DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

December 12, 2025

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

Dear Director Phelan:

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

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

Sincerely,

Angela D. Garner -S
Digitally signed by Angela D. Garner -S
Date: 2025.12.12 10:17:50 -05'00'

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITIES

NUMBER: 11-W-00316/5

TITLE: Illinois Healthcare Transformation (IHT)

AWARDEE: Illinois Healthcare and Family Services

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

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

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITIES

NUMBER: 11-W-00316/5

TITLE: Illinois Healthcare Transformation (IHT)

AWARDEE: Illinois Healthcare and Family Services

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

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

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

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

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

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

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

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

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

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

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

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

Title XIX Requirements Not Applicable to the HRSN Expenditure Authorities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00316/5

TITLE: Illinois Healthcare Transformation

AWARDEE: Illinois Healthcare and Family Services

1. PREFACE

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

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

The STCs have been arranged into the following sections:

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

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

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

2. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

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

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

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

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

3. GENERAL PROGRAM REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. REENTRY DEMONSTRATION INITIATIVE

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Have been found eligible for Medicaid.

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

a. The covered pre-release services are:

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

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

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

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

iv. Services provided by community health workers;

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

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

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

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

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

4.6. Participating Providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.10. Reentry Demonstration Initiative Implementation Plan. The state is required to submit a Reentry Demonstration Initiative Implementation Plan in alignment with the expectations outlined in the State Medicaid Director Letter (#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated). As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.12. Reentry Demonstration Initiative Planning and Implementation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. SUD PROGRAM AND BENEFITS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f. Components of the HIT Plan include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Communication, coordination, referral and related activities;

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

f. Monitoring the beneficiary's progress; and

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

Table 2 – SUD Case Management Provider Qualifications

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

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

6. HRSN SERVICES

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

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

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

a. Housing Interventions, including:

i. Housing supports without room and board, including:

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

2. Pre-tenancy navigation services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.3. HRSN Infrastructure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Capital investments;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Specifically, the protocol must include the following information:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.18. HRSN Implementation Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. SUPPORTED EMPLOYMENT SERVICES PILOT

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

7.1. Description of Eligibility

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. **Pre-employment services:**

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

ii. Person-centered employment planning;

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

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

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

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

b. **Employment sustaining services:**

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

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

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

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

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

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

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

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

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

c. The supported employment services benefit may not include:

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

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

iii. Facility-based habilitation or personal care services;

iv. Wage or wage enhancements for individuals; or

v. Duplicative services from other state or federal programs.

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

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

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

Table 4 – Supported Employment Service Providers

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

7.4. HCBS Beneficiary Protections.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. VIOLENCE PREVENTION AND INTERVENTION SERVICES PILOT

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

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

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

Table 5 – Violence Prevention and Intervention Staff

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

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

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

9.1. NMT for HRSN

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

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

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

9.2. NMT for Supported Employment Services.

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

10. PROVIDER RATE INCREASE REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Illinois [*insert does or does not*] make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.
For any such payments, as necessary to comply with the HRSN STC, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*]

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

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

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

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

11. MONITORING AND REPORTING REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12. GENERAL FINANCIAL REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 7: Main MEG Chart

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

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

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

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

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

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

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

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

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

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

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

Table 8: MEG Detail for Expenditure and Member Month Reporting

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

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

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

Table 9: Demonstration Years

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. MONITORING BUDGET NEUTRALITY

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

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

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

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

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

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

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

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

Table 10 - Hypothetical Budget Neutrality Test 1 – Reentry

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

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

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

Table 11 - Hypothetical Budget Neutrality Test 2 – SUD IMD

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 16: Capped Hypothetical BN Test

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

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

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

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

Table 17- Budget Neutrality Test Corrective Action Plan Calculation

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

14. EVALUATION OF THE DEMONSTRATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. DELIVERY SYSTEM

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

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

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

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

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

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

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

   ii. Full and partially delegated plans;

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

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

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

16. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION

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

Table 18: Schedule of Demonstration Deliverables

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

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

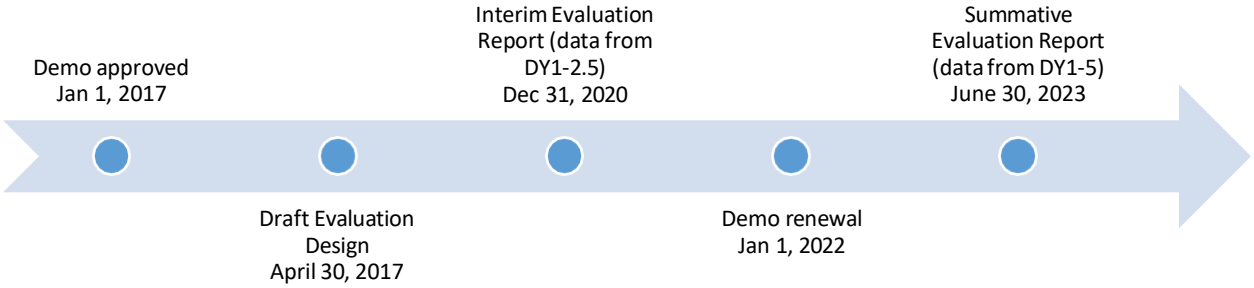
Attachment A
Developing the Evaluation Design

Introduction

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

Submission Timelines

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



Expectations for Evaluation Designs

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

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

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

The format for the Evaluation Design is as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Attachments

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

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

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

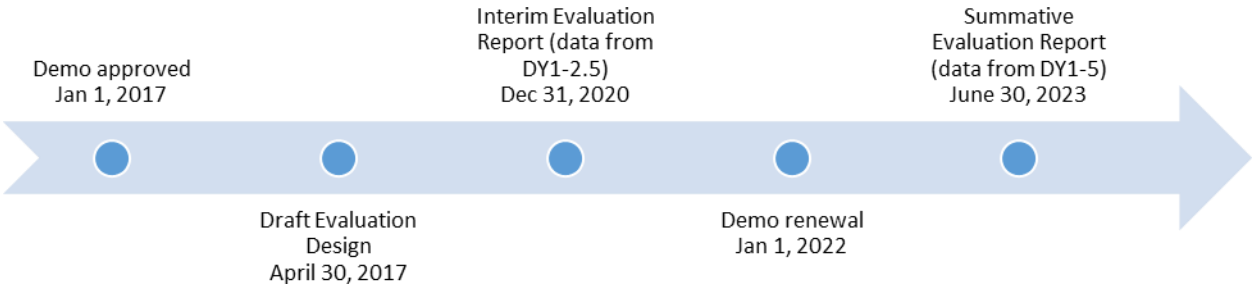
Attachment B
Preparing the Interim and Summative Evaluation Reports

Introduction

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

Submission Timelines

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



Expectations for Evaluation Reports

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

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

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

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

Intent of this Attachment

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

Required Core Components of Interim and Summative Evaluation Reports

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

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

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

J. Attachment(s).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attachment C
SUD Implementation Plan
Approved: June 28, 2018

Introduction

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

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

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

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

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

1115 Waiver Objectives

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

Waiver Achievement Milestones

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

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

Section I: Implementation Plan Milestones

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

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

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

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

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

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

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

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

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

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

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

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

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

Milestone #2-2 – Patient Placement

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

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

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

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

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

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

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

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

Milestone #3-2 Provider Review Process	Current Plan	Future State	Summary of Actions Needed/Timetable
A provider review process for all licensed programs including residential treatment to monitor if providers deliver care consistent with the specifications of the ASAM criteria for the types of services, hours of clinical care and credentials for staff.	Continue the monitoring schedule for all licensed residential providers.	Continue to monitor providers' adherence or fidelity to ASAM criteria, and the extent to which on-site monitoring is occurring.	No action needed

Milestone #3-3 – Standards of Care - Establishment of a Requirement that Residential Treatment Providers Offer MAT On-site or Facilitate Access to MAT Off-site

Illinois does not have a requirement that all residential treatment providers offer MAT on-site or facilitate access to MAT off-site. A few of our licensed residential providers do have MAT along with other residential services and some also offer MAT through linkage agreement with separately licensed Methadone programs or primary care physicians that can prescribe Buprenorphine, Vivitrol, etc.

Milestone #3-3 Implementation of a requirement that residential treatment offer MAT on-site or facilitate access off-site	**Current Plan**	**Future State**	**Summary of Actions Needed/Timetable**
Require all residential treatment providers to offer MAT on-site or facilitate MAT off- site	Very few residential programs offer MAT on-site and most do not have linkage agreements specifically for MAT off-site.	All residential treatment providers will be required to have MAT on-site or have linkage agreements for the MAT off-site.	SUPR will enact a policy change within 6 months that require all residential providers to have MAT on-site or a linkage agreement for MAT off-site. Illinois SUPR staff will start the formal amendment process for administrative rules to reflect these changes by February 2019. Projected effective date of December 2019.

Milestone #4 – Sufficient Provider Capacity at Each Level of Care Including Medication Assisted Treatment for OUD

Illinois has capacity information about providers that are subject to licensure by SUPR in all levels of care and uses this information to expand services and/or solicit new providers for funding opportunities in underserved areas. Illinois is also currently surveying active MAT providers to identify those accepting new patients and those with eligibility for Medicaid reimbursement and has received several federal grants to expand MAT services. The Illinois Department of Public Health (IDPH) is working on a qualitative study of active and inactive MAT providers to identify facilitators and barriers to office-based MAT. Many other activities to address the Opioid crisis are contained in SOAP, copy attached, and further explained in Milestone #5. Currently, with the exception of expanded MAT services, Illinois has sufficient provider capacity in the remaining levels of care as SUPR licenses approximately 1100 locations that provide SUD treatment statewide. This number does not include office-based MAT or other SUD treatment that is delivered directly by Illinois physicians or psychologists. Illinois will also ensure that a participant in any demonstration pilot authorized through the section 1115 demonstration population is eligible to receive the full array of Medicaid services offered by the State. When a pilot reaches its enrollment cap and/or the participant is no longer eligible to receive the pilot service, they will remain eligible for the broad Medicaid service package offered under the Medicaid State Plan.

Milestone #4 Sufficient Provider Capacity at Critical Levels of Care including Medication Assisted Treatment	Current Plan	Future State	Summary of Actions Needed/Timetable

Identify and expand, as needed, access to critical levels of care, including MAT for OUD.	Illinois is currently building capacity for OUD treatment in Illinois using a “hub and spoke” model where individuals with complex needs receive care through specialty treatment “hubs” responsible for coordinating care across health and SUD treatment systems, while individuals with less complex needs receive care through “spokes” comprising MAT-prescribing physicians and collaborating professionals who provide supportive services. Illinois is using federal State Targeted Response funds to pilot two Hub and Spoke projects in geographic areas of Illinois without access to MAT. SUPR is currently surveying active MAT providers to identify capacity. The IDPH is working on a qualitative study to identify active and inactive office based MAT. SUPR recently contracted with 12 new community based organizations to provide expanded OUD services. As of May 2018, nearly 2000 more patients have been admitted to these expanded services. Three new recovery homes for patients with OUD have also been added and 40 new individuals are receiving this service. Illinois will also ensure that a participant in any demonstration pilot authorized through the section 1115 demonstration population is eligible to receive the full array of Medicaid services offered by the State.	Illinois will evaluate the results of the Hub and Spoke pilots and replicate the model in future phases of implementation. Included in the capacity plan, Illinois will identify unmet needs and develop methods to address capacity insufficiency. IDPH, in cooperation with the SUPR Advisory Council, will compile targeted training activities for these MAT providers. Continue to monitor capacity for MAT and expand services as necessary. Continue to monitor capacity management to determine sufficient capacity for all levels of care.	Based upon the results of all SOAP activities in this area, study, Illinois will propose methods to address capacity insufficiency and include recommendations for re-distribution of services no later than July 2021.

Milestone #5 -1 – Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

On September 6, 2017, Illinois released its SOAP, along with an Executive Order, establishing the Governor's Opioid Prevention and Intervention Task Force. The SOAP forms the strategic framework for addressing the opioid epidemic in Illinois, setting a statewide goal of reducing opioid-related deaths by one-third in three years using a three-pillared approach of prevention, treatment and recovery and response. The Action Plan is a three-year plan with implementation in multiple phases. Contained within the plan are evidence-based strategies to achieve the overall goal and nine associated priorities, some of which address the milestone requirements in this implementation plan.

Milestone #5-1 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current Plan	Future State	Summary of Actions Needed/Timetable
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	The SOAP contains an overall priority of increasing the use of the Illinois Prescription Monitoring (PMP) program and reducing high-risk opioid prescribing through provider education and guidelines. Illinois law currently requires all prescribers with an Illinois controlled substance license to register with the PMP. The law also requires prescribers to document an attempt to access the PMP when providing an initial prescription for Schedule II narcotics, including opioids. The PMP currently identifies practitioners who are prescribing outside of Center for Disease Control and Prevention guidelines and sending letters informing them of how their practice compares to other providers in the same area of practice. PMP also sends providers of patients with a prescription history that might suggest “doctor shopping” behavior. Legislation was just passed that will require all health care professionals that hold a controlled substance license to take three of the mandated continuing education hours on proper opioid prescribing. I	Fully integrate the PMP into all electronic health record systems by 2021, prioritizing hospital systems in areas of high need for initial integration. Provide licensed delegates (e.g., registered nurses, physician assistants, certified nurse practitioners) and other non-licensed professionals access to the Illinois PMP. PMP will use identified high prescribers as the focus for dissemination of information about risk mitigation tools, prescribing guidelines, continuing medical education programs and academic detailing.	Continue implementation of the Electronic Health Records into the PMP DHS will implement technical infrastructure to enroll and give access to licensed delegates within 12 months The Department of Financial and Professional Regulation (DFPR) will adopt rules for the new continuing education requirement within 12 months. DFPR is currently in the process of implementing rules that will adopt the Federation of State Medical Boards’ Guidelines for the Chronic Use of Opioid Analgesics into the Medical Practice Act’s rules which govern al Illinois licensed physicians. This should be completed within 12 months.

Milestone #5-1 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current Plan	Future State	Summary of Actions Needed/Timetable
Facilitate naloxone access statewide and expand naloxone purchase, training and distribution services throughout Illinois Expand coverage of, and access to, naloxone for overdoes reversal	SUPR is currently supporting expanded naloxone purchase, training and/or distribution services in Illinois through its Drug Overdose Prevention Program (DOPP) including the use of funding provided through SAMHSA. To date, around 113,000 individuals have been trained in naloxone administration and around 1800 opioid reversals have been reported to the DOPP. In addition, over 17,000 naloxone kits have been distributed in Illinois. IDPH has released a statewide standing order for Naloxone and over 166 pharmacies and organizations have downloaded the standing order. IDPH has provided free naloxone and naloxone administration training to municipal and law enforcement agencies in 18 rural counties in south-central Illinois	Illinois will continue to utilize and expand training and use of naloxone to prevent overdose and to implement all other strategies contained within the SOAP.	Continue to maintain and expand training on the use of Naloxone and access to overdose prevention treatment and services.

Milestone #5-2 – SUD Health IT Plan

Illinois will provide CMS with assurance that it has sufficient health IT infrastructure/" ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. Specified below are strategies and activities already in place. HFS staff will complete any other required activities at a later date.

Milestone #5-2 SUD Health IT Plan	Current Plan	Future State	Summary of Actions Needed/Timetable
Infrastructure for SUPR Provider and Federal reporting	SUPR has an administrative data collections systems (DARTS) for patients who receive SUD treatment in Illinois that is reimbursed with state general revenue or other federal funding except for those recipients covered through a MCO. DARTS is used by all licensed, funded and or Medicaid certified providers in Illinois. DARTS collects demographic, substance use, financial, clinical and service information. DARTS also collects and produces the National Outcome Measures and generates the data needed for Provider Performance Reports. It is also used to fulfill the Federal Substance Abuse Prevention and Treatment Episode Data System reporting requirements. SUPR recently amended a data	Continue work with IHFS to ensure that all patient and service data is correct and linked appropriately and timely for state and federal reporting purposes	Ensure accuracy of shared data within 12 months
IT Plan for enhancing the Illinois Prescription Drug Monitoring Program (PDMP)	See Milestone #5 and the Attached SOAP, Strategy #5.	See Milestone #5	See Milestone #5

Milestone #6 – Improved Care Coordination and Transitions Between Levels of Care

This milestone requires that residential facilities ensure that beneficiaries are linked with community-based services and supports following stays in those facilities. Current administrative rules require linkage agreements with facilities for services not authorized by the licensed organization. Case management to

coordinate these linkages is reimbursed through state general revenue funds. A pilot to reimburse case management services for individuals who are involved in the Illinois criminal justice system and request diversion into SUD treatment as an alternative to incarceration is part of the 1115 Waiver for Illinois (see milestone #1). Illinois is in the process of transitioning all services to a Recovery Oriented System of Care that includes the projected expansion of recovery support services, pre- and post-treatment.

Milestone #6 Improved Care Coordination and Transitions between Levels of Care	Current Plan	Future State	Summary of Actions Needed/Timetable
Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community- based services and supports following stays in these facilities	Illinois has procedures in place to ensure residential and inpatient facilities link beneficiaries with community-based services. Current Licensing Regulations require Providers have linkage agreements with other community-based services.	Illinois will pursue administrative rule amendment to strengthen policies and linkage agreements relative to community-based services that cover other levels of SUD care and other primary care or mental health needs.	Illinois SUPR staff will start the formal amendment process for administrative rules to reflect these changes by February 2019. Projected effective date of December 2019.

Section II: Illinois Point of Contact for the Implementation Plan

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Section III: Relevant Documents

Appendix A, Attachment 1: SOAP Implementation Report

Attachment D

SUD Monitoring Protocol [Reserved]

Attachment E
Evaluation Design [Reserved]

Attachment F
HRSN Implementation Plan

Strategic approach to implementing the policy

In accordance with Illinois' Section 1115 Special Terms and Condition (STC) 6.18, the Health-Related Social Needs (HRSN) Implementation Plan provides additional detail on the strategic approach to implementing the HRSN services, including timelines for meeting critical implementation stages and milestones. The plan includes key activities to implement the housing and nutrition interventions that are described and outlined in Attachment G.

In developing the implementation plan, HFS has taken the following approach:

- Leverage Illinois' managed care organization (MCO) network: MCOs have been and will continue to be involved in the planning of the HRSN delivery process and will play a key role in building the network of HRSN providers and ensuring beneficiaries have access to HRSN services based on eligibility criteria.
- Leverage health care providers, who will play a central role in identifying beneficiaries who may be eligible for services and helping connect them to needed services and community-based organizations (CBOs).
- Leverage and expand on the strong social service network in Illinois: through the demonstration initiative, HFS will build the capacity of CBOs to deliver nutrition and housing supports to Medicaid beneficiaries and expand resources to improve health outcomes. HFS will continue to solicit input from CBOs who have been providing many of the services approved under the 1115 waiver and ensure there are systems available for them to access Medicaid reimbursement.
- Centralize and standardize processes and systems where it reduces duplication of effort and increases efficiencies. As feasible and appropriate, HFS will build services so the approach is uniform across settings and MCO contracts.
- Procure vendor(s) that will provide centralized infrastructure and technology to streamline implementation and service coordination across providers and MCOs and lead to sustainability in programming.

Key Activities and Timeline

The following outlines the key HRSN implementation activities and timeline:

A. *Stakeholder Engagement (Began February 2024)*

A key component of HFS' implementation planning is stakeholder engagement to ensure that services are delivered to meet the needs of beneficiaries and do not create unnecessary barriers in accessing services. This is an ongoing, iterative activity that will inform our planning at key milestones.

To date, HFS has convened a number of workgroups through engagement with the following stakeholders to inform our HRSN protocols and implementation plan: MCOs, Provider Technical Workgroups with HRSN service providers/CBOs and healthcare providers, sister agencies, national and local associations (e.g., National Institute for Medical Respite Care, Corporation for Supportive Housing). As we roll out implementation, we will continue to engage with stakeholders and solicit input, including from CBOs currently delivering HRSN services, regional homeless Continua of Care,

Food as Medicine partners, Medicaid beneficiaries, and individuals with lived experience. Further description of efforts with stakeholder workgroups is detailed in the *Key Partnerships* section of this plan.

B. *Procurement of Essential Vendors (January 2025-December 2026)*
The state intends to procure one or more vendors necessary to implement and deliver HRSN services that may include the following functionality:

1. Third Party Administrator (TPA) and/or other contractors as needed to support developing a network of HRSN providers and submitting claims for services. Key activities for the TPA may include:
    - Building a network of HRSN service providers
    - Providing support and technical assistance (TA) to HRSN service providers
    - Accepting referrals from other state agencies, providers, CBOs, and other entities for individuals who may be eligible to receive HRSN services.
    - Conducting and documenting eligibility determination and service authorization
    - Referring eligible beneficiary to an appropriate HRSN service provider
    - Accepting invoices and/or claims from HRSN providers and verifying invoices and/or claims are payable.
    - Facilitating payment to HRSN providers
    - Collecting data from HRSN providers and submitting data to HFS for monitoring, reporting and claiming
      Other activities may be developed as we further outline the requirements.
2. Community Information Exchange for HRSN Service Delivery: The state will evaluate and assess the need to procure a centralized Community Information Exchange (CIE) vendor to support screening, referral and coordination of care, including data sharing amongst partners, for Medicaid beneficiaries. Key functionality may include:
    - Collecting and documenting HRSN screening information
    - Closed loop referral system including status of referral and service delivery
    - Shared care plans that documents services beneficiaries are accessing across provider types
    - Exchanging data with other established systems

C. *Community Capacity Building (July 2025 – June 2027)*
One of the key factors to successful implementation of HRSN services within a Medicaid system is building the capacity and systems to support the HRSN service providers, i.e., community-based organizations (CBOs). This will occur through a two-pronged infrastructure approach: centralized and de-centralized. As described, HFS will invest in a centralized system to administer HRSN services. In addition, the state will support HRSN services providers through training and technical assistance (T/TA) and capacity building infrastructure grants, contingent on state funding appropriations. Infrastructure funding grants are intended to be front loaded in SFY26 and SFY27 (July 2025 – June 2027). In particular, the state intends to provide the following:

1. Outreach and education to providers interested in delivering HRSN services under the waiver demonstration so they are aware about process for becoming Medicaid

providers;
2. T/TA and support to providers interested in becoming Medicaid providers in collaboration
   with the University of Illinois' Medicaid Technical Assistance Center and other partners;
3. Capacity building/infrastructure funding (contingent on state-appropriated funding) in the areas of technology, workforce development/training, development of business or operational practices, and outreach and education.

D. *Phased Implementation of HRSN Services (July 2024 – June 2027)* There are two key factors that will impact the timing and roll-out of HRSN services: (1) the ability to update HFS, MCO, and other state systems in order to document, report and bill HRSN services, and (2) the procuring, contracting and implementation of a vendor to assist in the administration of HRSN services. Therefore, the state intends to phase-in services. Our approach includes:

1. Starting in January 2025, HFS will begin working with Illinois sister agencies already funding waiver eligible programs to determine approaches to supplement current state grant funding to a Medicaid reimbursement model to support HRSN service providers. HFS has already begun these conversations to identify programs that are not federally funded and meet requirements of the 1115 waiver.

2. By July 2025, identify existing housing services that are state grant funded and not currently billed through Medicaid that can be brought under waiver authority to test and build Medicaid infrastructure and systems for the 1115 HRSN waiver services. This may include:
   a. Housing supports without room and board
      i. Pre-tenancy navigation services
      ii. Housing transition and navigation services
      iii. Tenancy and sustaining services and individualized case management to assist individuals in maintaining housing stability
   b. Short-term pre-procedure, and/or post-hospitalization housing with room and board)

3. No sooner than October 2025, the following services will be implemented for providers who are able to provide required data and billing information to the MCOs. Beginning in July 2025, HFS will offer training and technical assistance to providers who want to begin billing HRSN services.
   a. Housing interventions
      i. Items listed above under D2
      ii. One-time transition and moving costs
      iii. Short-term post-transition housing for up to six months
      iv. Medically necessary home remediations
      v. Home/environmental accessibility modifications
   b. Nutrition interventions
      i. Case management services for access to food/nutrition
      ii. Nutrition counseling and instruction

iii. Home delivered meals
iv. Medically tailored meals
v. Pantry stocking/grocery provisions
vi. Nutrition prescriptions

Once HFS builds the centralized infrastructure to support HRSN service providers as outlined above, we expect that more providers will be able to claim for HRSN benefits under the 1115 waiver starting in 2027.

Plan for establishing and/or improving data sharing and partnerships

HFS will build upon existing processes to assure data sharing among healthcare, community-based social service providers and MCOs and to maximize coordination and delivery of HRSN services. There are various innovative efforts occurring within Illinois CBO networks that are attempting to address data sharing needs to better expedite service access and coordination through improving referral processes. This work is addressing the challenges that CBOs face with maintaining multiple record keeping systems due to various funding streams. HFS recognizes that the current landscape of HRSN providers includes enrolled Medicaid providers as well as community-based social services agencies new to Medicaid. . HFS will leverage existing strategies and develop additional mechanisms to address data sharing needs and will work with the MCOs and Provider Technical workgroups to further define infrastructure that must be created to successfully share screening data, eligibility status, services, and care plans.

A. *Approach*

As mentioned above, HFS's goal is to ensure that beneficiaries can access HRSN services through multiple entry points while also reducing duplication of effort and increasing efficiencies. As such, the state wants to leverage existing systems and build new centralized systems, as appropriate, where providers have access to the information they need to connect beneficiaries to services and deliver care.

HFS is going to engage in the following approach to share data among the partners, including MCOs, HRSN providers/CBOs and medical providers.

1. Leverage Existing Data Sharing Capacity.
   MCOs are contractually obligated to maintain a secure Provider web portal where all contracted providers have access, which includes population health, quality, utilization, eligibility verification, prior authorization, and claims information for PCP Enrollee populations.
   a. HFS will work with the MCO and Provider Technical workgroups to identify additional HRSN data elements to be included in the portal. Additional elements may include z codes, housing status, food insecurity screening, and other indicators.
   b. MCOs will make necessary system edits to their provider portals.
   c. Upon execution of data use agreements (DUA), enrolled HRSN providers will receive training and technical assistance on accessing the provider portal.
2. Evaluate and Plan for a Centralized Data Sharing System
   a. HFS will conduct landscape assessment of data sharing functionality for

purposes of investigating how to build upon and/or utilize existing strategies and infrastructure and to identify additional data sharing infrastructure needs.

b. HFS intends to procure a centralized TPA/CIE/Closed Loop Referral vendor(s) to support operations and data sharing among providers.

c. HFS intends for HRSN screening results to be shared among the healthcare, social service and MCO providers serving beneficiaries. HFS will work with MCO and Provider Technical workgroups to outline how beneficiaries will be initially screened and identified for HRSN services and how this information will be shared with the MCO and other providers. HFS' approach is to ensure there is "no wrong door" to entry into services. Therefore, eligible beneficiaries may be initially screened by a health care provider, CBO HRSN service provider or MCO, and that information should be available to others to reduce duplication of effort.

3. Allow for Data Sharing between Systems. HFS will identify existing data sharing processes, explore additional Data Matching opportunities, and identify other innovative practices to inform coordination of HRSN services and pursue how data can be shared between systems. For example:

   a. HFS will engage with the homeless Continua of Care (CoC) in Illinois and participate in the statewide CoC to learn about specific infrastructure barriers to data sharing and to develop solutions. Additionally, HFS will explore opportunities to leverage the regional Homeless Management Information Systems (HMIS) and potential to export this information into a large-scale data sharing platform.

   b. HFS will work with Illinois nutrition/food support providers such as regional food banks, Food as Medicine partners, health systems to explore opportunity for data sharing.

B. Reporting on HRSN-Related Data

The state will require all HRSN partners, including HRSN providers, health care providers and MCOs, to maintain and report on key data elements related to HRSN service delivery. Data will be stratified by key demographic subpopulations, for example, sex, age, race/ethnicity, primary language. The state, in collaboration with partners, will be required to track and report on the following key data elements, at a minimum:

1. Number of beneficiaries who have been screened positive or identified as having a need for
   HRSN services
2. Number of beneficiaries currently authorized and referred to receive an HRSN service (by service intervention)
3. Number of members denied for HRSN services
4. Number of members who have received an HRSN service (by service intervention)
5. Data to support evaluation of HRSN program (TBD by evaluation design)
6. Other data required by the state and STCs

Partners may be required to modify existing methods to track the information above or develop new strategies to meet these requirements and will receive training on what data needs to be collected.

C. Data Sharing Agreements

MCOs will be expected to enter into DUA with HRSN providers that complete the Department's requirements for HRSN provider enrollment. If the Department procures a TPA, MCOs and providers will be expected to enter into a DUA with the vendor. In consultation with the HFS Privacy Officer, sister agencies, MCOs, and provider stakeholder workgroups, the state will develop a unified approach to data sharing and consent.

Information about key partnerships

Early in the planning process of the state's 1115 demonstration extension, HFS completed a landscape scan of HRSN providers in Illinois. This effort was accomplished through a survey and focus groups targeting housing and food providers. These results informed the Department's ongoing approach to stakeholder engagement. HFS is partnering with providers and community-based organizations throughout the state that are focused on addressing HRSNs. These partnerships include state and national associations, other state agencies, the state's Office to Prevent and End Homelessness, health systems, managed care organizations, food banks, social service providers, and advocacy organizations. HFS has provided information about the Healthcare Transformation 1115 Demonstration to these organizations and other stakeholders throughout the development and planning period. HFS will continue to communicate and gather feedback through the planning and implementation phases of this demonstration.

HFS currently convenes several workgroups for purposes of HRSN service delivery planning:

- *State Agency Workgroup* – HFS meets monthly with state agencies administering HRSN related programs. This workgroup provides an opportunity to gather information and feedback, identify operational needs and assure cross-agency collaboration. Additional planning activities and discussion occurs with individual state agencies between workgroup meetings.
- *HRSN Provider Technical Workgroups* – comprised of HRSN providers, HFS is working with three separate workgroups addressing the following services: medical respite, housing supports, food/nutrition services. These workgroups consist of participants representing various sectors and regions of Illinois and include social service and healthcare providers, some of which are current enrolled Medicaid providers and many who are not. To date, workgroups have provided feedback on the state's approach to screening members for HRSN services, service descriptions and risk factors.
- *MCO Workgroup* – The managed care delivery system is a significant component of HRSN service delivery planning. HFS is working with its contracted MCOs and the Illinois Association of Medicaid Health Plans (IAMHP) for purposes of operational planning.
- *Persons with Lived Experience* – HFS plans to develop mechanisms to assure that beneficiaries and other persons with lived experience are provided the opportunity to inform HRSN service planning. By June 2025, HFS will convene listening sessions or a member advisory group to gather input.

Throughout ongoing planning phases and implementation, HFS will continue collaborating with these workgroups and other identified partners to inform operations, including but not limited to informing provider enrollment, technical assistance opportunities, MCO-HRSN provider

engagement and network building. In addition to existing partnerships, HFS plans to provide opportunities for additional stakeholder feedback. The Department is particularly interested in learning from beneficiaries and people with lived experience to inform operations planning. As soon as Quarter 2 of CY2025, HFS will conduct listening sessions to gather feedback from members.

Capacity Building: HFS recognizes the need for infrastructure and capacity building, especially for community-based providers of HRSN services that do not bill Medicaid today. HFS capacity building plans include the following:

- *Stakeholder Engagement*: HFS plans to engage with key stakeholders to inform plans for community-based provider capacity building, including the systems and functionality needed to support administrative operations.
- *Provider Training and Technical Assistance*: The Medicaid Technical Assistance Center (MTAC) is an HFS – University of Illinois system partnership. MTAC conducts a variety of support activities, including provider training and provider enrollment support. HFS will leverage MTAC's existing trainers and learning management system to offer training to HRSN providers. Training and technical assistance will be available as soon as June 2025.
- *Capacity Building Infrastructure Grants*: no later than October 20250F[1], HFS will issue a Request for Applications intended for community organizations and partners interested in delivering the new HRSN benefits. Awards are intended to support community organizations in building out infrastructure and operations to support HRSN service delivery within Illinois' Medicaid managed care system.
- *Procurement of Essential Vendors:* as described in Illinois' *Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning and Provider Qualifications for HRSN Services Protocol,* the state may procure a vendor1F[2] to support operations and administrative functions of HRSN service delivery.

[1] Subject to State of Illinois appropriation
[2] subject to State of Illinois appropriation

Plans for IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring and evaluation.

A. **Existing IT Infrastructure.** HFS will ensure appropriate updates to existing IT infrastructure to support and promote the successful delivery and monitoring of HRSN services. Specifically:
   1. HFS is updating state eligibility systems to reflect eligible HRSN populations and services as well as updates to the Medicaid Management Information System (MMIS) to appropriately support encounter information for payment and claims processing.
   2. HFS is updating the provider enrollment system to accommodate new HRSN provider types.
   3. In 2023, the Illinois General Assembly amended state statute granting authority to HFS to administer the Illinois Health and Human Services Innovation Incubator (HHSi2) project, funded through enhanced Medicaid administrative matching funds. This initiative is identifying and addressing opportunities to share data between state agencies. HFS will identify opportunities under HHSi2 to enable data exchanges between various data systems and state agencies to make sure that HRSN services are coordinated with other state programs and services.

B. **Infrastructure to Support HRSN-related Services.** As outlined above, HFS intends to procure a vendor(s) to support the delivery and coordination of care for HRSN-related services. During the first half of 2025, HFS will further define the requirements for this system which may include:
   - Collecting and documenting HRSN screening information
   - Closed loop referral system including status of referral and service delivery
   - Shared care plans that documents services beneficiaries are accessing across provider types

C. **Infrastructure for Invoicing for HRSN Services Delivered**. HRSN providers will be required to send invoices or claims for the delivery of authorized HRSN services to either a third-party administrator (TPA) or an MCO, based on the provider contracting and set-up. The particular process and roadmap for how this will occur is still being defined but may occur as follows:
   1. If the MCO, the MCO will be responsible for processing the invoice or claim and issuing payment to the HRSN provider. The MCO will generate an encounter for the service provided and send encounter data to the state.
   2. If the TPA, the TPA will be responsible for processing the invoice or claim and issuing payment to the HRSN provider. The TPA will submit encounter data to HFS.

D. **Monitoring and Oversight**. HFS is developing a plan to make sure that data is available to monitor the program as well as report on outcomes. HFS will require HRSN partners to document a minimum set of data elements so that the state can collect data on services delivered, appropriately claim, and measure the impact of the services. The specific data elements and system(s) for collecting the data will be identified as part of the monitoring protocol due by June 2025.

Plan for tracking and improving the share of Medicaid beneficiaries in IL who are eligible and enrolled in SNAP, WIC, TANF, and federal and state housing assistance programs

In Illinois, the Illinois Department of Human Services (IDHS) manages the Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Children (WIC) program and Temporary Assistance for Needy Families (TANF). Individuals and families are able to apply for Medicaid, SNAP, and TANF benefits using one statewide application. Applications may be submitted online through the Application for Benefits Eligibility (ABE) system, via phone by calling 1-800-843-6154, in person at a IDHS Family Community Resource Center (FCRC) or via mail or fax by completing a paper application. Many community-based organizations offer education and assistance with state benefits applications by utilizing healthcare navigators or other assister personnel. When applying online, applicants must select which benefits they are requesting. If a member does not select benefits, eligibility caseworkers are required to review eligibility for all programs. To apply for WIC in Illinois, an individual or family member can schedule an appointment with a local WIC office, often located at local health departments, community health centers or other community agencies.

While HFS and IDHS administer these programs separately, the two agencies coordinate and collaborate closely on policy implementation and programming enhancements for the Integrated Eligibility System (IES). The launch of the HRSN initiative provides the opportunity for more close coordination between the state agencies to maximize enrollment in federal and state programs. Through these partnerships, the state will identify opportunities to ensure eligible individuals are seamlessly enrolled in other federal and state programs for which they are eligible—including SNAP and WIC. Opportunities may include:

- *Expand access to the IES Benefits Eligibility API (Application Programming Interface).* IDHS recently created a secure, web service portal referred to as the IES Benefits Eligibility API. This portal allows entities who have entered into agreements with IDHS to verify enrollment in SNAP or TANF for purposes of determining eligibility for other benefits assistance programs. Accessing this portal requires documented consent from the individual seeking benefits assistance. HFS and IDHS will explore how to expand access to this portal to HRSN providers.
- *Medicaid members not receiving SNAP.* HFS will work with IDHS to conduct an analysis of Medicaid members who are not receiving SNAP but fall within the SNAP income eligibility thresholds.
- *Communications.* IDHS maintains the functionality of sending text messages to members who consent to messaging. This could be an option to alert members of the availability of additional benefits.

The HHSi2 team is currently engaging with sister state agencies to identify opportunities for data sharing. Early priorities for data matching and sharing through this project include WIC and housing stability programs.

HFS will continue to identify opportunities that connect to the design and implementation work for this demonstration. A key element of HRSN service design is establishing requirements for

MCOs, HRSN providers and others, that support the goal of connecting members to SNAP, WIC and/or other federal and state programs for which they are eligible.

Implementation timeline and evaluation considerations impacted by the timeline, such as staged rollout, that can facilitate robust evaluation designs.

HFS is outlining a timeline for covering HRSN services through coordination with operations, policy, finance, and IT subject matter experts (SMEs) to implement a phased in approach. Implementing a complex program with provider types that are atypical to the Medicaid enterprise requires a significant amount of effort. Many of the SMEs that are key to operationalizing these services are also working on other new initiatives in Illinois, such as the Certified Community Behavioral Health Center demonstration. There are other dependencies to the timeline, such as state budget timeline, scope and timing of vendor procurement, and MCO contracting process. HFS will determine the approach for a phased rollout of HRSN services based on geography, service type, or other factors. The state will prepare its evaluation design to accommodate a phased in approach. For example, the state intends to collect data on service delivery and expenditures through claims and specify a frequency for the state's pulling of HRSN claims through MMIS. This approach minimizes administrative burden for providers, as HFS does not wish to create redundant reporting requirements. Over time, the state intends to procure a TPA to streamline administration and expand the number of participating service providers. The TPA will streamline data collection and assure the quality of claims data submissions to MCOs, particularly for providers who do not have experience or capacity to submit Medicaid claims.

Key tasks/milestones of the following implementation plan have been identified in the attached Appendix A.

Information as required per STC 6.14 (HRSN Rate Methodologies)

Per CMS, this will be submitted to CMS as a separate deliverable.

Information as required per STC 6.15 (Maintenance of Effort)

Per CMS, this has been submitted to CMS as a separate deliverable.

Information as required per STC 6.16 (partnerships with state and local entities to assist beneficiaries in obtaining available non-Medicaid funded housing and nutrition supports upon conclusion of temporary benefits.

HFS will build upon its existing collaborations with sister state agencies and local entities to assure beneficiaries are connected to additional benefits and services for which they qualify. Connection to a member's MCO Care Coordinator will play an important role in this step. MCO Care Coordinators will be responsible for assuring that a member is connected to a local resource to assist with connection to other benefits. Illinois has a number of formal and informal networks of entities that provide beneficiary assistance in accessing public benefits or other programs. These networks include but are not limited to ACA navigators, HFS Application Agents, SNAP

Outreach Teams, community health workers. Such networks strengthened after the initial rollout of the Affordable Care Act and Medicaid expansion in 2014, when the state implemented a consumer assistance program. This work continues today among community health centers, local health departments, food banks, community-based organizations and other entities serving Medicaid beneficiaries who utilize Navigators, Certified Application Counselors, Community Health Workers, HFS Application Agents or other assisters to assist beneficiaries with applications or case status. It is common practice in Illinois for assisters to connect beneficiaries with other benefits either through direct application assistance or referral to organizations that assist with those applications.

HFS intends to utilize the existing Interagency Taskforce on Homelessness and the Community Advisory Council on Homelessness which are all facilitated by the Illinois Office to Prevent and End Homelessness. These groups include leaders across different State agencies and community organizations to help address the broad challenges of homelessness. HFS will also leverage the existing Social Services Advisory Committee, coordinated by the Illinois Department of Human Services, to engage with organizations and systems addressing food insecurity. Seeing this as an existing infrastructure opportunity, HFS will continue to leverage its participation by engaging these groups in developing workflows as well as facilitating ad hoc focus groups to explore opportunities to streamline benefit access and referral to additional resources.

Appendix A: Implementation Plan – Anticipated Timeline[3]

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-Mar 27	Apr – Jun 27
Program Development																										
Continued internal and external stakeholder feedback																										
Finalize eligibility coding, service definitions and staffing (medical respite, housing, nutrition)																										
Draft program workflows and protocols, including screening, authorization and referral for services																										
Internal and external stakeholder feedback on protocols																										
Milestone: Finalize protocols to start building technical specs																										

TPA/Billing Hub/CIE Vendor																										
Gather stakeholder feedback for TPA/CIE																										
Requirements gathering and RFP development																										
Vendor RFP and Selection																										
Milestone: RFP complete for publication																										
Milestone: Vendor(s) selected																										
Milestone: Vendor contract(s) signed																										
Vendor Implementation																										

[3] Blue shading = task/process; red shading = milestone

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-Mar 27	Apr – Jun 27
Milestone: TPA implementation complete **(tentative)**																										
Milestone: CIE implementation complete **(tentative)**																										
Rate Development																										
Initial development of rates and stakeholder engagement																										
Finalize rates																										
Develop billing process for HRSN service providers and implement rates																										
Milestone: HRSN service providers are able to submit invoices/claims and be paid																										
Provider Enrollment																										

Determine HRSN provider qualifications, education, credentials, training requirements																										
Develop rules for new provider types, categories of service																										
Set-up new provider types in IMPACT and in MMIS																										
Milestone: Providers can begin enrolling in IMPACT																										
Milestone: Providers can begin billing for HRSN services																										
Provider Capacity Infrastructure Building																										

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-Mar 27	Apr – Jun 27
Continue to receive input and feedback from potential HRSN service providers/CBOs about T/TA and capacity building needs																										
Develop T/TA approach with the Medicaid Technical Assistance Center (MTAC) to develop technical assistance for new provider types																										
Conduct initial outreach to new service providers																										
Milestone: Begin delivering initial provider education and technical assistance																										
Ongoing provider training																										

and technical assistance																										
Develop provider capacity infrastructure building grant opportunities																										
Milestone: Release RFP for funding, pending state funding appropriations																										
Milestone: Award first round of capacity building funding, pending availability of funding																										
Milestone: Award second round of capacity building funding, pending availability of funding																										
Monitoring and Evaluation																										
Develop monitoring protocol																										
Milestone: Submit monitoring protocol to CMS																										
Develop evaluation design																										

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-Mar 27	Apr – Jun 27
Milestone: Submit evaluation design to CMS																										
Train providers on proper data collection in order to claim and evaluate services																										
Milestone: HRSN budget neutrality tracking and reporting set-up (members and dollars)																										
Managed Care/Policy Development																										
Continue stakeholder engagement with MCOs																										
Determine role and requirements for MCOs, including billing and reporting																										
Determine non-risk payment																										

rate, approach and process																										
Initiate contract amendment process																										
Set-up program oversight																										
Milestone: MCOs update provider portals to include HRSN data elements																										
Milestone: Approval of MCO contract amendment																										
Work with MCOs to update provider billing guide																										
Create HRSN provider toolkit																										
Milestone: Approval of HRSN Managed Care policies																										
Milestone: Approve MCOs outreach and marketing plan																										

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-Mar 27	Apr – Jun 27
IT Setup/System Enhancements																										
Outline system requirements (provider types, services, billing, reporting)																										
Develop and update systems, including payment rates to MCOs																										
System Testing																										
Milestone: System meets requirements for go-live																										

Maintenance of Effort (MOE) Plan

In accordance with STC 6.15, Illinois will maintain a baseline level of state funding for ongoing social services related to housing transition supports and nutrition supports for the duration of the demonstration, not including one time or non-recurring funding. The following describes the state's plan outlining how baseline spending will be determined for these services throughout the state, and commitments to reporting and monitoring, as detailed within STCs 6.15 and 11.6.

1. Determining Baseline Spending

HFS will collaborate with partners and fiscal offices, including state agencies and the Illinois Governor's Office of Management and Budget (GOMB), to develop a process to review existing state authorities and expenditures covering housing transition supports and nutrition supports for Medicaid beneficiaries. Additionally, the state will determine the state fiscal year that the baseline will be established. Once the baseline year is determined and the process is developed, HFS, along with its partners, will identify the recurring state funds appropriated for ongoing social services related to housing transition supports and nutrition supports for Medicaid beneficiaries. Once all applicable recurring state funds have been identified, HFS will calculate the baseline. HFS has been working with these partners in implementation planning efforts and does not anticipate any challenges to determining baseline spending.

2. Maintaining Baseline Spending

HFS will continue to engage with partners through ongoing communication and collaboration to monitor state expenditures for housing transition supports and nutrition supports for Medicaid beneficiaries. Each partner involved will understand the services provided through the 1115 HRSN initiative and will help ensure that demonstration expenditures do not supplant existing efforts. HFS will convene state agencies to conduct annual projection and semi-annual expenditure-monitoring exercises. Additionally, information regarding the state's MOE will be included in the annual monitoring report.

Illinois compiled a baseline level of state funding for ongoing social services related to the categories of housing transition supports and nutrition supports comparable to the programs and for populations authorized under Illinois' 1115 Demonstration for the Maintenance of Effort (MOE) as required under STC 6.15. Illinois worked with state government partners to compile State Fiscal Year (SFY) 2023-24 data on estimated State spending for these services. Programs were included in the baseline if:

1. The services are similar to or the same as the housing transition and nutrition supports and are for populations comparable to those authorized under Illinois' 1115 Demonstration;
2. The services are partially or fully funded by Illinois State; and
3. Funding is ongoing, as opposed to time-limited investments.

IL HFS will work with state government partners following this same process to annually report on the MOE requirement in the Annual Monitoring Reports described in STCs 6.15 and 11.6.

PROGRAM		SFY 23-24 (estimated)
Housing		
IDoA - Emergency Senior Services Funds (ESS)	$	5,000,000
DHS - SUPR Permanent Supportive Housing	$	9,000,000
DHS - MH Rent Subsidies - Williams and Colbert	$	40,372,612
DHS - Housing MI Supportive	$	21,604,900
DHS - Housing First	$	2,499,842
DHS - House Navigators Emergency Room Pilot (Home Illinois)	$	1,000,000
DHS - Supportive Housing	$	16,490,100
DHS - Homeless Youth Services	$	8,403,100
Total Housing Supports	**$**	**104,370,554**
Nutrition		
IDoA - Home Delivered Meals	$	40,000,000
Total Housing Supports	**$**	**40,000,000**
Total Maintenance of Effort Baseline	**$**	**144,370,554**

ATTACHMENT G
ASSESSMENT OF BENEFICIARY ELIGIBILITY AND NEEDS, INFRASTRUCTURE PLANNING, AND PROVIDER QUALIFICATIONS FOR HRSN SERVICES PROTOCOL

Contents

As expressly required by Special Term and Condition (STC) 6.6, this protocol outlines the proposed uses of health-related social needs (HRSN) infrastructure expenditures, covered HRSN services, process for identifying beneficiaries with HRSNs, process by which clinical criteria will be applied, process for developing care plans, plan to avoid duplication/displacement of existing food assistance/nutrition services, and the State of Illinois' affirmation to meet enhanced monitoring and evaluation requirements as outlined in STC 11.6.b.ii and STC 14.6.

I. HRSN Infrastructure

1. HRSN Infrastructure Expenditure Limits

HFS is authorized to claim federal financial participation (FFP) in HRSN infrastructure expenditures for no more than the annual limits outlined in Table 4 of the STCs. Annual aggregate limits range from $50,000,000 to $275,000,000 in infrastructure investments necessary to support the development and implementation of HRSN services over the next five-year demonstration period, for a total aggregate limit of $765,000,000. The state estimates the following infrastructure expenditure limits by allowable use category over the lifecycle of the demonstration, subject to change based on state appropriations, availability of funds, and identified needs. The state used the annual infrastructure spending limits from the state's STCs, and an analysis of anticipated need to develop the estimated limits below.

Allowable Use Category	Percent (%) of Spend	Estimated Limits
Technology	35%	$268,000,000
Development of Business or Operational Practices	25%	$191,000,000
Workforce Development	25%	$191,000,000
Outreach, Education, and Stakeholder Convening	15%	$115,000,000
TOTAL:	**100%**	**$765,000,000**

2. HRSN Infrastructure Funding Purposes

Permissible infrastructure investments to support the development and implementation of HRSN services across the four CMS-approved administrative areas are outlined in the table below and subject to state appropriations, availability of funds, and identified needs. The state intends to operationalize HRSN Infrastructure uses through a mix of centralized state infrastructure activities as well as through localized activities to build capacity across the state.

HRSN Administrative Category	Permissible Infrastructure Activities
Technology	Eligible entities, as listed in subsection I.4, can leverage HRSN infrastructure funding to support a range of technology needs, including those that support closed-loop referral platforms and other community information exchange priorities. The permissible uses of centralized and/or local technology funding are: 1. Infrastructure/data platforms/systems needed to enable: a. Authorization of HRSN services, b. Referral to HRSN services,

HRSN Administrative Category	Permissible Infrastructure Activities
	c. Documentation of eligibility for HRSN services and tracking of enrollment, d. Closed loop referral to HRSN services, e. Record plans of care, f. HRSN service delivery, g. HRSN service billing, h. HRSN program oversight, monitoring, and reporting, including for activities beyond HRSN infrastructure (e.g., reporting on HRSN services delivered; monitoring to ensure individuals receive the services for which they were authorized; activities to prevent fraud, waste, and abuse across the HRSN program), i. Eligibility determination for other federal, state, and local programs, including but not limited to HUD housing supports, Supplemental Nutrition Assistance Program (SNAP), or Women, Infants and Children (WIC), etc., and j. Authorized exchange of information among health and human service partners. 2. Modifying existing systems to support HRSN service delivery and closed-loop referrals. 3. Developing an HRSN services eligibility screening tool. 4. Integrating data platforms/systems/tools. 5. Onboarding to new, modified, or existing systems. 6. Training for use of new, modified, or existing systems. 7. Supporting successful adoption of IT infrastructure and data platforms related to HRSN services.
Development of Business or Operational Practices	Eligible entities, as listed in subsection I.4, can leverage HRSN infrastructure funding to support a range of activities to support the development of business or operational practices such as procurement and planning, developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, and enrollee navigation. The permissible activities are: 1. Training and/or technical assistance on HRSN program and roles/responsibilities. 2. Procurement of administrative support to assist with the implementation of HRSN services, such as a third-party contractor, third-party administrator, or other entity, such as a community care hub, to carry out administrative functions. 3. Administrative items necessary to perform HRSN duties and/or expand HRSN service delivery capacity. 4. Development of policies and procedures related to: a. HRSN referral and service delivery workflows, b. Provider enrollment/credentialing, c. Billing/invoicing,

HRSN Administrative Category	Permissible Infrastructure Activities
	d. Data sharing, e. Program oversight/monitoring, f. Evaluation, g. Privacy and confidentiality, and h. Reporting Requirements.
Workforce Development	Eligible entities, as listed in subsection I.4, can leverage HRSN infrastructure funding to support a range of workforce development needs. The permissible workforce development activities are: 1. Necessary training, certification, technical assistance, and education for staff participating in the HRSN demonstration. 2. Cost of recruiting, hiring, and training new staff to provide HRSN. 3. Salary, fringe/benefits, sign-on bonuses, and retention bonuses for staff that will have a direct role in overseeing, designing, implementing, and/or executing HRSN responsibilities, time-limited to the start-up period, generally not lasting more than 18 months. 4. Privacy/confidentiality training/technical assistance related to HRSN service delivery. 5. Production costs for training materials and/or experts pertaining to the HRSN program.
Outreach, Education, and Stakeholder Convening	Eligible entities, as listed in subsection I.4, can leverage HRSN infrastructure funding to support outreach, education, and stakeholder convening. Permissible activities related to outreach, education, and stakeholder convening are: 1. Development and production of materials necessary for marketing, outreach, training, and education related to HRSN. 2. Translation of materials. 3. Development of culturally competent materials. 4. Review and approval of MCO materials. 5. Planning for, facilitating, and participating in community-based outreach events to support awareness of HRSN services. 6. Planning for, facilitating, and participating in learning collaboratives or stakeholder convenings for HRSN. 7. Community engagement activities necessary to support HRSN program implementation and launch. 8. Administrative or overhead costs associated with outreach, education, or convening directly tied to HRSN.

3. HRSN Infrastructure Implementation Timeline

a. Timeline for uses of Infrastructure Investments

i. The state may begin claiming FFP in infrastructure expenditures by eligible entities, as defined in section I.4, after the approval of this document, but no sooner than January 1, 2025. The exception is expenditures identified as

qualifying under an allowable use category that were expended prior to January 1, 2025, retroactive to the approval date, as allowed in STC 6.6. HRSN infrastructure investments are subject to state appropriations, availability of funds, and identified needs. The state intends to operationalize HRSN Infrastructure uses through a mix of centralized state infrastructure activities as well as through localized activities to build capacity across the state.

ii. The state will utilize a phased approach to disbursing infrastructure funds to ensure providers beginning their participation at different times have sufficient infrastructure and capacity.

iii. Funding may be available to eligible entities for capacity building throughout the demonstration period (i.e., an eligible entity may be able to access infrastructure funds when they are ready to prepare for and begin providing the HRSN services, and not necessarily at the implementation of the HRSN initiative.)

b. Approach to Infrastructure Funding and Uses

i. The state intends to operationalize HRSN Infrastructure uses through a mix of centralized state infrastructure activities as well as through localized activities to build capacity across the state.

ii. The state reserves the right to assume any of the below activities directly or through a contracted vendor.

iii. HFS will:

a. Develop a process to identify the opportunities and initiatives through which infrastructure funds may be available,
b. Conduct outreach and education to eligible entities regarding infrastructure funding opportunities,
c. Disburse funding to eligible entities and/or authorize funding to be used as HRSN infrastructure investments in accordance with this demonstration initiative,
d. Develop reporting templates for entities to report on funding uses, and
e. Review and analyze reports from entities on funding uses.

iv. HFS will implement a standardized process for evaluating, approving, and disbursing HRSN infrastructure funding that includes, for example:

a. Requirements for the eligible entity to outline intended uses of infrastructure funds and projected budget expenditures by allowable use category, including a strong justification for the need for HRSN infrastructure funding for each allowable use category, as applicable.
b. Requirements for the entity to demonstrate the ability to provide or support the provision of one or more HRSN services.

c. Monitoring and Oversight of Infrastructure Funding

i. HFS will ensure that any usage of HRSN infrastructure funds is consistent with the STCs, and will ensure that any HRSN infrastructure funding is subject to program integrity standards, including:

a. Participating in audit processes. HFS, or its vendor, will conduct audits to ensure that infrastructure funds are spent on permissible uses and

are documented and reported on appropriately.

b. Taking action to address non-compliance. HFS will take action to address any identified non-compliance with HRSN infrastructure funding parameters. If the funding recipient has failed to demonstrate appropriate performance, the state may impose corrective action (e.g., caps on funding, discontinuation of funding and/or recoupment of funding). The state will notify any funding recipient before initiating corrective action.

ii. Entities receiving HRSN infrastructure funding will be required to attest to non-duplication of funding with other federal, state, and local funds. HFS will monitor for funding irregularities and potential duplication of funds.

4. Entities Eligible for HRSN Infrastructure Funding

Both centralized and/or local infrastructure investments may be needed to support the development and implementation of HRSN services across the four CMS-approved administrative areas, subject to state appropriations, availability of funds, and identified needs. HFS may invest or approve funds for HRSN infrastructure to assist the following types of entities through various opportunities and initiatives:

a. State agencies, including HFS
b. Providers of HRSN services, including, but not limited to:
    i. Existing Medicaid providers
    ii. Housing agencies and providers
    iii. Food and nutrition services providers
    iv. Community-based organizations (CBOs)
    v. Social services agencies
    vi. Mental health or substance use disorder treatment providers
    vii. Child welfare providers
    viii. City, county, and local governmental agencies
    ix. Outreach and engagement providers
    x. Lived-Experience Workers/Community Health Workers
    xi. Tribal Providers and Organizations
    xii. Federally Qualified Health Centers
    xiii. Rural Health Clinics
    xiv. Case management providers (traditional and HRSN)
c. Healthcare Transformation Collaboratives
d. Managed care plans
e. Other vendors to carry out administrative functions, if needed

In addition, providers of HRSN services must meet the provider criteria described in this document to be considered eligible for the HRSN infrastructure funding.

II. HRSN Services

1. Use of a Third-Party Contractor or Other Contracted Vendor

HFS may use infrastructure funding to contract with or may direct managed care plans to contract with a third-party contractor, third-party administrator, or other entity, such as a

community care hub, to support HRSN providers that are new to Medicaid, perform service approval, care management, payment and administrative functions, and other functions deemed necessary to carry out the administration of HRSN services. The use of vendors and their scope may be phased in or out over the lifecycle of the demonstration, based on provider needs and the promotion of equitable access to HRSN services for eligible individuals.

2. HRSN Service Descriptions

The following services must be provided in ways that are person-centered, and culturally appropriate. Some HRSN services may be completed on behalf of the individual, without the individual being present.

HRSN Service	HRSN Service Description
Housing Interventions	Housing supports without room and board, which may include: 1. Pre-tenancy navigation services and housing transition and navigation services (e.g., finding and securing housing) to assist enrollees with obtaining housing and achieving their stability goals, which may include: a. Working with the individual to develop a housing support plan b. Reviewing, updating, and modifying the plan with the individual to reflect current needs and preferences, addressing housing retention barriers c. Assisting with addressing common barriers, such as obtaining needed documents and documentation (e.g., birth certificate, ID card, Social Security Card, proof of income) and assessing for unpaid bills and previously disconnected services (e.g., utilities) d. Assisting with searching for housing and reviewing options with the individual e. Assisting with completing housing applications f. Assisting with tenant screening and assessment g. Assisting with appeals, reasonable accommodation requests, and referring to legal aid services if needed related to fair housing issues h. As needed, facilitating linkages to state and federal benefit programs, benefit program application assistance, eviction prevention, tenant rights education, and other legal services i. May include access to Supplemental Security Income (SSI)/ Social Security Disability Insurance (SSDI) benefits using models such as SOAR (SSI/SSDI Outreach, Access, and Recovery) to provide application assistance and support through determination i. As needed, facilitating linkages to the coordinated entry system; school/college; employment opportunities; and medical, behavioral, and social services to support housing stability

HRSN Service	HRSN Service Description
	j. Assisting in coordinating transportation to ensure access to housing options before transition and on move-in day k. Ensuring the living environment is safe and move-in ready, including facilitating any inspections needed to ensure housing meets quality standards (HUD NSPIRE or HQS) and assessing and planning for accessibility requirements l. Assisting in arranging for and supporting the details and timing of the move, including moving company, utilities, address changes, furnishings, and household supplies m. Engaging the landlord and communicating with and advocating on behalf of the individual with the landlord n. Assisting the individual with communicating with the landlord and property manager o. Providing training and resources to assist the individual in complying with the individual's lease and tenant rights p. Working with the individual to establish a housing support crisis plan q. Providing supports to assist the individual in the development of independent living skills needed to remain housed 2. One-time transition and moving costs to assist with identifying, coordinating, securing, or funding one-time necessary items to help a person establish a basic household. Items may include: a. Security deposit b. Application and inspection fees, including inspections for visual lead hazards by an appropriately trained person c. Move-in fees or other fees such as first and last month's rent and elevator usage fees as required by the landlord for occupancy d. Fees associated with obtaining necessary documents or documentation (e.g., birth certificate, ID card, Social Security Card, proof of income) e. Utilities activation fees. Allowable utilities activation fees may include (and not to be duplicated by federally funded programs available): i. Water ii. Garbage iii. Sewage iv. Recycling v. Gas vi. Electric vii. Internet viii. Phone service activation (inclusive of landline phone service and cell phone service) f. Moving expenses including movers and packing supplies

HRSN Service	HRSN Service Description
	g. Payment in arrears (capped at a total of six months, inclusive of total arrears and prospective payments including rental payments covered under this HRSN demonstration) h. Pest eradication i. Purchase of household goods and furniture, which may include appliances necessary for food consumption, bedding, furnishings, cribs, bathroom supplies, and cleaning supplies 3. Tenancy and sustaining services and individualized case management, to assist individuals in maintaining housing stability. Services may include: a. Working with the individual to develop a housing support plan b. Reviewing, updating, and modifying the plan with the individual to reflect current needs and preferences, addressing housing retention barriers c. Establishing procedures and contacts to retain housing, including working with the individual to establish a housing support crisis plan d. Linkages to state and federal benefit programs, benefit program application assistance, eviction prevention, tenant rights education, and other legal services i. May include access to Supplemental Security Income (SSI)/ Social Security Disability Insurance (SSDI) benefits using models such as SOAR (SSI/SSDI Outreach, Access, and Recovery) to provide application assistance and support through determination e. As needed, facilitating linkages to the coordinated entry system; school/college; employment opportunities; and medical, behavioral, and social services to support housing stability f. Engaging the landlord and communicating with and advocating on behalf of the individual g. Providing supports to assist the individual in communicating with the landlord and property manager h. Providing training and connections to resources to assist the individual in complying with the terms of the lease i. Providing supports to assist the individual in the development of independent living skills needed to remain housed
	First month's rent as a transitional service Renewable up to a combined 6 months of room & board-only per demonstration period following additional allowable transitions.

HRSN Service	HRSN Service Description
	All section 1115 demonstration HRSN housing interventions with room and board are limited to global HRSN housing cap of a combined 6 months per rolling 12-month period.
	Short-term pre-procedure, and/or post-hospitalization housing (i.e., "medical respite" with room and board for up to six months per year, only where integrated, clinically-oriented recuperative or rehabilitative services and supports are provided. Pre-procedure and post-hospitalization housing are limited to a clinically appropriate amount of time. Services, at a minimum, include: 1. Specialized case management/care coordination for medical and social needs 2. Connections to other health-related services, including transportation to medical appointments 3. 24-hour access to a dedicated sleeping space (which may include a private room or shared room) 4. Three meals per day 5. Medication support 6. Wellness checks at least once every 24 hours 7. Screening and connections to other services and programs as appropriate (such as screening for behavioral health and or substance use-related needs) Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration. All section 1115 demonstration HRSN housing interventions with room and board are limited to global HRSN housing cap of a combined 6 months per rolling 12-month period.
	Short-term post-transition housing for up to six months, following allowable transitions. Services may include: 1. Short-term post-transition housing assistance: a. Rent or lease payments for dwellings that are an individual's primary residence. Dwellings must meet local zoning guidelines and local housing and building codes for safety, sanitation, and habitability. b. Hotel or motel costs, if being used as the individual's primary residence c. Renter's insurance if required by the lease. 2. Short-term post-transition housing with room and board for up to six months, where clinically oriented rehab services and supports may or may not be integrated, following allowable transitions, and limited to a clinically appropriate amount of time. This may include temporary housing settings that provide the individual with non-congregate, private

HRSN Service	HRSN Service Description
	sleeping space available to them 24 hours a day. This service excludes residential treatment settings, recovery homes, long-term care settings, and other institutional care settings. Allowable transitions include out of institutional care (e.g., NFs, Specialized Mental Health Rehabilitation Facilities, IMDs that are out of state, ICFs, acute care hospitals); out of congregate residential settings such as large group homes and recovery homes; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; out of carceral settings; and individuals transitioning out of the child welfare setting including foster care. Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration. Room and board-only interventions are limited to a combined 6 months per household per demonstration period. All section 1115 demonstration HRSN housing interventions with room and board are limited to global HRSN housing cap of a combined 6 months per rolling 12-month period.
	Medically necessary home remediations may include: 1. Air filtration devices, air conditioning, or ventilation improvements a. Air conditioners b. Heaters c. Air filters 2. Vacuum with HEPA filter sealed system 3. Humidifiers 4. Refrigeration for medication 5. Carpet replacement 6. Mold and pest removal 7. Installation of washable curtains or synthetic blinds 8. Housing safety inspections 9. Generators in emergency/extreme climate situations, scoped only to individuals with a high-risk clinical condition 10. Chore services (inclusive of heavy household cleaning, removal of hazardous debris or dirt, and removal of yard hazards)
	Home/environmental accessibility modifications, that are medically necessary, may include: 1. Wheelchair accessibility ramps 2. Widening of doorways 3. Electric door openers

HRSN Service	HRSN Service Description
	4. Bathroom facilities 5. Non-skid surfaces 6. Overhead track systems 7. Handrails 8. Grab bars 9. Stair Lift 10. Other modifications necessary for access, health, and safety, subject to HFS approval
Housing Interventions	Utility assistance, capped at six months in total prospective/retrospective payments, including activation expenses and back payments to secure utilities. Allowable utilities may include (and not to be duplicated by federally funded programs available): 1. Water 2. Garbage 3. Sewage 4. Recycling 5. Gas 6. Electric 7. Internet 8. Phone services
Nutrition Interventions	Case management services for access to food/nutrition, including, for example, education and/or linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees 1. Includes application assistance for SNAP, WIC, and other available food sources 2. Excludes SNAP outreach provided through the USDA's Food and Nutrition Service, or other federally funded nutrition linkage or case management programs
	Nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including guidance on selecting healthy food and meal preparation 1. Includes guidance on selecting healthy food, meal preparation, and cooking classes 2. Includes coaching and skill development in identifying healthy foods and permanent food sources 3. Includes nutrition education programming 4. May be supplemented with handouts, take-home materials, and other informational resources 5. May be provided in an individual or group setting 6. Services must be provided in accordance with evidence-based nutrition guidelines, follow food safety standards, person-centered and culturally appropriate, and individualized to one's dietary needs and preferences
	Home delivered meals, medically tailored meals, or pantry stocking/grocery provisions. Services may include: 1. Home delivered meals

HRSN Service	HRSN Service Description
	a. Up to 3 meals a day, for up to 6 months. This may include prepared foods, meal kits, or restaurant meals. b. Individual may pick up food from a food vendor or have food delivered if delivery service is available c. This service may take into account an individual's household size, and be administered through a voucher or prepaid card d. Meals must be provided in accordance with evidence-based nutrition guidelines, follow food safety standards, be person-centered and culturally appropriate, and individualized to one's dietary needs and preferences 2. Assessment for medically tailored meals and medically tailored groceries, where not otherwise covered under Medicaid a. An initial assessment with a clinician or other qualified staff including registered dietician nutritionists, to develop a medically appropriate nutrition care plan b. Reassessment and modification of the medically appropriate nutrition care plan by a clinician or other qualified staff including registered dietician nutritionists 3. Medically tailored meals a. Up to 3 meals a day, for up to 6 months. Meals are tailored to support individuals with health-related conditions for which nutrition supports would improve health outcomes. This service includes: i. The preparation and provision of the prescribed meals consistent with the nutrition care plan or an individual's diagnosis ii. Delivery of the meal, if available 4. Medically tailored groceries as prescribed by a clinician or other qualified staff including registered dietician nutritionists, based on an assessment and a medically appropriate nutrition care plan or an individual's diagnosis for up to 3 meals a day, for up to 6 months. Individual may pick up medically tailored groceries from a food vendor or have food delivered if delivery service is available. 5. Pantry Stocking/grocery provisions, including refrigerated items a. Provisions for up to 3 meals a day, for up to 6 months. b. An individual can purchase an assortment of foods aimed at promoting improved nutrition. The individual may pick up the food from the food vendor, or have food delivered, if delivery service is available. c. This service may take into account an individual's household size, and be administered through a voucher or prepaid card d. Items must be provided in accordance with evidence-based nutrition guidelines, follow food safety standards, be person-centered and culturally appropriate, and individualized to one's dietary needs and preferences

HRSN Service	HRSN Service Description
	e. Examples of allowable foods include: Fruits and vegetables; meat, poultry, and fish; dairy products; breads and cereals; snack foods and non-alcoholic beverages; and seeds and plants, which produce food for the household to eat In accordance with the CMS Coverage of HRSN Services Table, additional meal support may be permitted when provided to the household of a child identified as high-risk or a pregnant individual, as defined by clinical and needs-based criteria. In accordance with the CMS Coverage of HRSN Services Table, these services may be renewed for additional six-month periods if the individual still meets the clinical and needs-based criteria. Provision of 3 meals per day of home delivered or medically tailored meals is not available concurrently with medically tailored groceries, pantry stocking, or nutrition prescriptions.
	Nutrition prescriptions, tailored to health risk, certain nutrition-sensitive health conditions and/or demonstrated outcome improvement. Services may include: 1. Assessment for and generation of a nutrition prescription, completed by a clinician or other qualified staff including registered dietician nutritionists, where not otherwise covered under Medicaid 2. Filling of nutrition prescriptions, that cover, for example: a. Fruit and vegetable prescriptions b. Protein box prescriptions c. Food pharmacies d. Healthy food vouchers In accordance with the CMS Coverage of HRSN Services Table, additional meal support may be permitted when provided to the household of a child identified as high-risk or a pregnant individual, as defined by clinical and needs-based criteria. In accordance with the CMS Coverage of HRSN Services Table, these services may be renewed for additional six-month periods if the individual still meets the clinical and needs-based criteria.

3. HRSN Provider Qualifications

All HRSN service providers are expected to meet certain qualifications that ensure they can provide high-quality services to eligible individuals. Managed care plans will be required to ensure that HRSN service providers meet and maintain compliance with these minimum qualification requirements. Qualifications may include, for example:

a. The ability to demonstrate the organization/providers' capabilities and/or experience with effectively delivering the HRSN service as determined by HFS.
b. The ability to comply with applicable federal and state laws

c. The ability to maintain sufficient hours of operation and staffing to serve the needs of HRSN participants
d. The ability to provide services as authorized by the enrollee's managed care plan
e. The ability to track and report services to enable billing and quality oversight
f. The ability to demonstrate the capacity to provide culturally and linguistically appropriate, responsive, and trauma-informed service delivery as determined by HFS
g. A history of responsible financial stewardship and integrity as demonstrated by satisfactory deliverables related to grantmaking entities (government or private foundation) and/or recent annual financial reports

Certain HRSN services will require additional qualifications for providers to offer the HRSN service as follows:

a. Housing services providers must have knowledge of the principles, methods, and procedures of housing services covered under the demonstration, or comparable services meant to support individuals in obtaining and maintaining stable housing.
b. Housing services providers must meet any applicable standards of care.
c. Housing services providers providing short-term pre-procedure, and/or post-hospitalization housing must demonstrate the ability to adhere to the National Institute for Medical Respite Care (NIMRC) Standards of Care.
d. Nutrition services providers must have expertise in the principles, methods, and procedures of the nutrition services covered under the demonstration, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs.
e. Nutrition services providers must follow best practice guidelines and industry standards for food safety.
f. When applicable, nutrition services providers should staff, consult, or otherwise have access to a registered dietician or advisor with a public health, nursing, or nutrition-related background.

Examples of qualified providers for HRSN services are listed in the table below.

HRSN Service	Eligible Provider Type
Housing Supports without Room and Board, Short-term Post-transition housing	• HUD Continuum of Care Provider • Supportive Housing Provider • Providers of services for individuals experiencing homelessness • Mental health or substance use disorder treatment provider • Social Service Agency • Affordable housing provider • Federally qualified health center • Rural health clinic • Healthcare system
Short-Term Pre-procedure and/or Post-hospitalization Housing	Current Illinois medical respite provider, or other providers, such as: • Interim housing facility with additional on-site support • Shelter bed with additional on-site support • Converted home with additional on-site support

HRSN Service	Eligible Provider Type
Nutrition Interventions	• Food pantry • Food bank • Mobile market/pantry • Charitable food organization • Area Agencies on Aging Nutrition Network • Healthcare or public health organization

III. Identifying Individuals with HRSNs and Applying Clinical Criteria

1. Eligible Populations

Individuals eligible to receive HRSN services are state plan populations enrolled in full-scope Medicaid coverage and have a documented medical need for the services. Individuals eligible only for a limited benefit Medicaid package are not eligible for the demonstration. HRSN services must be determined appropriate for the documented need. Medical appropriateness must be based on clinical and health-related social risk factors listed under subsection III.2. below. The following populations will be eligible to receive covered HRSN services provided that they also meet the applicable clinical and social risk criteria and the covered HRSN service is determined to be medically appropriate:

COVERED POPULATIONS
Full-scope Medicaid covered individuals enrolled in managed care who meet the applicable social and clinical risk criteria as described in the table below. This is inclusive of children and families that meet the appropriate eligibility criteria.

2. Medical Appropriateness and Risk Factors

To ensure the services are medically appropriate, the state will require that individuals identified as needing HRSN services meet the following clinical and social risk criteria. To qualify for an HRSN service, an individual must:

a. Meet the Medicaid eligibility criteria for a covered population as described above in section III.1;
b. Have one of the social risk factors described in the table below;
c. Have one of the clinical risk factors described in the table below; and,
d. Meet any additional eligibility criteria and requirements that apply in connection with the specific HRSN service.

HRSN Service	Social Risk Factor	Clinical Risk Factor	Clinical Risk Factor Definitions
Housing Interventions	• Homeless as defined by 24 CFR 91.5. • At risk of homelessness as defined by 24 CFR 91.5 except for the annual income requirement in 24 CFR 91.5 (1)(i*)*	• Have received care in EDs, hospitals, or crisis centers on multiple occasions (twice in six months or four times in 12 months) • Have been identified to be high-risk or high-cost based on service	• "High-risk based on service utilization or healthcare history" is defined as an individual with physical health condition(s) or symptom(s) that could lead to a complex physical health need if not treated

HRSN Service	Social Risk Factor	Clinical Risk Factor	Clinical Risk Factor Definitions

		utilization or healthcare history
		• Have one or more chronic conditions
		• Have complex physical health needs
		• Have a behavioral health need requiring improvement or stabilization to prevent deteriorated functioning
		• Are experiencing a pregnancy or are in their 12-month post-partum period
		• Infants up to one year old with one of the following:
		  ○ Neonatal intensive care unit graduate
		  ○ Neonatal Abstinence Syndrome
		  ○ Prematurity, defined by births that occur at or before 36 completed weeks gestation
		  ○ Low birth weight, defined as weighing less than 2500 grams or 5 pounds 8 ounces upon birth
		  ○ Positive maternal depression screen at an infant well-visit
		  ○ Congenital Syphilis
		  ○ Perinatal HIV
		• Individuals who are individuals with intellectual or developmental disabilities (I/DD)
		• A health condition, including behavioral health and developmental syndromes, stemming
			(e.g., pre-diabetes, hypertension, high-cholesterol).
			• "High-cost based on service utilization or healthcare history" is defined as having received care in EDs, hospitals, or crisis centers on multiple occasions (twice in six months or four times in 12 months), or residing in an institutional care setting or having been discharged from an institutional care setting in the last six months, or $50,000+ total in non-LTSS cost over a six month period.
			• "Chronic Conditions" is defined as having one or more chronic conditions including but not limited to those identified in Social Security Act section 1945(h)(2). Examples of conditions can include: diabetes, BMI over 25, cardiovascular disease, respiratory disease, hypertension, physical disability (e.g. amputation, visual impairment), mental illness, substance use disorder, cancer, hyperlipidemia, chronic obstructive pulmonary diseases, HIV/AIDS diagnosis, chronic kidney disease.
			• "Complex physical health needs" is defined as persistent, disabling, or progressively life-threatening physical health

HRSN Service	Social Risk Factor	Clinical Risk Factor	Clinical Risk Factor Definitions
		from trauma, child abuse, and neglect	conditions that require improvement or stabilization to prevent deteriorated functioning (as defined by Institute of Medicine, National Academies of Sciences). • "Behavioral health need" defined as an individual with a persistent, disabling, progressive or life-threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals (as defined by Substance Abuse and Mental Health Services Administration (SAMHSA)
Short-Term Pre-procedure and/or Post-hospitalization Housing	• Homeless as defined by 24 CFR 91.5. • At risk of homelessness as defined by 24 CFR 91.5 except for the annual income requirement in 24 CFR 91.5 (1)(i*)*	• Are at-risk of Emergency Department (ED), hospitalization, or institutional care • Are in the ED or hospitalized or • Are in institutional care; and ○ Have an acute medical condition that can be safely managed in a recuperative care program setting, and ○ Medical respite care is necessary to provide the conditions to support recovery from the acute medical condition.	• "At-risk of ED/hospitalization or institutional care" is defined as an individual who has an increased probability or likelihood of needing urgent medical attention, admission to a hospital, or placement in an institutional setting due to their health condition (including behavioral health conditions), as identified by a provider or established clinically developed predictive modeling technology." This may include someone who is undergoing a transplant procedure or recovering post-transplant. This may

HRSN Service	Social Risk Factor	Clinical Risk Factor	Clinical Risk Factor Definitions
			also include someone who needs to adhere to a treatment regimen, such as cancer treatment or dialysis. • "Institutional care" is defined as care provided within a congregate living environment designed to meet the functional, medical, personal, social, and housing needs of individuals with physical, mental, and/or developmental disabilities (as defined by CMS).
Nutrition Interventions	• Identified as having low or very low food security as defined by USDA	• Have a chronic condition (such as diabetes, cancer, HIV/AIDS or others) • Have been determined to be high-risk or high-cost based on service utilization or healthcare history • Have a behavioral health need requiring improvement or stabilization to prevent deteriorated functioning • Are pregnant or up to 12-months postpartum • Experiencing social isolation placing at risk for early death, neurocognitive disorders, sleep disruption, cardiovascular disease, and elder abuse	• "High-risk based on service utilization or healthcare history" is defined as an individual with a physical health condition(s) or symptom(s) that could lead to a complex physical health need if not treated (e.g., pre-diabetes, hypertension, high cholesterol).

3. **Publicly Maintaining Social and Clinical Risk Criteria**
The state will maintain the social and clinical risk criteria detailed in the table above on the public-facing HFS 1115 Demonstration Waiver Home page for the Healthcare Transformation Section 1115 Demonstration (linked here: https://hfs.illinois.gov/medicalproviders/cc/1115demonstrationwaiverhome.html). HFS will

also require that MCOs maintain the criteria on a public-facing webpage. Should CMS approve any HFS-requested changes to the social/clinical risk criteria, the content will be updated on HFS and MCO webpages in alignment with federal transparency requirements at 42 CFR Part 431.

4. HRSN Identification and Screening

a. Identification

The State will ensure individuals can be identified for HRSN services through multiple pathways. Working with HRSN services providers and managed care plans, the State will establish the following identification strategies:

i. Managed care plan review of encounter data, claims data, and other relevant and accessible data sources

ii. Managed care plan identification through enrollee encounters (e.g., care management)

iii. Referrals from providers, including those from housing services providers, nutrition services providers, healthcare providers including existing Medicaid providers, community-based organizations, and sister state agencies.

iv. Self-referrals

b. HRSN Services Screening and Referral Tool

i. The State will develop a standardized Screening and Referral tool/question set that incorporates housing and nutrition questions from a nationally recognized tool, such as the Accountable Health Communities Health-Related Social Needs Screening Tool (2021); the social criteria; and the clinical criteria for each HRSN service.

ii. Providers and managed care plans may use this tool (or embed the tool/question set within their EHR/data or care management platform in a manner that can be tracked and recorded as part of this demonstration) to document the identification of the individual needing or requesting HRSN services.

iii. Materials and information will be available to individuals so they can connect to their managed care plan or a local provider to have a Screening and Referral tool completed.

c. Eligibility Determination

i. Verifying Medicaid eligibility and managed care plan assignment will be completed along with the HRSN Services Screening and Referral Tool.

ii. Once the HRSN Services Screening and Referral Tool is completed and submitted, a service authorization will be generated in a timely manner. The service authorization will be based on the service(s) needed, confirmation of medical appropriateness, and service limits consistent with the STCs, HRSN Coverage Table, HFS policy, and the person-centered service plan, as applicable and clinically indicated. Service authorization timeframes will be based on service needed and an individual's urgency.

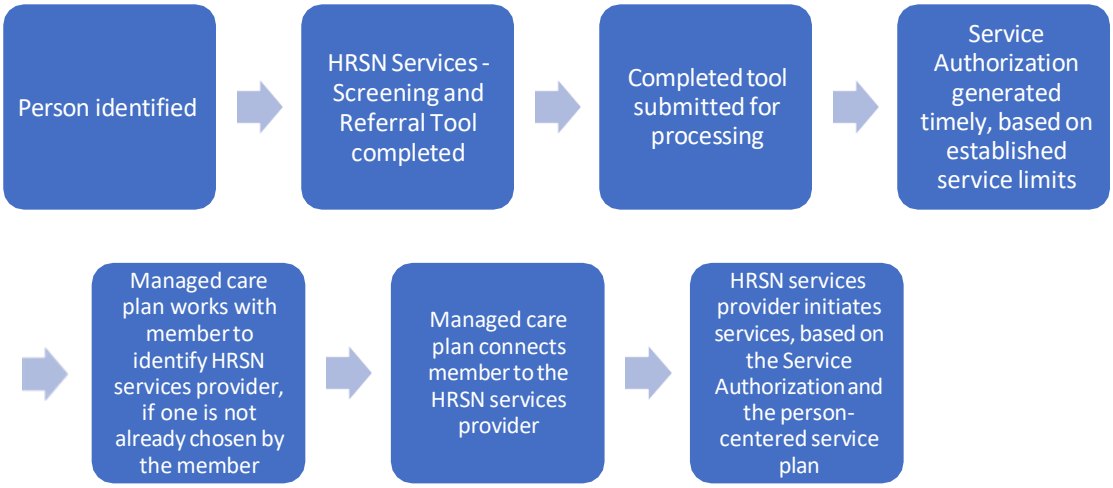
d. Closed-loop Referrals

i. The managed care plan will be responsible for assuring the individual is connected to the HRSN services, and will document within their care management system, the steps taken to connect the individual, to ensure

that the loop has been closed and the individual receives the needed services.

ii. If a person is eligible for an HRSN service, but no provider of the service is available at the time of identification, the managed care plan will work within its system and within its provider network to connect the individual to needed services and supports.

The following workflow illustrates a potential pathway by which an individual goes from being identified as needing housing supports to receiving housing supports:



e. Rescreening Approach and Frequency

i. Once approaching the end of the service authorization period, and as clinically indicated, an HRSN Screening and Referral Tool and subsequent Eligibility Determination for service reauthorization will occur.

ii. Once an individual has reached the maximum authorized benefit (in accordance with the STCs, the CMS HRSN Coverage Table, and any limits established by HFS), the individual's managed care plan will assist them in identifying additional benefits and services to support their health and HRSNs.

5. HRSN Implementation Settings

a. Eligible settings may include places such as provider offices, community-based organization offices, housing services provider sites, housing support services agency sites, drop-in centers, encampments, outside where someone may be residing, food and nutrition services provider sites, shared-use kitchens, churches and other places of worship, markets/stores including local farmers markets and community markets, farms, community gardens, a person's residence, or other places in the community chosen by the individual to meet in-person. Services may be provided in-person, telephonically, or through HIPAA-compliant virtual platforms.

b. Eligible settings for short-term pre-procedure and/or post-hospitalization housing must have appropriate clinicians who can provide medical and/or behavioral health care, or appropriate connections to services, as applicable to the NIMRC model of medical respite care being offered in that setting. The facility cannot be primarily

used for room and board without necessary additional recuperative support services. Short-term pre-procedure and/or post-hospitalization settings must also offer transitional supports to help enrollees secure stable housing and avoid future readmissions. The setting may include an individual or shared interim housing setting, where residents receive the services described in subsection II.2.

IV. HRSN Care Plans

1. **Developing HRSN Care Plans**
   Managed care plans will conduct care management for individuals approved for HRSN services. Responsibilities will include:
   a. Developing the person-centered care plan with the individual and their chosen support network, to be reviewed and revised at least every 12 months. This plan will be informed by the HRSN Services Screening and Referral Tool
   b. If not already identified, referring the individual to an HRSN provider for the services identified on the HRSN Screening and Referral Tool, supporting choice of provider where possible
   c. Ensuring that the appropriate connections have been made between the individual and the HRSN Providers and that services are being provided, ensuring a closed-loop referral process has been followed
   d. Maintaining regular communication with the individual and any HRSN Providers delivering services to the individual
   e. Identifying other services the individual may need, including other social care services, other public benefits, and services or assistance provided through other programs
   f. Following a closed-loop referral process to ensure proper connections have been made and the individual receives the appropriate services and level of support needed
   g. Coordinating with other social support services and care/case management the individual is receiving

2. **Enrollee Rights and Protections to Culturally and Linguistically Appropriate HRSN Services**
   Enrollees eligible for HRSN services will have beneficiary protections similar to those associated with offering home and community-based services (HCBS) and as required by the CMS STCs. All HRSN services will be provided in a manner that is culturally responsive and ensures meaningful access to linguistically appropriate services. HFS will require managed care plans and community providers to provide services consistent with the U.S. Department of Health & Human Services, National Culturally and Linguistically Appropriate Services Standards (National CLAS Standards). HRSN service providers and case managers will assist beneficiaries in understanding the HRSN coverage model and the resolution of issues regarding HRSN services, coverage, access, and rights.

   To ensure conflict of interest protections and compliance with HCBS conflict of interest standards, the state will prohibit the delegation, contracting, or subcontracting of functions that would result in a single entity conducting the assessment, service planning, and service provision except as provided by applicable state or federal requirements. If a single entity provides such services, the state will establish protocols to ensure that assessment, service

planning, and service provision are performed in such a manner that guards against conflicts of interest in accordance with all applicable requirements.

3. **Avoiding Duplication of Services**
   No HRSN service will be covered that is duplicative of a state or federally funded service or other HRSN service the individual is already receiving.

   The state will establish policies and procedures to ensure that an individual is not receiving the same level of benefit or service from multiple sources. Part of the care management functions and service authorization process will include a review of an individual's existing benefits and services, including SNAP ,WIC and Older Americans Act Nutrition Services. Any needed HRSN services will be appropriately adjusted for individuals also receiving SNAP and or WIC services and based on the identified social and clinical risks from the person's completed HRSN Screening and Referral Tool.

   As applicable, the HRSN Providers and the managed care plans will assist individuals with enrollment to receive SNAP and WIC services, as applicable.

V. Commitment to Enhanced Monitoring and Evaluation Requirements

The State of Illinois will meet the enhanced monitoring and evaluation requirements stipulated in STC 11.6.b.ii and STC 14.6 which require the state to monitor and evaluate how the renewals of recurring nutrition services in STC 6.2.b affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services. The state's approach and selected metrics will be captured in the monitoring plan and evaluation design and will be implemented upon CMS approval.

Attachment H
Monitoring Protocol [Reserved]

Attachment I
HRSN Related Provider Payment Increase Assessment - Attestation Table

The reported data and attestations pertain to HRSN related provider payment increase requirements for the demonstration period of performance DY 7 through DY 11 (July 1, 2024 to June30, 2029).

Category of Service	Medicaid Fee-for-Service to Medicaid Managed Care to Medicare Fee-for-service Ratio	Medicare Fee-for-service Ratio
Primary Care Services	86.49% STC l0.5(b). HFS extracted claims and encounters for dates of service from January 1, 2024 - - December 31, 2024 for primary care. We then multiplied those number of services by the Medi.care rates to evaluate how our payments compare to what Medicare would have paid. We used the primary care codes including all E/M codes, well visit codes, select ED codes, and FQHC encounter rates that had indications for a primary care encounter for each Medicare region of Illinois per 10.S(b). These codes represent all of the professional codes that HFS identified for primary care payable under lllinois Medicaid.	89.37% STC 10.6(b). HFS extracted claims and encounters for dates of service from January 1, 2024 - December 31, 2024 for primary care. We then multiplied those number of services by the Medicare rates to evaluate how our payments compare to what Medicare would have paid. We used the primary care codes including all E/M codes, well visit codes, select ED codes, and FQHC encounter rates that had indications for a primary care encounter for each Medicare region of Illinois per 10.S(b). These codes represent all of the professional codes that HFS identified for primary care payable under Illinois Medicaid.
Obstetric Care Services	87% STC 10.S(a)	87% STC I0.6(a)
Behavioral Health Care Services	82%	82%

STC 10.S(a) STC 10.6(a)

In accordance with STCs 10.1 through 10.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment increases for each service will be effective beginning on *[insert date]* and will not be lower than the highest rate for that service code in DY 7 plus a two-percentage point increase relative to the rate for the same or similar Medicare billing code through at least *{inse11 date}.*

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service catego1y to which the rate increase must be applied will include all service codes that fit under the states definition of the category, except the behavioral health codes do not have to include inpatient care services.

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

managed care provider payment rate and utilization data.

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

181a. Illinois is not subject to the provider payment rate increase because the Medicaid to Medicare provider payment rate ratio in each service category and delivery system is equal to or greater than 80 percent prior to the first day of DY 9 (July I, 2026).

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

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

Illinois **does make** Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and/ or obstetric care.

[Select the applicable requirement, must check either a. orb. below]

□a. For any such payments, as necessary to comply with the HRSN STC, I agree to submit by no later than *[insert date]* for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate

increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting infonnation (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than *[insert date]*.

181b. Illinois is not subject to the provider payment rate increase.

Illinois **does** include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

[Select the applicable requirement, must check either a. orb. below]

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

181b. lllinois is not subject to the provider payment rate increase.

[Select the applicable requirement, must check either a. orb. below]

□ a. lf the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 10.8, I attest that necessary arrangements will be made to assure that 100 percent of the two percentage point managed care plans' provider payment increase will be paid to the providers of those service catego1ies and none of this payment rate increase is retained by the managed care plans.

18lb. Illinois is not subject to the provider payment rate increase.

Illinois further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 10.

I, *Laura Phelan. State Medicaid Director.* attest that the above information is complete and accurate.

Provide signature M□ r het==

Laura Phelan

Provide date 'is/ /-u/ -:J.. <::

Attachment J
Reentry Demonstration Initiative Services

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

Covered Service	Definition
Pre-Release Case Management	Case management to assess and address physical and behavioral health needs and social determinants of health needs. The purpose of case management in the context of the reentry demonstration component is to: • Support the coordination of services delivered during the pre-release period and upon release; • Ensure linkages to community-based services, providers, and social supports; and • Facilitate the arrangement of appointments and access to healthcare services delivered in the community. Pre-release case management services include the following required activities: • Assessment and reassessment. • Development of a person-centered care plan. • Referral and related activities. • Monitoring and follow-up activities.
Medication Assisted Treatment (MAT)	State Plan – MAT for opioid use disorders (OUD) (1905(a)(29)) Medications covered under Prescription drug benefit (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25) Counseling covered under Rehabilitation services benefit (1905(a)(13)(c), 42 CFR § 440.130(d))
30-day Supply of Prescription Medications	State Plan – Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)
Prescribed Drugs and Medication Administration	State Plan – Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)
Physical and Behavioral Health Clinical Consultation Services, as clinically appropriate, to diagnose health conditions,	As defined in the State Plan, primarily: • Screening services (1905(a)(13), 42 CFR 440.130(b)) • Physician Services (1905(a)(5), 42 CFR 440.50)

provide treatment, and support pre-release case managers' development of a post-release treatment plan and discharge planning	• Behavioral health rehabilitation services (1905(a)(13)(c), 42 CFR § 440.130(d)). For the purpose of CAA section 5121 alignment, clinical consultation services will include necessary Early and Periodic Screening, Diagnostic and Treatment screenings for individuals under age 21.
Diagnostic services including laboratory and radiology services	State Plan Services that are medically necessary, appropriate for the unique setting, and that are in support of demonstration goals: • Physician services (1905(a)(5), 42 CFR § 440.50) • Diagnostic services (1905(a)(13), 42 CFR § 440.130(a)) • Laboratory and radiology services (1905(a)(3), 42 CFR § 440.30)
Treatment for Hepatitis C, HIV, TB, and Other Conditions	As defined in the State Plan, primarily: • Physician services (1905(a)(5), 42 CFR § 440.50) • Diagnostic services (1905(a)(13), 42 CFR § 440.130(a)) • Laboratory and radiology services (1905(a)(3), 42 CFR § 440.30) • Behavioral health rehabilitation services (1905(a)(13)(c), 42 CFR § 440.130(d)). • Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)
Family Planning Services and Supplies	State Plan – Family planning services (1905(a)(4)(C), 42 CFR 441.20)
Services Provided by Community Health Workers	SPA – pending submission CHW services are a preventive health service designed to prevent disease, illness and injury, prevent the progression of chronic conditions, and may include: • Health Promotion and Education • Health System Navigation and Resource Coordination • Screening and assessment to identify health-related social needs and barriers to accessing health care
Medical Equipment and	State Plan – Medical Equipment and Supplies

Supplies	(1905(a)(7), 42 CFR 440.70(b)(3))

Attachment K
Reentry Demonstration Initiative Implementation Plan

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

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

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

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

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

of Juvenile Justice (IDJJ) facilities, Cook County Temporary Juvenile Detention Center, and for individuals ages 18-21 (or former foster youth up to age 26) who are incarcerated in Illinois Department of Corrections (IDOC) facilities or Cook County Jail. Illinois intends to use this 1115 Waiver Reentry Demonstration Implementation Plan as its internal operational plan for services delivered to youth incarcerated at facilities operated by the three carceral partners identified in this plan. The state plans to initially phase in 1115 Reentry Demonstration services with these three carceral system partners due to the vast differences in capacity of county jails and youth detention facilities throughout Illinois. In addition to capacity and resource needs, recent Illinois legislation (the Pre-Trial Fairness Act) has changed detention patterns throughout the state. Lengths of detention, especially for youth, are often less than 30 days. Most youth who are detained in Illinois are being released from jails and detention centers pre-adjudication. The number of post-adjudicated youth who are incarcerated in local facilities is relatively low. HFS has developed an operational plan to develop processes with local carceral facilities that are not participating in this 1115 Reentry Demonstration to implement the provisions mandated by Section 5121 of the CAA, 2023. This plan includes defining a standardized process for identifying post-adjudicated youth, establishing data sharing mechanisms, assuring provision of services, providing training and technical assistance, including leveraging existing providers and developing resource networks for carceral settings. The technical assistance between HFS and the local carceral facilities will be an important component to assure the provision of services to youth post-release.

Implementation Update (November 2025)

Milestone	Status
Waiver Milestones	
Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated	• Suspension strategy for incarcerated individuals in the state prison system already in place • Systems changes to support eligibility and enrollment changes needed for pre-release coverage expected to go live as early as Q3 of CY 2026 • Individuals already afforded opportunity to apply for Medicaid • HFS expects to finalize program guidance to participating facilities as early as Q2 of CY 2026 • Facilities will demonstrate compliance with all milestones activities as part of readiness assessment
Milestone 2: Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community	• Systems changes to support reentry provider enrollment and billing expected to be complete as early as Q3 of CY 2026 • HFS expects to finalize case management service requirements as early as Q1 of CY 2026 • Facilities will demonstrate ability to provide the full set of reentry services as part of readiness assessment
Milestone 3: Promoting continuity	• HFS expects to finalize case management service

of care	requirements as early as Q1 of CY 2026 • HFS expects to finalize managed care requirements to support transitions and meet all applicable milestone activities as early as Q2 of CY 2026
Milestone 4: Connecting to services available post-release to meet the needs of the reentering population	• HFS expects to finalize managed care requirements to support transitions and meet all applicable milestone activities as early as Q2 of CY 2026
Milestone 5: Ensuring cross-system collaboration	• HFS expects to finalize program guidance to participating facilities as early as Q2 of CY 2026 • HFS expects to develop tools and processes for facility readiness assessment as early as Q2 of CY 2026 • HFS expects to assess readiness of facilities to allow for initial facilities to go live as early as Q3 of CY 2026

Expected Facility Phase-in Schedule by Demonstration Year

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

Implementation Milestones

As a part of ongoing implementation planning, HFS, in partnership with IDOC, IDJJ, the entities at Cook County, and the Illinois Criminal Justice Information Authority (ICJIA), will identify non-service related needs[1] of facilities in order to comply with each of the following milestones. HFS will also establish a process for approving uses of non-services expenditures that will be eligible for federal match.

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

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

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

Suspension Strategy for Incarceration (Milestone 1.a)

Action: Implement a State policy for a suspension strategy during incarceration (or implement an alternative proposal to ensure that only allowable benefits are covered and paid for during incarceration, while ensuring coverage and payment of full benefits as soon as possible upon release), with up to a two-year glide path to fully effectuate.

Current State

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

Future State: Planned Activities and Timeline

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

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

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

Identified Challenges and Plans to Address Each

- **Ensuring Seamless and Continuous Coverage Upon Reentry**. Sometimes, as a result of the process described above, or variability in release dates/times, there can be a lag time between the date of an individual's release from a carceral setting and the date that their Medicaid coverage becomes unrestricted. To continue to mitigate this issue, Illinois will follow current procedures that include a dedicated email for Medicaid members and providers if there are any issues with accessing a service due to a lag in updating a person's Medicaid status to unrestricted. This process ensures that no one is denied a needed service. Facilities will also be required to establish workflows that include communication with an individual's assigned managed care plan, if applicable, once the date of release is known, and then communication again to confirm reentry on the actual release date. If applicable, communication will be made by the person's pre-release case manager. As a part of implementation planning, HFS will continue to work with partners on this process to identify timing and process improvements, as needed.
- **Challenges with Data, Technology, and Workforce Capacity.** HFS and the correctional partners anticipate a varying degree of challenges related to data/information sharing, technology/systems, and workforce capacity. Through ongoing implementation planning, HFS will continue to engage partners to identify specific challenges and create mitigation strategies that help promote quality data/information exchanges, effective technology solutions, and a supported workforce.

Connecting Individuals to Medicaid (Milestone 1.b)

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

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

Current State

ILLINOIS DEPARTMENT OF CORRECTIONS. Individuals incarcerated at an IDOC facility may apply for medical benefits in advance of their scheduled release date. Applications

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

Individuals are also offered the opportunity to apply for SNAP benefits at the same time as the Medicaid application. Currently the process for joint SNAP/Medicaid applications takes place within 5-10 days of release from custody due to time frame requirements as outlined by USDA Food and Nutrition Services SNAP rules. HFS is currently discussing options to assure Medicaid applications are adjusted for the 90-day pre-release period with IDOC and IDHS.

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

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

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

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

submission processes are in place if Illinois eligibility criteria is met.
The JTDC does not have a formal process in place at this time to enroll juvenile residents into Medicaid, however all implementation plans for this demonstration at Cook County Jail will also apply to the JTDC.

Future State: Planned Activities and Timeline

- As early as Q1 CY 2026, HFS will provide a notice to all participating facilities outlining the expectations regarding application assistance, completion, and submission of Medicaid applications, including access to fair hearing procedures and activities for adverse actions related to Medicaid coverage or services. Application assistance may be provided by the carceral facilities or community-based partners (including HFS Application Agents or health insurance navigators) as appropriate. As part of their readiness reviews, facilities will have to have relevant policies and procedures in place. HFS will offer technical assistance as needed.
- As early as Q2 CY2026, IDOC facilities will update their process and workflows so that Medicaid application assistance is occurring prior to an individual's 90-day pre-release period, if that date is known.
- As early as Q3 CY 2026, HFS will have a listing of all existing data-sharing agreements and facilities with access to IES and ABE. As needed, IDOC, IDJJ, and the partners at Cook County will continue to execute data-sharing agreements so that all participating facilities have the appropriate access to the appropriate systems to fully meet this milestone as they join the pilot. For example, HFS is currently working on an enhancement request to add IDOC, IDJJ and county facilities as an option in the ABE Provider Portal. This will provide them the ability to apply for multiple individuals and track applications in a dashboard.

Identified Challenges and Plans to Address Each

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

still occur. Individuals will be provided with assistance on how they can follow through with the process upon their release.

Medicaid Renewal or Redetermination Assistance (Milestone 1.c)

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

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

Current State

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

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

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

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

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

Future State: Planned Activities and Timeline

- As early as Q2 CY 2026, HFS will provide a notice to all participating facilities outlining the expectations regarding renewal and redetermination assistance. As part of their readiness reviews, facilities will assure that relevant policies and procedures are in place. HFS will provide technical assistance as needed or upon request.

- As early as Q1 CY2026, participating facilities will complete a self-audit as part of their readiness to determine if process improvements are needed to better support individuals in their custody to have continued Medicaid enrollment, as needed.[5]
- As early as Q1 CY 2026 , HFS will review current state redetermination procedures to determine if process improvements are needed to better ensure that Medicaid enrollees in custody receive timely notification about Medicaid redetermination/renewal requirements, (e.g., also sending redetermination notices to physical addresses on file, if they are a carceral setting).

Identified Challenges and Plans to Address Each

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

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

Action: Implement a state requirement to ensure that all Medicaid-enrolled individuals who are incarcerated at a participating facility have Medicaid and/or managed care plan cards or some other Medicaid and/or managed care Enrollment documentation (e.g., identification number, digital documentation, instructions on how to print a card, etc.) provided to the individual upon release, along with information on how to use their coverage (coordinated with the requirements under milestone #3 below).

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

Current State

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

ILLINOIS DEPARTMENT OF CORRECTIONS. For individuals incarcerated in an IDOC facility, the individual receives a *Notice of Decision* after application for Illinois Medicaid. The eligibility determination notice is sent back to the facility or to the individual's host site. It is only sent to the individual's host site if the individual also applies for SNAP benefits at the same time (which is the majority of cases), as those applications are submitted with the address where the individual will be residing. If the individual declines the SNAP application, the Medicaid eligibility determination notice comes back to IDOC within 45 days and is placed in the individual's medical file. Upon

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

release, individuals are provided information on how to access their Medicaid benefits along with their user ID and security questions to access their online Medicaid case. They are also provided with reference materials, such as the *Medicaid Application Follow-Up* handout and *Instructions for Parolees* handout.

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

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

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

Future State: Planned Activities and Timeline

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

Identified Challenges and Plans to Address Each

- **Timeliness and Format of Material Availability.** Carceral settings do not always allow individuals to receive certain formats of materials while within the institution, (e.g., printed materials, online materials) and an individual's Medicaid application may be in process, which can be a challenge to helping individuals understand their coverage. Illinois will leverage pre-release case managers and

warm/hot hand-off procedures to assist with any challenges identified by individuals to help them obtain the information they need so they can understand how to access their healthcare coverage.

Accessing Medicaid Applications (Milestone 1.e)

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

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

Current State

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

Future State Activities to be Completed and Timeline

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

Identified Challenges and Plans to Address Each

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

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

Illinois is setting out to implement broad and inclusive parameters to provide pre-release services to individuals transitioning to the community from carceral settings and will follow the parameters as set by STC 4. The approach is intended to ensure access to high

quality, comprehensive services and supports to successfully transition recently incarcerated people to a safe setting, with access to relevant services and supports thus reducing the likelihood of recidivism and promoting better health outcomes. HFS expects to meet this milestone fully as early as Q3 CY 2026

Identification Process (Milestone 2.a)

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

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

Current State

While Illinois is not presently identifying individuals eligible for the reentry demonstration initiative's set of pre-release services, the following outlines the process that HFS is exploring with IDOC, IDJJ, and the partners at Cook County. Modifications may be made, as implementation occurs, based on the needs of the individuals intended to benefit from this initiative, to ensure that equitable access to services is occurring. The state is currently exploring potential identification processes to be adopted by participating facilities. The following steps are in draft form and are subject to revisions, based on continued discussions and collaboration with the reentry stakeholders:

- Step 1 – Identify release date:
    - Long-term stays – The person's release date is set.
        - The carceral facility will develop processes to track when an individual begins their 90-day pre-release period.
    - Short-term stays – The person's release date is unknown.
        - When an individual is in custody at a facility with known release timeframes that average less than 90 days (e.g., Cook County Jail), the individual will be presumed to be within their 90-day pre-release period. Carceral facilities with short-term stays will be required to track and confirm the length of time that an individual has been in their 90-day pre-release period and will be prohibited from billing for pre-release services beyond the 90-day time frame.
- Step 2 – Verify Medicaid status: Person is identified as having Medicaid[6]
- Step 3 – Assign case manager: A pre-release case manager will be assigned to the individual (with the individuals' consent). HFS will continue planning efforts with reentry partners to determine whether pre-release case managers are staff, contractors of carceral facilities, or community in-reach providers (which may vary by facility).

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

- Step 4 – Determination of need: The pre-release case manager completes a pre-release services review and determination. If the person is eligible for pre-release services (based on need), the facility will submit this information through the established notification process used currently to identify the person as being in or leaving a carceral setting. The pre-release services review will include a health assessment that will identify if any of the covered pre-release services are needed.
- Step 5 – Provision of services: Pre-release services will be covered through Medicaid Fee-for-Service, based on needs identified through the pre-release services review and determination process[7]
- Step 6 – Preparation for release: Facility discharge processes for this person will include a pre-release services screening as close to one week prior to their release date that will include:
    - A health assessment and file review to identify any medications, over-the-counter drugs, and durable medical equipment needed upon discharge

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

As one potential example for how this may be operationalized, IDOC performs an R&C (Receiving and Classification) physical on all people who transition to the prison system including a screening for acute and chronic conditions. Further, IDOC is currently working to implement an electronic health record for the prison system. In this instance, IDOC may implement a standardized process across sites that leverages their R&C, as well as the anticipated electronic health record.

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

Future State: Activities to Be Completed and Timeline

- As early as Q2 CY 2026, HFS will finalize the identification process outlined above.

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

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

Identified Challenges and Plans to Address Each

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

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

Action: Cover and ensure access to the minimum short-term, prerelease benefit package,

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

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

Facility Service Level Descriptions	
Pre-release service Service Level 1	**Medicaid Benefit Category or Authority**
Pre-Release Case Management	1115 Reentry Demonstration Authority Case management to assess and address physical and behavioral health needs and social determinants of health needs. The purpose of case management in the context of the reentry demonstration component is to: • Support the coordination of services delivered during the pre-release period and upon release; • Ensure linkages to community-based services, providers, and social supports; and • Facilitate the arrangement of appointments and access to healthcare services delivered in the community. Pre-release case management services include the following required activities: • Assessment and reassessment. • Development of a person-centered care plan.

	• Referral and related activities. • Monitoring and follow-up activities.
Medication Assisted Treatment (MAT)	State Plan • State Plan – MAT for opioid use disorders (OUD) (1905(a)(29)) • Medications covered under Prescription drug benefit (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25) • Counseling covered under Rehabilitation services benefit (1905(a)(13)(c), 42 CFR § 440.130(d))
30-day supply of all prescription medications and over-the-counter drugs (to be provided at time of release) **Service Level 2**	State Plan – Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)
Physical and Behavioral Health Clinical Consultation Services, as clinically appropriate, to diagnose health conditions, provide treatment, and support pre-release case managers' development of a post-release treatment plan and discharge planning	As defined in the State Plan, primarily: • Screening services (1905(a)(13), 42 CFR 440.130(b)) • Physician Services (1905(a)(5), 42 CFR 440.50) • Behavioral health rehabilitation Services (1905(a)(13)(c), 42 CFR § 440.130(d)). For the purpose of CAA section 5121 alignment, clinical consultation services will include necessary Early and Periodic Screening, Diagnostic and Treatment screenings for individuals under age 21. As
Diagnostic services including laboratory and radiology services	State Plan Services that are medically necessary, appropriate for the unique setting, and that are in support of demonstration goals: • Physician services (1905(a)(5), 42 CFR § 440.50) • Diagnostic services (1905(a)(13), 42 CFR § 440.130(a)) • Laboratory and radiology services (1905(a)(3), 42 CFR § 440.30)
Treatment for Hepatitis C,	As defined in the State Plan, primarily:

HIV, TB, and Other Conditions	• Physician services (1905(a)(5), 42 CFR § 440.50) • Diagnostic services (1905(a)(13), 42 CFR § 440.130(a)) • Laboratory and radiology services (1905(a)(3), 42 CFR § 440.30) • Behavioral health rehabilitation services (1905(a)(13)(c), 42 CFR § 440.130(d)). • Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)
Prescribed drugs and medication administration	State Plan – Prescription drugs (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)
Family Planning Services and Supplies **Services provided by community health workers**	State Plan – Family planning services (1905(a)(4)(C), 42 CFR 441.20) SPA – pending submission CHW services are a preventive health service designed to prevent disease, illness and injury, prevent the progression of chronic conditions, and may include: • Health Promotion and Education • Health System Navigation and Resource Coordination • Screening and assessment to identify health-related social needs and barriers to accessing health care
Medical equipment and supplies and/or medical equipment upon release	State Plan – Medical Equipment and Supplies (1905(a)(7), 42 CFR 440.70(b)(3))

Current State

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

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

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

Future State: Activities to be Completed and Timeline

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

Identified Challenges and Plans to Address Each

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

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

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

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

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

as a co-designed approach to ensure that *pre-release case management services* will enhance and expand what is happening today.

Current State

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

- IDOC works with the University of Illinois at Chicago (UIC) who provides a case manager for individuals with HIV/AIDS, Diabetes, or individuals in need of transgender care. The case manager connects individuals to post-release community providers in order to assist in the transition of care.
- Individuals with high mental health needs and who are at risk of homelessness are connected to community mental health programs and case managers associated with permanent supportive housing, mental health providers, and wrap around services in order to assist with their transition of care.
- At two facilities (and expanding to four), IDOC has a collaborative partnership with the Safer Foundation. Through their Supportive Reentry Network Collaborative (SRNC), Safer Foundation connects with individuals at least once during pre-release and assists in coordinating the individuals' care and linkage to providers post-release. The SRNC also links individuals to MAT services post-release.
- Treatment Alternatives for Safe Communities (TASC) provides services including SUD assessments; clinical reentry management; and linkages to community-based SUD treatment, mental health treatment, and other supportive services necessary to assist individuals transition back into the community.
- Newly launched in October 2024, the GRO Community provides case management services in individual and group programs during the pre-release period along with post-release connections to ongoing program support and services, such as post-release case management and housing support.
- Heritage Behavioral Health uses a certified community recovery support specialist to provide case management in groups in pre-release, with connections to post-release case management and other supports as needed.
- IDOC's Parole Re-Entry Group (PRG) is comprised of approximately 16 Casework Supervisors who work with the Field Services Representative at each IDOC facility to review the cases of individuals who are at risk of homelessness and help place them in appropriate housing (transitional housing, Recovery Home, high need mental health, nursing home placement, etc.) with appropriate services based on needs. Connections are made to individuals in their pre-release period, with services and connections continuing in their post-release period, mainly focused on housing security.

- IDOC contracts with other agencies that provide substance abuse treatment programming in some IDOC facilities. Case managers or contractual staff work to ensure post-release Recovery Home placement and/or continued treatment based on level of need for individuals releasing from those programs.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. The IDJJ Aftercare Specialist is the primary care manager for the reentry process. Incarcerated youth and families participate in a multi-disciplinary Youth and Family Team meeting once per month, including a release review meeting prior to the approval of release to the community. The staffing includes the Aftercare Specialist, who works with the rest of the team to identify Aftercare services and supports, including a wide range of community support programs and treatment providers. IDJJ currently has relationships with more than 50 community vendors who can provide services to youth in community. IDJJ is also engaged with in a geo-mapping project with Chapin Hall through the University of Chicago to identify locations of each partnership in relation to youth discharge addresses. The project is designed to be a tool for case managers to identify resources for youth upon release.
COOK COUNTY. The Cook County Sheriff's Office and Cook County Health have a long-standing relationship with community providers. Cook County Health is also the largest safety net health system in Cook County, providing services that include behavioral health and crisis care, MAT, specialty care, and services to address HRSNs, such as housing and transportation. CountyCare, the managed care plan operated by Cook County Health, tracks and monitors the zip codes for all members who are auto-assigned from Cook County Jail. CountyCare then subsequently identifies community resources where the individual resides so that care coordinators can refer and connect members to these resources. In addition, CountyCare staff have access to various community resources (website, registries, etc.)

Future State: Activities to be Completed and Timeline

- As early as Q1 CY 2026, HFS will complete a landscape review of current case management programs providing pre-release and post-release services to assist in better defining providers of the pre-release case management services and expectations of pre-release case management services for this demonstration.
- As early as Q3 CY 2026, all managed care plans will identify a Reentry Liaison, and their contact information will be made available to all participating facilities. Participating facilities will also identify a point of contact for managed care plans. This will further bolster knowledge sharing and communication regarding the availability of community-based providers in the communities Medicaid members are returning to.
- Upon a facility's initiation of providing the pre-release case management services, case management processes, at a minimum, will include warm hand-offs, (e.g., direct contact and linkage) to community-based providers.
- HFS will monitor for implementation challenges, and make program changes, as needed to ensure appropriate connections to community-based providers are occurring.

Identified Challenges and Plans to Address Each

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

Milestone 3: Promoting Continuity of Care

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

Person-Centered Care Planning (Milestone 3.a)

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

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

Current State

ILLINOIS DEPARTMENT OF CORRECTIONS. IDOC currently utilizes the Ohio Risk Assessment System (ORAS) on all individuals, which assesses an individual's risk to recidivate as well as their criminogenic needs that contribute to that risk. ORAS contains multiple assessments, and the main domains cover justice involvement, school problems and employment, family, substance use, and lifestyle. The Corrections Assessment Specialists (CAS) in each facility administer that assessment and then work with individuals that score Moderate, High, or Very High risk to develop and implement an individualized case plan. This case plan aims to route individuals through clinical services programming, education, and re-entry-related goals during their incarceration. The case plan can be continued upon release with the Re-Entry CAS staff in our Parole

Offices. This assessment identifies any medical or mental health issues and addresses potential barriers that could be present, as well as what needs to be done to address those; however, this plan i*s not medical or mental health discharge planning*.
IDOC Mental Health, at the higher level of care units located in a few of IDOC's facilities, participate in the discharge planning process with individuals in custody pre-release. Those facility teams work with IDOC's Re-Entry Unit's high needs placement team to ascertain appropriate release plans to include placement and connection to post-release community services.
Individuals in a contracted substance abuse treatment program and individuals with medical needs who work with the UIC case manager also participate in this level of care planning.
ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. IDJJ's Aftercare Specialists link youth to community providers who provide physical and behavioral health needs. The Aftercare Specialist helps the youth and family identify health providers who are covered by Medicaid and support youth in obtaining and attending appointments. Through this demonstration, current activities will be evaluated, and improvement opportunities will be identified, including linkage to managed care post-release. As outlined in milestone 2.c, the Aftercare Specialist is the primary care manager and youth and families participate in a multi-disciplinary Youth and Family Team meeting once per month, including a release review meeting prior to the approval of release to the community. The staffing includes the Aftercare Specialist, who works with the rest of the team to identify Aftercare services and supports, including a wide range of community support programs and treatment providers. The medical and behavioral health team includes a Medical Doctor or Nurse Practitioner (primary care), a psychiatrist, a licensed mental health professional, and a licensed substance use disorders provider. Currently the staffing process includes:

- A discharge plan summary that includes:
    - Care provided
    - Care that is still need (inclusive of medications)
    - Appointment dates/times/and locations of any outstanding appointments or services needed

  The summary is reviewed with the youth and a copy is sent with the youth.
- Parent/guardians contact regarding the discharge plan for youth under18 (if possible).
- Youth are allowed to test for HIV if they have not had a test within 90 days.
- Upon release, youth are given a month supply of any medication that has been prescribed.
- Youth receive Narcan and education on its use.

COOK COUNTY. The Sheriff's Office conducts a voluntary assessment upon a person's entry into the Cook County Jail. This assessment provides recommendations for programming and services to individuals in custody while they are in the Cook County Jail and identifies probable needs for when they leave custody by providing connections

to supportive resources. In addition, upon release, the Sheriff's Office Community Resource Center offers each individual an opportunity to meet with a reentry care coordinator and connect them to services in the community based on their individualized needs.

Cook County Health assigns social workers to patients with mental health needs to assist residents with connecting to housing and medication resources in the community post release. The program focuses on the highest risk individuals with Serious Mental Illness. In addition, separate staffing resources perform case management and post release education for the SUD population while in jail to facilitate continuity of care. All CountyCare members and individuals who apply to Medicaid can connect with a CountyCare staff person who is onsite twice a week. A Social Determinants of Health (SDOH) screener is conducted to quickly assess the needs of these individuals and to refer them to community resources. While CountyCare has a delegated model for care management, all justice-involved members assigned to CountyCare receive care management and coordination to support continuity of care. With the SDOH screener within the member's file, a care coordinator is able to review and include within their individualized plan of care. CountyCare can also track members who were auto enrolled to CountyCare when applying to Medicaid while incarcerated. CountyCare monitors which members completed a Health Risk Screening (HRS) and the risk-level assigned to the member based on the HRS and engagement with their care coordinator. Care plans are completed for members who are assessed to be of higher risk (level 2 & 3). Once these members are released and integrated into the community, the care coordination team utilizes the individualized plan of care to connect members into the care coordination processes and workflows to ensure their healthcare needs are being met and they are effectively connected to community resources.

Future State: Activities to be Completed and Timeline

- As early as Q2 CY 2026, HFS will issue a policy requiring pre-release case managers to develop a person-centered care plan prior to release. The policy will include timeframes for the development and completion of the care plan, the components to be addressed, and the entities with which the care plan must be shared (e.g., treatment providers, post-release case managers, person's managed care plan, carceral facility, person's mandatory supervised release contact).
- As early as Q4 CY 2025, IDJJ (and other facilities as applicable) will evaluate their current Aftercare Specialist activities to identify opportunities to improve the way that individuals are connected to needed physical and behavioral health services upon reentry, including enhancements to the multidisciplinary team. Improvements will build on this milestone and the person-centered care planning process.
- Participating facilities, in partnership with the entity(ies) that will be providing pre-release case management, will submit a care plan template as part of readiness activities. At a minimum, the care plan is to include the following:
    - Goals and Actions to support one's physical and behavioral health needs

    - Goals and Actions to support one's HRSNs (e.g. access to nutritious food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social and familial connections, quality education, and opportunities for meaningful employment)
    - Goals and Actions to support one's LTSS needs
    - Delineation of what needs to be done pre-release vs. post-release
- Before providing any services, participating facilities, community-based providers (if using an in-reach model), and managed care plans, will have executed data sharing agreements as applicable, to share the person-centered care plan, relevant assessment information, and clinical history. This will be in accordance with all applicable laws, including Section 1902(a)(7) of the Social Security Act; 42 CFR Part 431, Subpart F; 42 CFR Part 2; and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, Breach Notification, and Enforcement Rules (the HIPAA Rules). Facilities will update and maintain policies and procedures on obtaining signed releases of information. Part of the readiness assessment will also include a review of data sharing agreements that are executed and/or in process.
- Upon delivering pre-release case management services, case managers will use available assessments, as well as their own, comprehensive assessment to inform the development of the person-centered care plan. Case managers will ensure that signed releases of information are obtained as necessary and that all security and privacy laws are adhered to.

Identified Challenges and Plans to Address Each

- **Case Management Workforce Challenges**. Illinois anticipates that there could be challenges related to case/care management role delineation. To support facilities, community-based providers, and managed care plans, HFS will provide guidance regarding clear expectations on the role that the pre-release case manager will have, along with strategies for other care/case managers and programs to utilize to enhance coordination and collaboration with the pre-release case managers.
- **Individuals with Short-Term Stays or Unpredictable Release Dates.** It is anticipated that the hardest group to have a developed person-centered care plan developed prior to release will be those with short stays, quick turnarounds, or unpredictable release dates. HFS will develop "short-term stay" best practices, in collaboration with stakeholders, and will disseminate this to facilities during readiness activities.
- **Data and Information Sharing.** It may be a challenge to execute the needed data-sharing agreements between parties. Such agreements often require significant lead time given the legal review process necessary by all parties. HFS will develop guidance and templates to support the execution of such agreements, as needed.

Timely Access to Post-Release Health Care Items and Services (Milestone 3.b)

Action: Implement state policies to provide or facilitate timely access to any post-release health care items and services, including fills or refills of prescribed medications and medical supplies, equipment, appliances or additional exams, laboratory tests, diagnostic, family planning, or other services needed to address the physical and behavioral health care needs, as identified in the course of case management and the development of the person-centered care plan.

Timely access to care is critical to achieving one's health- and HRSN-related goals and Illinois will establish policies that will ensure that these needs are met as individuals transition to the community.

Current State

ILLINOIS DEPARTMENT OF CORRECTIONS. Individuals are released from custody with a 30-day supply of prescribed medication and an additional 2-week prescription order to take to the pharmacy. Individuals at risk of homelessness are placed with community agencies that assist in connecting them to post-release care, especially those with high mental health and/or medical needs that result in placement in mental health centers or in nursing homes. Individuals with HIV/AIDS, Diabetes, or who need transgender care are able to work with a contracted case manager from UIC who connect to continued medical care post-release.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. IDJJ's Aftercare Specialists link youth to community providers who provide for physical and behavioral health needs. The Aftercare Specialist helps the youth and family identify health providers who are covered by Medicaid and support youth in obtaining and attending appointments.

COOK COUNTY. Currently, for individuals being released to the community, processes are in place for priority groups like SUD and Seriously Mentally Ill patients to ensure the receiving clinic/hospital knows the patient was discharged and is transitioning to their site for post-release care. Due to the implementation of the Illinois Pretrial Fairness Act (2023) which abolished cash bail, and the movement of individuals being detained and released quickly, Cook County Health has implemented a flexible approach to ensure members who complete the intake processes have an opportunity to receive health services while detained. Further, the Sheriff's Office provides direct case management to individuals leaving custody upon their release to link them with services. As part of this, many physical resources are offered to individuals upon release including weather appropriate clothing, books, Chicago Transit Authority (CTA) cards, non-perishable meals, Narcan kits, and fentanyl testing strips.

Additionally, all CountyCare members who have been released have access to care coordination. CountyCare has established various processes to help find members and engage them in care. CountyCare members detained at Cook County Jail meet with the Social Work Transitional Care Coordinator to complete a transition plan that includes demographic information and assessment of the needs of the member through an SDOH screener. Transition needs are identified and documented in the care management system for warm hand-off to the care coordinator. Presently, the goal is to contact the member within 14 days upon release from Cook County Jail. CountyCare leverages the care coordination model to connect with these members who have been recently released from

Cook County Jail. CountyCare conducts home visits to support outreach efforts. Once members are engaged, they are connected to their care coordinator. Through care coordination, they are connected to any necessary healthcare services.

Future State: Activities to be Completed and Timeline

- As early as Q2 CY 2026, HFS will issue a policy that will require that a component of the pre-release case manager activities will include the facilitation of timely access to any post-release health care items and services, including fills or refills of prescribed medications and medical supplies, equipment, appliances or additional exams, laboratory tests, diagnostic, family planning, or other services needed to address the physical and behavioral health needs of the individual, as identified through the course of pre-release case management and the development of the person-centered care plan.
- The person-centered care plan described in milestone 3.a will include actions to be completed both pre- and post-release to facilitate timely access to any post-release health care items and services, including fills or refills of prescribed medications and medical supplies, equipment, appliances or additional exams, laboratory tests, diagnostic, family planning, or other services needed to address the physical and behavioral health needs of the individual.
- Providers of pre-release and post-release case management and facilities (and to the extent of involvement, managed care plans) will be required to work collaboratively to ensure that processes are complementary to each other which will promote the seamless facilitation of these services. At a minimum, they must have established processes that ensure that:
    - Prescribed medications are "in-hand" upon release
    - Durable medical equipment is either "in-hand" or that there is an established plan for connecting the member to the needed equipment upon release (same day if possible and within 48 hours if clinically appropriate)
    - Follow up visits for primary or specialty care are scheduled
    - Labs/diagnostics are ordered
    - Needed behavioral health services are scheduled/in place
    - A post-release case manager is identified (including warm/hot hand-off processes and timeframes)

  Processes must include provisions on how case managers and individuals receiving services will be kept aware of prescriptions, appointments, authorizations, etc.
- HFS will work with reentry partners to identify the range of potential post-release case managers and develop processes for pre-release case managers to hand-off person-centered care plans and support transition of case management activities.
- HFS will monitor for implementation challenges and disparities in accessing services, and make program changes, as needed to ensure appropriate connections to services are occurring.

Identified Challenges and Plans to Address Each

- **Case Managers' Ability to Ensure Timely Connections to Care**. While policies, procedures, and systems may be in place, case managers and individuals receiving these services may encounter barriers to accessing care or arranging for access to care for varying reasons. As one example, some community providers want to wait until the individual is released before scheduling an appointment. To support case management efforts, HFS will provide technical assistance to support case managers as they work to address barriers to needed care and services, as well as issue information to providers regarding the importance of timely service provision for this population.

Transferring Relevant Health Information (Milestone 3.c)

Action: Implement state processes to ensure, if applicable, that managed care plan contracts reflect clear requirements and processes for transfer of the member's relevant health information for purposes of continuity of care (e.g., active prior authorizations, care management information or other information) to another managed care plan or, if applicable, state Medicaid agency (e.g., if the beneficiary is moving to a region of the state served by a different managed care plan or to another state after release) to ensure continuity of coverage and care upon release (coordinated with the requirements under milestone #1 above).

Current State

Illinois does not currently have a process in place to transfer relevant health information from one managed care plan to another or to other state Medicaid agencies for this population. However, managed care plans do have contractual obligations and expectations around transitions of care for the purposes of continuity of care and quality transitions when a person is changing setting locations (e.g., institutional setting to a community setting) or changing coverage (e.g., managed care plan to managed care plan, managed care plan to FFS).

Future State: Activities to be Completed and Timeline

- HFS will continue to work with reentry stakeholders as they explore options and best practices for involving managed care plans in this demonstration. At a minimum, HFS expects managed care plans to be involved in a person's care coordination once the individual returns to the community and managed care plan enrollment is effective. HFS will continue to work with managed care plans to identify expectations around member engagement and connectivity to services and HRSNs post-release. Managed care contracts will be updated to include requirements for transferring health related information for HRSN services, including reentry services, as early as Q3 CY 2026.

Identified Challenges and Plans to Address Each

- **Timely and Effective Data Exchanges.** Facilities, community-based organizations, and managed care plans do not have an effective data exchange platform today. HFS will explore potential technology solutions to support timely

and effective data exchanges between partners participating in the reentry demonstration initiative.

Ensuring Coordinated Care (Milestone 3.d)

Action: Implement state processes to ensure case managers coordinate with providers of pre-release services and community-based providers, if they are different providers. Implement a state policy to require case managers to facilitate connections to community-based providers pre-release for timely access to services upon reentry in order to provide continuity of care and seamless transitions without administratively burdening the beneficiary, e.g., identifying providers of post-release services, making appointments, having discussions with the post-release case manager, if different, to facilitate a warm handoff and continuity of services. A simple referral is not sufficient. Warm hand-offs to a post-release case manager and follow-up are expected, consistent with guidance language in the case management section.

Coordination of care is a foundational activity for the pre-release case managers and as such, Illinois will implement a process that will promote communication and collaboration throughout the transition process.

Current State

ILLINOIS DEPARTMENT OF CORRECTIONS. At the present time, this pre-release practice is not happening widely across IDOC. Individuals at risk of homelessness with high mental health needs often engage in virtual or telephone interviews with community mental health agencies that are able to provide housing, mental health, community support and wrap around services in order to complete an assessment and placement interview.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. Youth Correctional Facilities leverage the Aftercare Specialist and the Youth and Family Team meeting process to promote coordinated care. This meeting, conducted one per month, serves as a staffing to identify needed Aftercare services and supports and to ensure that connections are being made.

COOK COUNTY. For individuals connected to CountyCare, using the care coordination process, connections are made to needed services, including connections based on the results of the SDOH screener. Cook County Health itself offers a large suite of services within its network that provides individuals with quick and seamless access. Presently, the goal is to connect with members within 14 days of release and complete a health-risk screen again within 60 days of release to identify any further needs. For some members, CountyCare works with organizations such as Safer Foundation and CARA via a warm hand-off process.

Future State: Activities to be Completed and Timeline

- As early as Q2 CY 2026, HFS will issue a policy that will require that a component of the pre-release case manager activities will include the facilitation of connections to community-based providers pre-release for timely access to services upon reentry. This will include requirements related to any warm/hot hand-offs to post-release case management services, as applicable. This policy will also detail the elements that are expected to be included in the warm/hot hand-off between the pre- and post-release case managers, the role of the

managed care plan Reentry Liaison, and the timeframe expectations around activities to be completed related to the warm hand-off.

- As described in milestone 3.a, the person-centered care plan will include actions to be completed both pre- and post-release to facilitate timely access to any post-release health care items and services, and as also indicated in milestone 3.b, case managers will have responsibility for ensuring that follow up visits for primary or specialty are scheduled, labs/diagnostics are ordered, needed behavioral health services are scheduled/in place, and a post-release case manager is identified, as needed.

Identified Challenges and Plans to Address

- **Challenges with Provider Coordination**. Case managers may face challenges with identifying and effectively communicating with community-based providers to make appointments and other needed connections. HFS will work with managed care plans to develop and conduct provider awareness campaigns so that they are familiar with this initiative and how they can participate in the initiative to promote successful transitions to the community for these individuals. Further opportunities to help promote coordination among providers will be explored, including timely and effective data exchanges.
- **Challenges with the Warm Hand-off**. If unexpected release dates occur, or if releases out-of-county or out-of-state occur, case managers may experience a disconnect in timing or information. When a warm hand-off is not feasible pre-release, a post-release warm hand-off should occur within 48 hours, if a post-release case manager is identified. If a post-release case manager is not identified upon release, at a minimum, the pre-release case manager will conduct a warm hand-off with the Reentry Liaison and/or assigned care coordinator affiliated with the individual's managed care plan, if it is known. HFS will partner with facilities to monitor for implementation challenges, and make program changes, as needed to ensure warm/hot hand-off activities are occurring.

Milestone 4: Connecting to Services Available Post-Release to Meet the Needs of the Reentering Population

A vital part of this demonstration will be to have a robust case management process that will provide support for members both pre- and post-release. This case management process will help keep members connected to needed services and supports throughout their transition to the community. To support these efforts, clear monitoring mechanisms and protocols will be established. HFS expects to meet this milestone fully as early as Q3 CY2026.

Ensuring Timely Post-Release Services (Milestone 4.a)

Action: Develop state systems to monitor individuals who are incarcerated and their person-centered care plans to ensure that post-release services are delivered within an appropriate timeframe. We expect this generally will include a scheduled contact

between the reentering individual and the case managers that occurs within one to two days post-release and a second appointment that occurs within one week of release to ensure continuity of care and seamless transition to monitor progress and care plan implementation. These short-term follow-ups should include the pre-release and post-release (if different) case managers, as possible, to ensure longer term post-release case management is as seamless as possible. In keeping with the person-centered care plan and individual needs, CMS is providing these general timeframes as suggestions, but recognizes that depending on the beneficiary's individualized needs and risk factors, a case manager may determine that the first scheduled contact with the beneficiary should occur, for example, within the first 24 hours after release and on a more frequent cadence in order to advance the goals of this demonstration.

Current State

IDOC, IDJJ, and the Cook County sites have variation in the connectivity between pre-release and post-release services. Further, Illinois does not have a state system or systems in place currently to monitor individuals and their person-centered care plans to ensure that post-release services are being delivered as needed.

Future State: Activities to be Completed and Timeline

- Implementation steps included in milestone 3 are applicable for this milestone.
- HFS, through continued implementation planning and demonstration roll out, will work with reentry partners to ensure that clear roles and responsibilities are outlined regarding expectations for monitoring and communicating.
- HFS will monitor engagement levels and timeframes between interactions of members and case managers, as well as monitor encounter-level data for services received by members and will adjust requirements of case managers and managed care plans as needed to ensure that members are accessing needed services.

Identified Challenges and Plans to Address Each

- **Member Contact Post-Release**. Post-release case managers may find it difficult to successfully contact members post-release, due to a member's variability in availability or access to a reliable contact method. To mitigate possible unable to reach/contact scenarios, pre-release case managers will include alternative contact numbers in the member's person-centered care plan. The pre-release case manager will also provide the member with the post-release case manager's contact information, if it will be a different case manager from the one providing pre-release case management. As applicable, a person's mandatory supervised release, probation, or Aftercare contact will also be included in this process. Additional mitigation strategies will be explored as a component of ongoing implementation planning and demonstration roll out.

Ensuring Ongoing Case Management (Milestone 4.b)

Action: Develop state processes to monitor and ensure ongoing case management to ensure successful transitions to the community and continuity of care post-release, to provide an assessment, monitor the person-centered care plan implementation and to

adjust it, as needed, and to ensure scheduling and receipt of needed covered services.

Current State

Across IDOC, IDJJ, the Cook County sites, both dedicated facility staff and various, locally based, community partners provide case management in an individual's post-release period, although there is variation in the amount and scope of post-release case management, and utilization varies based on individual's needs (e.g., at risk of homelessness, SUD) and program capacity and resources. Managed care plans may also currently play a role in case/care management for these individuals.

ILLINOIS DEPARTMENT OF CORRECTIONS. IDOC's partnership with the Safer Foundation at two facilities (and expanding to four), as well as their partnerships with GRO and TASC are examples of successful programs that provide both pre- and post-release case management services.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. IDJJ partners with various organizations and vendors to help support juveniles in aftercare. Case management is a component of these services.

COOK COUNTY. Individuals connected to CountyCare currently receive care coordination. Members are tagged within its case management system so that these cases can be more readily pulled and tracked on a monthly basis. CountyCare tracks Health Risk Screening rates, care plan completion rates and engagement with care coordinators/managers. CountyCare also tracks demographic data from this particular cohort to best understand this population. CountyCare also examines claims data related to this cohort and tracks top health and mental health diagnosis to understand the overall needs of this population.

Future State: Activities to be Completed and Timeline

- As part of ongoing implementation planning and demonstration roll out, HFS will work with reentry stakeholders, including managed care plans, to build capacity of reentry case management providers, and develop a statewide process for monitoring the provision of needed post-release case management services.
- In addition to the items listed in Milestone 4.a, as early as Q3 CY 2026, HFS will issue guidance to the managed care plans outlining the process they must follow to monitor and ensure ongoing case management is occurring post-release for members who received pre-release services.
- As early as Q2 CY 2026, HFS will issue best practices for case managers providing case management to members post-release that will include completing an assessment, monitoring and updating the person-centered care plan, and ensuring the scheduling and receipt of needed covered services.

Identified Challenges and Plans to Address Each

- **Post-release Case Management Workforce**. It is not known yet whether Illinois' landscape of reentry providers has a current level of case management workforce with capacity to provide the necessary, local-level and intensive case management services to these members. HFS will work with stakeholders and

partners, including managed care plans and carceral facilities, to assess capacity building needs and develop a workforce development strategy for the delivery of post-release case management services.

- **Member Contact Post-Release**. As described in milestone 4.a, post-release case managers may find it difficult to successfully contact members post-release, due to a member's variability in availability or access to a reliable contact method. To mitigate possible unable to reach/contact scenarios, pre-release case managers will include alternative contact numbers in the member's person-centered care plan. The pre-release case manager will also provide the member with the post-release case manager's contact information, if it will be a different case manager from the one providing pre-release case management. As applicable, a person's mandatory supervised release, probation, or Aftercare contact will also be included in this process. Additional mitigation strategies will be explored as a component of ongoing implementation planning and demonstration roll out.

Ensuring Connections to Other Services (Milestone 4.c)

Action: Develop state processes to ensure that individuals who are receiving services through the Reentry Section 1115 Demonstration Opportunity are connected to other services needed to address LTSS and HRSN, such as housing, employment support, and other social supports as identified in the development of the person-centered care plan.

Current State

To the extent that these individuals are connected with a managed care plan post-release, processes are currently in place (e.g., the health risk screen/assessment process) to identify services needed, including those to address any needed long-term services and supports (LTSS) and health-related social needs (HRSN). Additionally, when a person is reentering the community from IDOC, IDJJ, and the Cook County sites, case management activities, as described within other sections of this implementation plan, include assistance to connecting individuals to needed services and supports, which may include LTSS and HRSN. With the concurrent implementation of HRSN services within this 1115 demonstration, connections to these services will be an expectation within this initiative.

Future State: Activities to be Completed and Timeline

The same activities described in milestones 4.a and 4.b will be used to connect members to needed LTSS and HRSN services. HFS will develop protocols for connecting individuals to the HRSN interventions within this demonstration and will leverage the use of the same screening and referral tool/questions. HFS will also develop protocols for connecting individuals to Medicaid covered non-emergency medical transportation and non-medical transportation authorized within this demonstration.

Identified Challenges and Plans to Address Each

The same challenges identified in milestones 4.a. and 4.b are applicable to this milestone.

Ensuring Effective Response Times and Time Needed for Effective Transition Navigation (Milestone 4.d)

Action: Implement state policies to monitor and ensure that case managers have the necessary time needed to respond effectively to individuals who are incarcerated who will likely have a high need for assistance with navigating the transition into the community.

Current State

There is no current state process for monitoring and ensuring that case managers have the necessary time needed to respond effectively to individuals that are incarcerated.

Future State: Activities to be Completed and Timeline

- As early as Q2 CY 2026, HFS will issue a policy that details how the State will monitor pre-release case management to ensure that case managers have the necessary time needed to respond effectively to individuals who are incarcerated who will likely have a high need for assistance with navigating the transition into the community.
- As part of readiness activities, participating facilities, and any case management partners, will have to demonstrate how they will accurately monitor pre-release case management activities and make adjustments as needed to ensure that case managers have the necessary time needed to respond effectively to individuals who are incarcerated who will likely have a high need for assistance with navigating the transition into the community.

Identified Challenges and Plans to Address Each

- **Case Management Workforce Challenges**. It is not known yet whether the State of Illinois has a current case management workforce that is fully capable of providing the needed, local-level and intensive case management services to these members. The State will work with stakeholders and partners, including managed care plans and carceral facilities, to assess capacity building needs and develop a development strategy to ensure that case managers are able to respond effectively to those individuals with a high need for assistance with navigating the transition into the community.
- **Individuals with Short-Term Stays or Unpredictable Release Dates.** For individuals with short-term stays or unpredictable release dates, it may be a challenge to ensure that enough time is given to adequately plan for an effective transition to the community. HFS will develop "short-term stay" best practices, in collaboration with stakeholders, and will disseminate this to facilities during readiness activities. As mentioned under Milestone 2a, HFS will require facilities with short-term stays to track the length of time that an individual has been in their 90-day pre-release period, and providers will be prohibited from receiving Medicaid reimbursement for services outside of the 90-day pre-release period.

Milestone 5: Ensuring Cross-System Collaboration

HFS will engage stakeholders throughout the planning and implementation of pre-release services so that plans are well defined and promote clear communication, robust coordination, and meaningful engagement across partners. HFS expects to meet this milestone fully as early as Q3 CY 2026.

Readiness Assessment (Milestone 5.a)

Action: Establish an assessment outlining how the state's Medicaid agency and participating correctional system/s will confirm they are ready to ensure the provision of pre-release services to eligible beneficiaries, including but not limited to, how facilities participating in the Reentry Section 1115 Demonstration Opportunity will facilitate access into the correctional facilities for community health care providers, including case managers, in person and/or via telehealth, as appropriate. A state could phase in implementation of pre-release services based on the readiness of various participating facilities and/or systems.

Preparation and planning activities will be completed prior to covering any pre-release services. Participating correctional facilities and managed care plans will work closely with HFS to review (and test, as indicated) all activities that will be carried out by the facility, the managed care plan, and the case manager to ensure that coordinated and seamless processes are in place.

Current State

The State has not yet developed the readiness assessment tool and process.

Future State: Activities to be Completed and Timeline

- As early as Q1 CY 2026, HFS will develop Readiness Assessment that will include the following sections, in accordance with STC 4.9:
    - Pre-release Medicaid application and enrollment processes
    - Screening process for pre-release services
    - Provision and/or facilitation of pre-release services
    - Coordination amongst partners
    - Reentry planning, pre-release case management, and assistance with care transitions
    - Medicaid requirements
    - Data exchanges
    - Reporting
    - Staffing and project management
- As early as Q2 CY 2026, MTAC will develop and provide training and technical assistance to interested facilities related to Medicaid provider enrollment and billing/claiming processes and expectations.
- For this demonstration, facilities that may participate are IDOC facilities, IDJJ facilities, Cook County Jail, and the JTDC. These same facilities are eligible to participate and can request technical assistance from MTAC as they prepare for a Readiness Assessment review. HFS will use the monitoring and evaluation

process from this demonstration to identify opportunities and best practices for jail sites and may include jails outside of Cook County as facilities that are able to participate in the pre-release services initiative through this demonstration in subsequent DYs. Additional county jails may be included in this demonstration if they demonstrate capacity to assure that the reentry population may access the minimum required services of case management, MAT, and 30-day supply of prescriptions upon release.

- As early as Q2 CY 2026, a facility may submit a readiness assessment to HFS. The following must also occur once a readiness assessment is successfully completed and prior to any services being initiated under this reentry initiative:
    - Provider Eligibility:
        - Facilities must meet all readiness assessment components to be eligible to participate in the reentry initiative.
        - Facilities must identify which pre-release services that will be provided. If at the time of their readiness assessment review, a facility is not going to be providing the full complement of pre-release services approved in the reentry demonstration initiative, the facility must provide a plan and timeline for when they will be able to provide or facilitate the provision of all pre-release services approved in reentry demonstration initiative.
    - Provider Qualifications:
        - Providers of any clinical-related pre-release services must meet applicable licensure/certification requirements.
        - All providers must meet any additional provider qualification requirements, to be identified by HFS, as early as Q2 CY 2026.
    - Provider Enrollment Process:
        - All providers providing pre-release services to Medicaid members in the approved facility, must first be enrolled as a Medicaid provider prior to rendering services, following current Illinois provider enrollment processes.
- As early as Q3 CY 2026, pre-release services can be provided and covered by Illinois Medicaid FFS. Services can only be billed for after the facility completes a readiness assessment and is approved by HFS.

Identified Challenges and Plans to Address Each

- **Provider Enrollment**. It is anticipated that it could be administratively burdensome for correctional facilities and community-based providers to enroll as Medicaid providers. To assist, non-services funds, and technical assistance through MTAC may be available to facilities and community-based providers.
- **Billing and Claiming**. It is anticipated that Medicaid billing and claiming processes could also be administratively burdensome for correctional facilities

and community-based providers. To assist, non-services funds[8] and technical assistance through MTAC may be available to facilities and community-based providers.

Organizational Level Engagement, Coordination, and Communication (Milestone 5.b)

Action: Develop a plan for organizational level engagement, coordination, and communication between the corrections systems, community supervision entities, health care providers and provider organizations, state Medicaid agencies, and supported employment and supported housing agencies or organizations.

Current State

At the foundation of reentry efforts, several comprehensive plans exist in Illinois to enhance the reentry ecosystem, including Illinois Department of Human Services' (DHS) Reimagine Public Safety Illinois, which is a result of Illinois' Reimagine Public Safety Act (430 ILCS 69) and the Illinois' Reentry Council Strategic Plan. Further, HFS, IDOC, IDJJ, the partners at Cook County, and ICJIA all have partnerships and initiatives with various organizations and sister agencies in Illinois to support the justice-involved population. At the onset of this demonstration initiative's application, HFS began convening stakeholder workgroups and these groups will continue to meet to inform the implementation and design of this Reentry Demonstration Initiative. HFS, along with its reentry stakeholders, will continue to seek ways to enhance coordination and communication among partners and will ensure alignment with the foundational plans in place in Illinois to enhance programs and services to wrap around individuals interfacing with the justice system and carceral settings.

ILLINOIS DEPARTMENT OF CORRECTIONS. As individuals served by the IDOC are also likely to be served by other organizations and state agencies, coordination, engagement, and communication between departments is a key part of reentry efforts. This includes monthly meetings with the Illinois Department of Human Services (DHS) and coordination with the DHS' Department of Mental Health as needed. IDOC also works collaboratively with the Illinois Department of Public Health (IDPH) for individuals needing a higher level of care and/or having a higher level of need, such as those needing to access state mental health facilities.

IDOC is currently working on several housing-related initiatives that require significant coordination and collaboration, including:

- Participating in the Illinois Housing Development Authority's (IHDA) reentry pilot to connect people to permanent supportive housing immediately upon release. That process begins pre-release, and if accepted/approved the individual is transitioned to their own apartment upon reentry.

[8] Non-service related needs may include: Technology and IT, hiring of staff and training, adoption of certified electronic health record technology, purchase of billing systems, development of protocols and procedures, additional activities to promote collaboration, planning focused on developing processes and information sharing protocols, and other activities to support a milieu of appropriate activities for the provision of pre-release services

- Working with community mental health providers that participate in DHS's Housing is Recovery Program. IDOC contracts with two community mental health agencies/providers for permanent supportive housing and services.
- Working with ICJIA on the Flexible Housing Pool Program in Cook County, which has contracted a case management provider that is versed in providing services to individuals with high mental health and medical needs. Individuals at risk of homelessness and with high mental health needs are connected to these organizations pre-release for referral, assessment, case planning, and are released to them for service provision and permanent supportive housing post-release.
- Partnering with the Division of Substance Use, Prevention and Recovery's (SUPR) licensed Recovery Home providers for post-release transitional housing and case management for individuals at risk of homelessness and with substance abuse service needs.

IDOC also participates in the Summit of Hope, which is coordinated by IDPH. These reentry summits are hosted annually in different communities throughout the state and is geared toward individuals on supervision. This is a large collaborative effort that helps provide access to screenings and to services such as housing, state identification assistance, vaccinations, and access to hygiene products.

ILLINOIS DEPARTMENT OF JUVENILE JUSTICE. Similar to IDOC, IDJJ has networks of providers to help connect individuals to needed services. These relationships consist of both formal contracts and informal referral partners.

COOK COUNTY. In addition to the partners already outlined in this plan, Cook County Health has developed a synergized strategy to help different teams (Cermak Health Services, CountyCare, Patient Access, etc.) work together. This includes establishing relationships with the financial counselors operating within Cook County Jail to ensure a smooth and warm handoff for all Medicaid applicants and CountyCare members. In addition, CountyCare has established data exchanges with adult probation. However, the data reporting optimization is still in development. The desired state is collaboration across entities to ensure that justice-involved members can be identified, found and engaged in healthcare services.

Future State: Activities to be Completed and Timeline

- As implementation planning progresses and roll out of the demonstration occurs, HFS will continue to convene various workgroups to strengthen communication and collaboration among partners. Additional forums and opportunities for engaging other stakeholders, including those with lived experience, will be explored.
- As early as Q1 CY 2026, HFS, in collaboration with sister agencies and other justice-involved partners, will develop a stakeholder engagement plan to assure organizational level engagement, coordination, and communication. Corrections systems, community supervision entities, health care providers and provider organizations, state Medicaid agencies, and supported employment and supported

housing agencies or organizations will all be part of this plan and existing forums and workgroups will be leveraged.

Identified Challenges and Plans to Address Each

- **Potential for Competing Priorities and Resource Allocation Needs for Ongoing Implementation Planning and Collaboration.** HFS anticipates that an ongoing challenge will be competing priorities and resource allocation issues among reentry stakeholders, especially sister state agencies. Through frequent implementation meetings, HFS will work with the various stakeholders to facilitate the ongoing active participation and input needed for a successful implementation of the reentry demonstration initiative.

Awareness and Education about Medicaid Coverage and Health Care Access (Milestone 5.c)

Action: Develop strategies to improve awareness and education about Medicaid coverage and health care access among various stakeholders, including individuals who are incarcerated, community supervision agencies, corrections institutions, health care providers, and relevant community organizations (including community organizations serving the reentering population).

Current State

Illinois leverages a robust strategy to ensure awareness of and education about Medicaid coverage and health care access. Illinoisians are encouraged to use a phone line or a website to connect to health care coverage options.

Future State: Activities to be Completed and Timeline

- As outlined in milestone 1, HFS will work with IDOC, IDJJ, and the partners at Cook County to ensure that enhancements are made to existing processes to help provide education about Medicaid coverage.
- HFS will leverage existing forums and workgroups described in milestone 5.b to also improve awareness and education to partners.
- HFS will explore additional opportunities to increase awareness and education, such as through provider communications, managed care plan member and provider resources and communications, and other public campaigns that are promoting health and access to health care coverage and services.

Identified Challenges and Plans to Address Each

- **Workforce Turnover.** A potential challenge in reaching and maintaining this milestone is knowledge deficit that can be caused by staff turnover. HFS, in collaboration with IDOC, IDJJ, and the partners at Cook County, will ensure that local processes account for and plan to address this by having clearly established workflows for staff to follow in educating and connecting individuals to coverage as needed.
- **Individual Health Literacy.** We know that not all individuals eligible for Medicaid will access Medicaid. To help better promote education and

understanding about Medicaid, local facility strategies will utilize peers and those with lived experience to help build and share key messages and to translate program and promotional materials into plain language. For those served by DJJ, education will be provided to the family in addition to the youth.

Monitoring Health Care Needs and HRSN (Milestone 5.d)

Action: Develop systems or establish processes to monitor the health care needs and HRSN of individuals who are exiting carceral settings, as well as the services they received pre-release and the care received post-release. This includes identifying any anticipated data challenges and potential solutions, articulating the details of the data exchanges, and executing related data-sharing agreements to facilitate monitoring of the demonstration...

Current State

As described within this plan, systems and processes for monitoring the health care needs and HRSN of individuals exiting carceral settings are localized and vary by setting and an individual's needs.

Future State: Activities to be Completed and Timeline

- HFS will leverage existing systems and processes to the extent possible to establish a system or process for specifically monitoring the health care needs and HRSN of individuals participating in the reentry demonstration initiative. HFS will work with partners, including IDOC, IDJJ, Cook County, case management organizations, other pre-release and post-release providers, and managed care plans to inform this system or process.
- As outlined in milestones 3 and 4, pre-release case management and post-release case management will be foundational for these processes.
- As applicable, tracking health care needs and HRSN will be incorporated into the monitoring protocol and evaluation design.

Identified Challenges and Plans to Address Each

- **Potential for Variation Needed.** It is possible, especially in the early stages of implementation, that manual processes will need to be operationalized first. This will be known at the time of a facility's readiness assessment and minimum reporting and tracking components will be established and clearly communicated. Another potential variation includes the connection to post-release case managers. Organizations and capacity vary by region in the state. HFS and its partners will develop plans to monitor capacity and outputs in the post-release period.

Attachment L
Reentry Demonstration Initiative Reinvestment Plan [Reserved]