed need by a physician or other licensed practitioner of the healing arts for recovery support are eligible for this pilot.

The state may institute annual enrollment limits in this pilot as specified in the table below:

Demonstration Year (DY)	Enrollment Limit (beneficiaries)
DY 1	160
DY 2	240
DY 3	240
DY 4	320
DY 5	320

Description of Services

Peer recovery support services are delivered by individuals in recovery from a substance use disorder (peer recovery coach) who is certified to provide counseling support to help prevent relapse and promote recovery.

Provider Qualifications

Provider	Qualifications	Services
Certified Peer Recovery Coach	Certification through an Illinois Department of Human Services-approved training program that provides peer recovery coaches with a basic set of competencies necessary to perform the peer support function.	Evidence-based practices that provide counseling support and care coordination activities that connect beneficiaries with resources and services

	<p>Peer recovery coaches must be supervised by a competent behavioral health professional (as defined by the State) and must demonstrate the ability to support the recovery of others from substance use disorders.</p> <p>Peer recovery coaches must participate in ongoing continuing education.</p>	<p>that help prevent relapse and promote recovery.</p>
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31. Crisis Intervention Services Pilot. Under this pilot, the state will cover mental health services under expenditure authority because the state may implement this pilot less than statewide and may institute annual enrollment limits. The state may not claim, and CMS will not make available, FFP for services delivered in any facilities that meet the definition of Institution for Mental Diseases (IMD) under this pilot unless for services provided in accordance with the inpatient psychiatric services for individuals under age 21 benefit as set forth in section 1905(a)(16) of the Act and in 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

Description of Eligibility

Beneficiaries aged 6 through 64 who are experiencing a psychiatric crisis and require stabilization and support, including 24-hour clinical supervision and observation are eligible for this pilot.

The state may institute annual enrollment limits in this pilot as specified in the table below:

Demonstration Year (DY)	Enrollment Limit (number of episodes)
DY 1	4247
DY 2	6370
DY 3	8493
DY 4	8493
DY 5	8493

Description of Services

Crisis intervention services support stabilization, rapid recovery, and discharge of the individual experiencing psychiatric crisis. The services covered in this pilot include:

- a. Crisis assessment and stabilization: Assessing the crisis situation and providing immediate clinical attention to prevent exacerbation of the condition(s) and prevent injury to the beneficiary or others.
- b. Treatment Planning: The provider shall prepare an individualized written treatment plan, based upon information obtained in the assessment process.

- c. Counseling services: Short-term counseling designed to stabilize the beneficiary;
- d. Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual or family member with ongoing care to prevent future crises.

Services provided to the beneficiary’s family and significant persons in the life of the beneficiary must be for the direct benefit of the beneficiary, in accordance with the beneficiary’s needs and treatment goals identified in the beneficiary’s treatment plan, and for the purpose of assisting in the beneficiary’s recovery. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act. The state may not claim, and CMS will not make available, FFP for services provided in any facilities that meet the definition of an Institution for Mental Diseases (IMD) under this pilot unless for services provided in accordance with the inpatient psychiatric services for individuals under age 21 benefit as set forth in section 1905(a)(16) of the Act and in 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

Provider Qualifications

Services are provided in a licensed acute care general hospital, a Psychiatric Residential Treatment Facility (PRTF), or a community residential treatment center that has 16 or fewer beds and does not meet the definition of an IMD. All services are administered by a qualified mental health professional or rehabilitative services associate. The provider qualifications under this pilot are the same as the qualifications described in the Medicaid state plan in the Appendix to Attachment 3.1-A Pages 16 and 16(A).

32. Evidence-based Home Visiting Services Pilot. Under this pilot, the state will cover evidence-based home visiting services under expenditure authority because the state may implement this pilot less than statewide and may institute annual enrollment limits.

Description of Eligibility

Beneficiaries eligible who are mothers during their 60 day postpartum period who gave birth to a baby born with withdrawal symptoms and Medicaid eligible children up to 5 years old who were born with withdrawal symptoms as elaborated upon below are eligible for this pilot.

The state may institute annual enrollment limits in this pilot as specified in the table below:

Demonstration Year (DY)	Enrollment Limit (by Medicaid family unit)
DY 1	218
DY 2	467
DY 3	769
DY 4	893
DY 5	1,038

Description of Services

The state will provide the evidence-based home visiting services described below.

Postpartum Home Visiting Services

Under this pilot, the state will cover evidence-based postpartum home visit services to beneficiaries during their 60 day postpartum period.

- Diet and nutritional education;
- Stress management;
- STD prevention education;
- Tobacco use screening and cessation education;
- Alcohol and other substance misuse screening and counseling;
- Depression screening;
- Domestic and intimate partner violence screening and education;
- Breastfeeding support and education (NFP may refer beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service);
- Guidance and education with regard to well woman visits to obtain recommended preventive services;
- Medical assessment of the postpartum mother and infant (NFP only);
- Maternal-infant safety assessment and education (e.g., safe sleep education for Sudden Infant Death Syndrome (SIDS) prevention);
- Counseling regarding postpartum recovery, family planning, needs of a newborn;
- Assistance for the family in establishing a primary source of care and a primary care provider (e.g., ensure that the mother/ infant has a postpartum/ newborn visit scheduled); and
- Parenting skills and confidence building.

Child Home Visit Services

Under this pilot, the state will cover home visit services to Medicaid eligible newborn infants born with withdrawal symptoms to beneficiaries until the child reaches 5 years of age. The Medicaid child is eligible to receive services until they are 5 years old as long as they continue to be eligible for Medicaid and the demonstration is in effect. For example, if the demonstration is not renewed, a child may only receive services up to the date of expiration of the demonstration.

- Breastfeeding support and education (EBHVP providers may refer beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service);
- Child developmental screening at major developmental milestones from birth to age 5; and
- Parenting skills and confidence building.

Provider Qualifications

Qualified mental health professionals and mental health professionals will provide the home visiting services. The provider qualifications under this pilot are the same as the qualifications described in the Medicaid state plan in the Appendix to Attachment 3.1-A Pages 16 and 16(A).

33. HCBS Requirements for the 1915(i)-like Pilots. Under the demonstration, the state will also implement four pilots that are similar to services that could be provided under a 1915(i) state plan amendment. The state has elected to cover these services under expenditure authority to allow limitations on services that would not be allowable under a 1915(i) state plan amendment as the state may implement this pilot less than statewide and may institute annual enrollment limits. The four pilots are listed below and described in more detail in STCs 34 through 37.

- Assistance in Community Integration Services Pilot
- Supported Employment Services Pilot
- Intensive In-Home Services Pilot
- Respite Pilot

The state must comply with the following HCBS requirements for all of the pilots listed above.

- a. **Person-Centered Planning.** The state agrees to use person-centered planning processes to identify eligible clients' HCBS needs and the resources available to meet those needs, and to identify clients' additional service and support needs.
- b. **Conflict of Interest.** The state agrees that the entity that authorizes the services is external to the agency or agencies that provide pilot services. The state also agrees that separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.
- c. **HCBS Requirements.** The state will assure compliance with all HCBS requirements, including for those services that could be authorized under section 1915(i).

34. Assistance in Community Integration Services (ACIS) Pilot. Under this pilot, the state will cover a set of HCBS, specifically assistance in community integration services that could be covered under a 1915(i) state plan amendment. The state has elected to cover these services under expenditure authority to allow limitations on the services that would not otherwise be allowable under a 1915(i) state plan amendment as the state may implement this pilot less than statewide and may institute annual enrollment limits.

Description of Eligibility

Eligibility for these services include individuals who would be eligible under a 1915(i) SPA program as described in the needs-based criteria below.

The state’s needs-based criteria are specified below:

- a. Health criteria (at least one)
 - i. Repeated incidents of emergency department (ED) use (defined as more than 4 visits per year) or hospital admissions or
 - ii. Two or more chronic conditions as defined in Section 1945(h)(2) of the Act.
- b. Housing Criteria (at least one)
 - i. Individuals who will experience homelessness upon release from the settings defined in 24 CFR 578.3; or
 - ii. Those at imminent risk of institutional placement.

The state may institute annual enrollment limits in this pilot as specified in the table below:

Demonstration Year (DY)	Enrollment Limit (beneficiaries)
DY 1	n/a – State will not implement the pilot until DY 2.
DY 2	2,250
DY 3	2,800
DY 4	3,375
DY 5	3,750

Description of Services

- a) Pre-tenancy supports:
 - i. Conducting a functional needs assessment identifying the beneficiary’s preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual); providing assistance in budgeting for housing and living expenses; and providing assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of tenancy.
 - ii. Assisting beneficiaries with connecting to social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs.
 - iii. Developing an individualized plan based upon the functional needs assessment as part of the overall person centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed.
 - iv. Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
 - v. Providing supports and interventions per the person-centered plan.

b) Tenancy sustaining services:

- i. Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
- ii. Coordinating and linking the recipient to services and service providers including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports.
- iii. Entitlement assistance including assisting beneficiaries in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency.
- iv. Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports.
- v. Providing supports to assist the beneficiary in the development of independent living skills, such as skills coaching, financial counseling, and anger management.
- vi. Providing supports to assist the beneficiary in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
- vii. Coordinating with the beneficiary to review, update and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
- viii. Connecting the beneficiary to training and resources that will assist the individual in being a good tenant and lease compliance, including ongoing support with activities related to household management.

The state will not cover the following services under this pilot:

- a. Payment of rent or other room and board costs;
- b. Capital costs related to the development or modification of housing;
- c. Expenses for utilities or other regular occurring bills;
- d. Goods or services intended for leisure or recreation;
- e. Duplicative services from other state or federal programs; and
- f. Services to individuals in a correctional institution or an IMD.

Provider Qualifications

Provider	Education (minimum)	Experience (minimum)	Skills (preferred)	Services
Assistance in Community Integration Services 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 Assistance in Community Integration Services meant to support the client’s ability to obtain and maintain residence in independent community settings.	Pre-tenancy supports, tenancy sustaining services (as outlined above).

35. Supported Employment Services Pilot. Under this pilot, the state will cover a set of HCBS, specifically employment services that could be covered under a 1915(i) state plan amendment. The state has elected to cover these services under expenditure authority to allow limitations on the services that would not otherwise be allowable under a 1915(i) state plan amendment as the state may implement this pilot less than statewide and may institute annual enrollment limits.

Description of Eligibility

The pilot serves Medicaid beneficiaries aged 14 or older who meet the criteria below. The beneficiary meets at least one of the following health needs-based criteria and is expected to benefit from supported employment services, which means expressing a desire to work:

Beneficiary assessed to have a behavioral health need, which is defined as one or both of the following criteria:

- 1) 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; and/or

- 2) Substance use needs, where an assessment using the American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient SUD treatment. The ASAM is a multi-dimensional assessment approach for determining a beneficiary's need for SUD treatment.

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

- 1) Unable to be gainfully employed for at least 90 consecutive days due to a mental or substance use impairment.
- 2) More than one instance of inpatient substance use treatment in the past 2 years.
- 3) At risk of deterioration from mental illness and/or SUD, including one or more of the following:
 - a) Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness.
 - b) 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.
 - c) Past psychiatric history, with no significant functional improvement that can be maintained without treatment and/or supports.
 - d) Dysfunction in role performance, including one or more of the following:
 - i) Behaviors that disrupt employment or schooling, or put employment at risk of termination or schooling suspension.
 - ii) A history of multiple terminations from work or suspensions/expulsions from school.
 - iii) Cannot succeed in a structured work or school setting without additional support or accommodations.
 - iv) Performance significantly below expectation for cognitive/developmental level.

The state may institute annual enrollment limits in this pilot as specified in the table below:

Demonstration Year (DY)	Enrollment Limit (beneficiaries)
DY 1	n/a - State will not implement the pilot until DY 2.
DY 2	2,250
DY 3	2,800
DY 4	3,375

DY 5	3,750
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Description of Services

The services under this pilot are described specifically below.

Supported Employment Services benefit package: The supported employment services benefit package will be offered to eligible beneficiaries through a person-centered planning process where 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 to be necessary for an individual to obtain and maintain employment in the community. Supported employment services are individualized and may include any combination of the following services:

Pre-employment services:

- a. Pre-vocational/job-related discovery or assessment
- b. Person-centered employment planning
- c. Individualized job development and placement
- d. Job carving
 - o 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.
- e. Benefits education and planning
 - o 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.
- f. Transportation (only in conjunction with the delivery of an authorized service)

Employment sustaining services:

- a. Career advancement services
 - o 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.
- b. 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.
- c. 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.
- d. Job coaching
- e. 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.
- f. Transportation (only in conjunction with the delivery of an authorized service)
- g. 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.
- h. 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.

The supported employment services benefit does not include:

- a. Generalized employer contacts that are not connected to a specific enrolled individual or an authorized service
- b. Employment support for individuals in sub-minimum wage, or sheltered workshop settings
- c. Facility-based habilitation or personal care services
- d. Wage or wage enhancements for individuals
- e. Duplicative services from other state or federal programs

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).

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.

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 – 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).

36. Intensive In-Home Services Pilot. Under this pilot, the state will cover intensive in home services, which include face-to-face, time-limited, focused interventions to stabilize behaviors that may lead to crisis or may result in inpatient hospitalizations or residential care and the state may implement this pilot less than statewide and may institute annual enrollment limits.

Description of Eligibility

Beneficiaries aged 3 to 21 who meet the requirements of Tier A (high physical, high behavioral health needs) or Tier B (high behavioral health, low physical needs) of the Integrated Health Home. The beneficiary must have at least one of the following:

- i. A history of the following: Frequently experiences hallucinations, delusions, unusual thought processes, strange thought processes and bizarre/idiosyncratic behavior. Evidence of ongoing delusions or hallucinations or both.
- ii. Risk of more than one inpatient psychiatric hospital admission within the past 12 months and meeting three or more of the clinical criteria from the IM-CANS in the following categories:
 - 1. Behavioral or emotional needs
 - 2. Risk behaviors
 - 3. Caregiver Resources and needs
 - 4. Life functioning domains
- iii. Risk of having one or more crisis episodes (i.e., Mobile Crisis Response contacts) within the last 6 months and meeting three or more of the clinical criteria from the IM-CANS in the following categories:
 - 1. Behavioral or emotional needs
 - 2. Risk behaviors
 - 3. Caregiver Resources and needs
 - 4. Life functioning domains

The state may institute annual enrollment limits in this pilot as specified in the table below:

Demonstration Year (DY)	Enrollment Limit (beneficiaries)
DY 1	n/a - State will not implement the pilot until DY 2.
DY 2	10,775
DY 3	15,852
DY 4	18,650
DY 5	18,650

Description of Services

The intensive in-home services covered under this pilot consist of the following two services defined below:

- a. Intensive In-Home Clinical (IIH-C)
 - o IIH-C is a face-to-face, time-limited, focused intervention targeted to

support and stabilize a child/youth in their home or home-like setting. IIH-C is a strengths-based, individualized, and therapeutic service driven by a clinical intervention plan that is focused on symptom reduction.

- b. Intensive In-Home Support (IIH-S)
 - o IIH-S is a time-limited, focused intervention targeted to support and stabilize a child/youth in their home or home-like setting. IIH-S is an adjunct service that may only be provided in conjunction with Intensive In-Home - Clinical (IIH-C) services. The goal of IIH-S is to support the client and family in implementing the therapeutic interventions, skills development, and behavioral techniques that are focused on symptom reduction, as outlined in the IIH-C clinical intervention plan.

Provider Qualifications

Provider	Education (minimum)	Experience (minimum)	Skills (preferred)	Services
Community Mental Health Centers (CMHCs)	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 arrangements of a CMHC.	Formal, face-to-face therapeutic contacts with the client or client’s family, as specified in the clinical education plan.
Behavioral Health Clinics (BHCs)	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 arrangements of a BHC.	Formal, face-to-face therapeutic contacts with the client or client’s family, as specified in the clinical education plan.

37. Respite Services Pilot. Under this pilot, the state will cover respite services that could be covered under a 1915(i) state plan amendment. The state has elected to cover these services under expenditure authority as the state may implement this pilot less than statewide and may institute annual enrollment limits.

Description of Eligibility

Respite services provide safe and supportive environments on a short-term basis to Medicaid clients age 3 up to age 21 with behavioral health conditions when their families need relief. The services are available beginning in demonstration year 3 (beginning July 1, 2020). The beneficiary must meet the requirements of the Tier A (high physical, high behavioral health needs) or Tier B (high behavioral health, low physical needs) of the Integrated Health Home. The beneficiary must have at least one of the following:

- a. Rating of three on psychosis (thought disorder) in the core items of the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS). A rating of three indicates the individuals’ problems are dangerous or disabling requiring immediate and/or intensive action. An individual may experience dangerous hallucinations, delusions, or bizarre behavior. Behavior may be associated with a psychotic disorder that places the individual or others at risk of physical harm.
- b. Risk factor of more than one inpatient psychiatric hospital admission within the past 12 months and meet three or more of the clinical criteria from the IM-CANS in the following categories:
 - a. Behavioral or emotional needs
 - b. Risk behaviors
 - c. Caregiver Resource sand needs
 - d. Life functioning domains.
- c. Risk factor of having one or more crisis episodes (i.e., Mobile Crisis Response contacts) within the last 6 months and meeting three or more of the clinical criteria from the IM-CANS in the following categories:
 - a. Behavioral or emotional needs
 - b. Risk behaviors
 - c. Caregiver Resource sand needs
 - d. Life functioning domains.

The state may institute annual enrollment limits in this pilot as specified in the table below:

Demonstration Year (DY)	Enrollment Limit (beneficiaries)
DY 1	n/a - State will not implement the pilot until DY 3.
DY 2	n/a - State will not implement the pilot until DY 3.
DY 3	3,871

DY 4	3,871
DY 5	3,871

Description of Services

Respite care is a set of individualized time-limited services that provide families scheduled relief to help prevent stressful situations, including avoiding a crisis or escalation within the home. Services can be delivered in or out of the home as long as they take place in community-based settings.

- Services must be provided on a scheduled basis and planned as part of a child’s individualized care plan and therefore are not to be utilized as emergency child care
- Services will be culturally competent and aligned with the family’s beliefs and preferences
- Services shall not exceed seven hours per event, 21 hours per month, or 130 hours annually
- Services are not standalone and must be offered in conjunction with other treatment services

Provider Qualifications

Provider	Education (minimum)	Experience	Skills (preferred)	Services
Respite 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 respite services (as outlined above), or comparable services that support the Medicaid beneficiary	Respite services (as outlined above).

VI. COST SHARING

38. Cost Sharing. Cost sharing imposed upon individuals under the demonstration is consistent with the provisions of the approved state plan.

VII. DELIVERY SYSTEM

39. Delivery System. Illinois' SUD/ODU Medicaid delivery system is based on an integrated managed care model for physical and behavioral health. It utilizes Managed Care Organizations (MCOs) to deliver integrated physical and behavioral health services, including SUD, for individuals enrolled in managed care. The state delivers SUD services via FFS for beneficiaries who are not in mandatory managed care or who are still in their managed care plan choice period. The state must inform CMS 60 days from the date of approval if it will deliver the pilot services via its managed care plans or via FFS. The state must send a letter to CMS within 60 days of approval explaining which pilot services will be delivered via the managed care plans for the beneficiaries enrolled in managed care and which pilot services, if any, will be delivered FFS for individuals enrolled in managed care. The state will deliver all pilot services for individuals not enrolled in managed care via FFS. Starting July 1, 2018, all SUD demonstration services are delivered through a managed care delivery system, with the exception of the dual eligible population, American Indians/Alaska Natives (AI/AN), participants who are presumptively eligible, participants in the Breast and Cervical Cancer program, participants with comprehensive third party insurance, and participants eligible through Asylees and Torture Victims. Beginning October 1, 2018, title V children and the spend-down medically needy population will receive their Medicaid state plan services and the OUD/SUD treatment services via managed care. The exempted populations receive services via the fee-for-service (FFS) delivery system, including OUD/SUD treatment services.

VIII. GENERAL REPORTING REQUIREMENTS

40. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

41. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of \$5,000,000 (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 singly or collectively referred to as "deliverable(s)")) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

- a. Thirty calendar days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
- b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).
 - i. CMS may decline the extension request.
 - ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.

- iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.
- c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
- d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
- e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.
- f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example, what quarter the deferral applies to and how the deferral is released.

42. 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 the Implementation Protocol 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.

43. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 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 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.

IX. MONITORING

44. Monitoring Reports. The state must submit three Quarterly Reports and one compiled Annual Report each DY. The information for the fourth quarter should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60 calendar days) following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90 calendar days) following the end of the DY. 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 Monitoring Reports must follow the framework 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 shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
- b. Performance Metrics: Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing 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 should be reported separately.
- 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.
- e. SUD Health IT: The state will include a summary of progress made in regards to SUD Health IT requirements outlined in STC 27.

45. Close-Out Report. Within 120 calendar days prior to the expiration of the demonstration, the state must submit a Draft Close-Out Report to CMS for comments.

- a. The draft report must comply with the most current guidance from CMS.
- b. The state will present to and participate in a discussion with CMS on the close-out report.
- c. The state must take into consideration CMS' comments for incorporation into the final close-out report.

- d. The final close-out report is due to CMS no later than 30 calendar days after receipt of CMS' comments.
- e. A delay in submitting the draft or final version of the close-out report may subject the state to penalties described in STC 41.

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

- a. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.
- b. CMS will provide updates on any amendments or concept papers under review, 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.

47. 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 calendar 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 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 quarter in which the forum was held, as well as in its compiled Annual Report.

X. EVALUATION OF THE DEMONSTRATION

48. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with 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 accord with the CMS-approved, draft 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.

49. 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.

50. Draft Evaluation Design. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than 180 days after the effective date of these STCs. 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 state must use an independent evaluator to develop the draft Evaluation Design.

51. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within 60 days after receipt of CMS' comments. 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 days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. 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.

52. 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 documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets 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 (NQF).

53. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's 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 that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

- c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due 1 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 the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
- e. The Interim Evaluation Report must comply with Attachment B of these STCs.

54. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period, July 1, 2018 through June 30, 2023, within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

- a. Unless otherwise agreed upon in writing by CMS, the state must submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
- b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

55. 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, and/or the summative evaluation.

56. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

57. 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. 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 10 business 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.

58. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall 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 shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal 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 STC 42.

XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

59. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures subject to the Budget Neutrality agreement:

- a. Tracking Expenditures: In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the BN expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00304/0) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered.
- b. Cost Settlements: For monitoring purposes, cost settlements attributable to the demonstration must be recorded 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. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
- c. Pharmacy Rebates: When claiming these expenditures the state may refer to the July 24, 2014 CMCS Informational Bulletin, which contains clarifying information for quarterly reporting of Medicaid Drug Rebates in the Medicaid Budget and Expenditures (MBES) (<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-24-2014.pdf>). The state must adhere to the requirement at section 2500.1 of the State Medicaid Manual that all state collections, including drug rebates, must be reported on the CMS-64 at the applicable Federal Medical Assistance Percentage (FMAP) or other matching rate at which related expenditures were originally claimed.

- d. Use of Waiver Forms: For each demonstration year, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver names listed below. Expenditures should be allocated to these forms based on the guidance which follows.
- i. SUD IMD: All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD.
 - ii. Withdrawal Mngt: All expenditures for costs of withdrawal management services.
 - iii. SUD Case Mngt: All expenditures for costs of SUD case management services.
 - iv. Peer Supports: All expenditures for peer supports pilot services.
 - v. Crisis Intervention: All expenditures for costs of crisis beds pilot services.
 - vi. EBHV: All expenditures for costs of evidence-based home visiting pilot services.
 - vii. ACIS: All expenditures for the Assistance in Community Integration Services pilot.
 - viii. SupportEmploy: All expenditures for the supported employment pilot services.
 - ix. InHomeServices: All expenditures for the intensive in-home pilot services.
 - x. Respite: All expenditures for respite pilot services.

For each demonstration year, separate Forms CMS-64.21 Waiver and/or CMS-64.21P Waiver must be completed, using the waiver names listed below for the title XXI-funded children who receive services through these pilots:

- i. Crisis Intervention: All title XXI expenditures for costs of crisis beds pilot services for the title XXI-funded children eligible under the Medicaid state plan.
- ii. InHomeServices: All title XXI expenditures for costs of crisis beds pilot services for the title XXI-funded children eligible under the Medicaid state plan.

- e. Demonstration Years. The demonstration years are as follows:

Demonstration Year 1	July 1, 2018 through June 30, 2019	12 Months
Demonstration Year 2	July 1, 2019 through June 30, 2020	12 Months
Demonstration Year 3	July 1, 2020 through June 30, 2021	12 Months
Demonstration Year 4	July 1, 2021 through June 30, 2022	12 Months

Demonstration Year 5	July 1, 2022 through June 30, 2023	12 Months
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60. Budget Neutrality Monitoring Tool. The state and CMS will jointly develop a budget neutrality (BN) monitoring tool (using a mutually agreeable spreadsheet program) for the state to use for quarterly BN status updates including established baseline and member months data and other in situations when an analysis of BN is required. The tool will incorporate the “C Report” for monitoring actual expenditures subject to BN. A working version of the monitoring tool will be available for the state’s first Annual Report.

61. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided through this under the Medicaid program, including those provided through the demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. 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.

FFP will be provided for expenditures net of collections in the form of pharmacy rebates, cost sharing, or third party liability.

62. Expenditures Subject to the Budget Neutrality Agreement. For the purpose of this section, the term “expenditures subject to the budget neutrality agreement” means expenditures for the EGs outlined in Section XII, Monitoring Budget Neutrality for the Demonstration, except where specifically exempted. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

63. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using separate CMS-64.10 waiver and 64.10 waiver forms, with waiver name “ADM.”

64. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2 year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

65. Reporting Member Months. The following describes the reporting of member months for demonstration populations.

- a. For the purpose of calculating the BN expenditure limit and for other purposes, the state must provide to CMS, as part of the BN Monitoring Tool required under STC 59, the actual number of eligible member months for the each MEG defined in subparagraph D below. The state must submit a statement accompanying the BN Monitoring Tool, which certifies the accuracy of this information. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revision.
- b. The term “eligible member/months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.
- c. The state must report separate member month totals for individuals enrolled in the Illinois Behavioral Health Transformation demonstration and the member months must be subtotaled according to the MEGs defined in STC 58(d).
- d. The required member month reporting MEGs are:
 - i. SUD IMD: SUD IMD Member Months are months of Medicaid eligibility during which the individual is an inpatient in an IMD under terms of the demonstration for any day during the month and must be reported separately.
 - ii. WithdrawalMngt: Withdrawal Management member months are months of Medicaid eligibility when the individual is receiving withdrawal management services for any day during the month and must be reported separately.
 - iii. SUD Case Mngt: Case Management member months are months of Medicaid eligibility when the individual is receiving SUD Case Mngt services for any day during the month and must be reported separately.
 - iv. Peer Supports: Peer Supports member months are months of Medicaid eligibility when the individual is receiving peer supports services for any day during the month and must be reported separately.
 - v. Crisis Intervention: Crisis intervention services member months are months of Medicaid eligibility when the individual is receiving crisis beds services for any day during the month and must be reported separately.
 - vi. Evidence Based Home Visiting Pilot (EBHV): EBHV member months are months of Medicaid eligibility when the individual is receiving crisis beds services for any day during the month and must be reported separately.
 - vii. ACIS: ACIS member months are months of Medicaid eligibility when the individual is receiving ACIS services for any day during the month and must be reported separately.
 - viii. Supported Employment: Supported employment member months are months of Medicaid eligibility when the individual is receiving Supported Employment services for any day during the month and must be reported separately.

- ix. In-Home Services: In-Home Services member months are months of Medicaid eligibility when the individual is receiving In-Home Services for any day during the month and must be reported separately.
- x. Respite: Respite services member months are months of Medicaid eligibility when the individual is receiving respite services for any day during the month and must be reported separately.

66. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable Medicaid expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report those expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for both Medical Assistance Payments (MAP) and state and Local Administrative Costs (ADM). As a supplement to the Form CMS-37, the state will provide updated estimates of expenditures subject to the budget neutrality limit. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 calendar days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

67. Extent of Federal Financial Participation (FFP) 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 demonstration as a whole for the following, subject to the limits described in Section XII:

- 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.

68. Sources of Non-Federal Share. The state certifies that the matching non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds must not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provision, as well as the approved Medicaid state plan.

69. State Certification of Funding Conditions. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state government to return and/or redirect any portion of the Medicaid payments. 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, and 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.

70. Program Integrity. The state must have a process in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

71. Limit on Title XIX Funding. The state will be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STCs 72 and 74, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the state using the procedures described in Section XI. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

72. Risk. The state will be at risk for the per capita cost (as determined by the method described below) for state plan and hypothetical populations, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the 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.

73. Calculation of the Budget Neutrality Limit and How It Is Applied. For the purpose of calculating the overall budget neutrality limit for the demonstration, annual budget limits will be calculated for each DY on a total computable basis, by multiplying the predetermined PMPM cost for each EG (shown on the table in STC 74) by the corresponding actual member months total, and summing the results of those calculations. The annual limits will then be 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 limit by Composite Federal Share, which is defined in STC 76 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names; SUD IMD.

74. Impermissible DSH, Taxes, or Donations. CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). 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 Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

75. Main Budget Neutrality Test. The trend rates and per capita cost estimates for each EG for each year of the demonstration are listed in the table below.

MEG	TREND	DY 1 PMPM	DY 2 PMPM	DY 3 PMPM	DY 4 PMPM	DY 5 PMPM
SUD IMD Pilot	1.7%	\$3,248.30	\$3,303.52	\$3,359.68	\$3,416.79	\$3,474.88
SUD Case Management Pilot	1.7%	\$132.22	\$134.47	\$136.75	\$139.08	\$141.44
Withdrawal Management Pilot	1.7%	\$558.00	\$567.49	\$577.13	\$586.94	\$596.92
Peer Recovery Support Services Pilot	1.7%	\$162.50	\$165.26	\$168.07	\$170.93	\$173.83
ACIS Pilot	1.7%	n/a	\$416.62	\$423.71	\$430.91	\$438.24

Supported Employment Services Pilot	1.7%	n/a	\$416.70	\$423.78	\$430.99	\$438.32
Intensive In-Home Support Services Pilot	1.7%	\$948.00	\$964.12	\$980.51	\$997.17	\$1,014.13
Respite Services Pilot	1.7%	n/a	n/a	\$299.88	\$304.98	\$310.16
Evidence Based Home Visiting Pilot	1.7%	\$250.00	\$254.25	\$258.57	\$262.97	\$267.44
Crisis Intervention Services Pilot	1.7%	\$2,025.00	\$2,059.43	\$2,094.44	\$2,130.04	\$2,166.25

76. Hypothetical Model. As part of the SUD initiative, the state may receive FFP for the continuum of services to treat OUD and other SUDs, provided to Medicaid enrollees in an IMD. These are state plan services that would be eligible for reimbursement if not for the IMD exclusion. Therefore, they are being treated as hypothetical for the purposes of budget neutrality. The other pilots could all be approved under state plan authority; with the exception that the state is using additional targeting authority which would not be allowable under state plan authority. As a result, the pilot services are also being treated as hypothetical for the purposes of budget neutrality. Hypothetical services can be treated in budget neutrality in a way that is similar to how Medicaid state plan services are treated, by including them as a “pass through” in both the without-waiver and with-waiver calculations. However, the state will not be allowed to obtain budget neutrality “savings” from any of the SUD or pilot services.

77. Composite Federal Share Ratios. 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 Illinois on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/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.

78. Exceeding Budget Neutrality. The budget neutrality limits calculated in STC 72 will apply to actual expenditures for demonstration services as reported by the state under section XI of these STCs. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

79. Enforcement of Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration, rather than on an annual basis. However, if the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Target Definition	Percentage
DY 1	Cumulative budget neutrality limit	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit	1.0 percent
DY 1 through 4	Cumulative budget neutrality limit	.5 percent
DY 1 through 5	Cumulative budget neutrality limit	0 percent

XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION APPROVAL PERIOD

Due Date	Deliverable	STC
30 calendar days after approval date ⁴	Written acknowledgement of the award and acceptance of the STCs	N/A; <i>see</i> Approval letter
60 calendar days after approval date	Letter to CMS explaining which pilot services will be delivered via managed care plans and which pilot services will be delivered via FFS for beneficiaries enrolled in managed care plans	STC 39
90 calendar days after approval date	SUD Implementation Protocol	STC 21
150 calendar days after SUD program approval date	SUD Monitoring Protocol	STC 22
180 calendar days after effective date of STCs	Draft Evaluation Design	STCs 26 and 49
60 calendar days after receipt of CMS comments	Revised Draft Evaluation Design	STCs 26(a)
30 calendar days after CMS Approval	Approved Evaluation Design published to state's website	STCs 26(a) and 50
December 31, 2020	Mid-Point Assessment	STC 23
One year prior to the end of the demonstration, or with renewal application	Draft Interim Evaluation Report	STC 53
60 calendar days after receipt of CMS comments	Final Interim Evaluation Report	STC 53(d)
18 months of the end of the approval period	Draft Summative Evaluation Report	STC 54
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	STC 54(a)

⁴ Approval date refers to the date marked on the approval letter for this demonstration.

30 calendar days of CMS approval	Approved Final Summative Evaluation Report published to state's website	STC 54(b)
Periodic Deliverables	Monitoring Calls	STC 46
Quarterly Deliverables Due 60 days after end of each quarter, except 4 th quarter	Quarterly Monitoring Reports	STC 44
	Quarterly Expenditure Reports	STC 44(c)
Annual Deliverables Due 90 days after end of each 4 th quarter	Annual Reports	STC 44
Within 120 calendar days prior to the expiration of the demonstration	Draft Close-out Operational Report	STC 45
30 calendar days after receipt of CMS comments	Final Close-out Operational Report	STC 45(d)

ATTACHMENT A

Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about 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 on 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). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

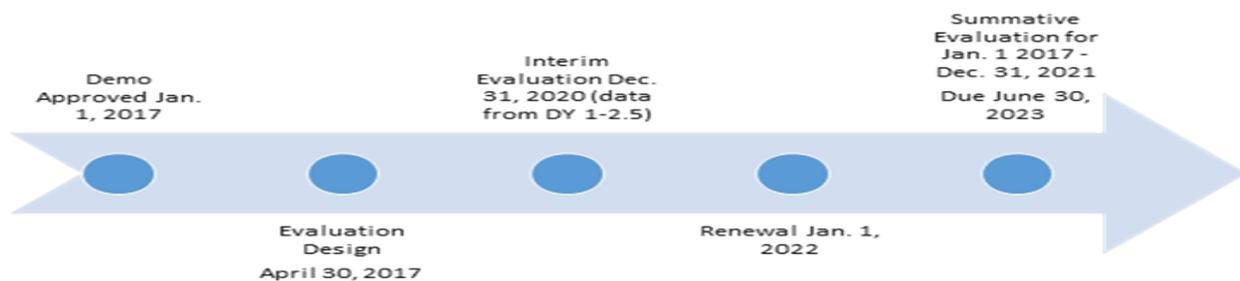
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals.

The format for the Evaluation Design is as follows:

- General Background Information;
- Evaluation Questions and Hypotheses;
- Methodology;
- Methodological Limitations;
- Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). 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) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state’s Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

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 brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
- 4) 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.
- 5) Describe the population groups impacted by the demonstration.

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

1. 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 could be measured.
 2. 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 is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. 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>
 3. Identify the state’s hypotheses about the outcomes of the demonstration:
 4. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
 5. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.
- 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, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes 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 will be measured and how. Specifically, this section establishes:

- 1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
- 2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include 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. 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.) Include numerator and denominator information. Additional items to ensure:
- a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
 - b. Qualitative analysis methods may be used, and must be described in detail.
 - c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
 - d. 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 (NQF).
 - e. 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 (HIT).
 - f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.
- 5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

- 6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to 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). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
 - b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

- c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
- d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of 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 detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the 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. For example:

- 1) When the state demonstration is:
 - a. Long-standing, non-complex, unchanged, or
 - b. Has previously been rigorously evaluated and found to be successful, or
 - c. 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; and

- b. No or minimal appeals and grievances; and
- c. No state issues with CMS-64 reporting or budget neutrality; and
- d. No Corrective Action Plans (CAP) 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, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include “No Conflict of Interest” 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 cost, 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 or if CMS finds that the draft Evaluation Design is not sufficiently developed.
- 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 an Interim and Summative Evaluation. 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

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. 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 provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on 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). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is 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). To this end, 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. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application 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.

Intent of this Guidance

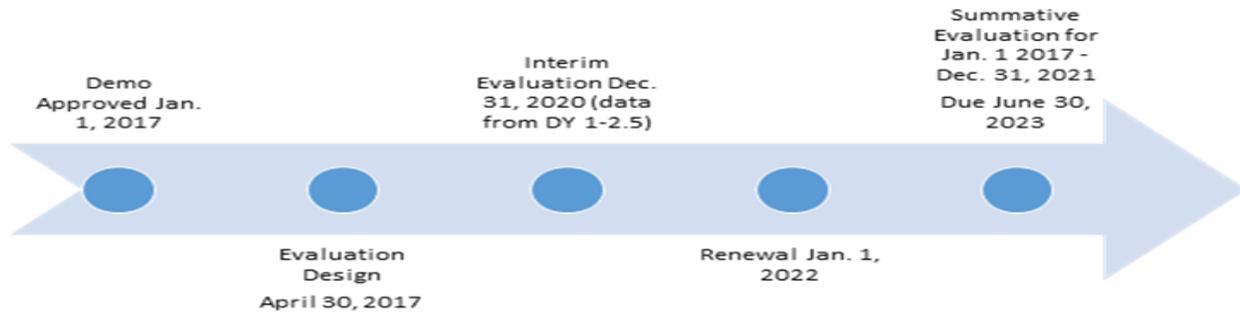
The Social Security Act (“the Act”) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance 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.

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).

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 this timeline). 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 to the state’s website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS , pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report 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. A copy of the state’s Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report 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. Therefore, the state’s submission must include:

- 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 issues 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 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;
 - 4) 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.
 - 5) Describe the population groups impacted by the demonstration.
- C. Evaluation Questions and Hypotheses** – In this section, the state should:
- 1) 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. 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.
 - 2) Identify the state’s hypotheses about the outcomes of the demonstration;
 - a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
 - b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
 - c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

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

An interim 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.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made 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. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. Evaluation Design – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. Target and Comparison Populations – Describe the target and comparison populations; include inclusion and exclusion criteria.
3. Evaluation Period – Describe the time periods for which data will be collected
4. Evaluation Measures – What measures are used to evaluate the demonstration, and who are the measure stewards?
5. Data Sources – Explain where the data will be obtained, and efforts to validate and clean the data.
6. Analytic methods – Identify specific statistical testing which will be 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.
 - A) Methodological Limitations - This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.
 - B) Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.
 - C) Conclusions – In this section, the state will present the conclusions about the evaluation results.

- 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) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
 - a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

D. 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 interpretation 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.

E. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

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?

F. Attachment

Evaluation Design: Provide the CMS-approved Evaluation Design

**Attachment C:
Reserved for Evaluation Design**

**Attachment D:
Reserved for Substance Use Disorder (SUD) Implementation Protocol**

**Attachment E:
Reserved for SUD Monitoring Protocol**