APPENDIX III

Illinois' Behavioral Health Transformation

Section 1115 Demonstration Waiver

Prepared by
Illinois Department of
Healthcare and Family Services

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ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Section 1: Program Description

Section 1.1: Overview and introduction

Illinois is one of the largest funders of health and human services (HHS) in the country. With $32 billion spent across its HHS agencies,[1] amounting to more than 40% of its total budget, the State is deeply invested in the health and well-being of its 12.9 million residents and 3.2 million Medicaid members.[2,3] There is an urgent need to get more from this investment: the State must improve health outcomes for residents while slowing the growth of healthcare costs and putting the State on a more sustainable financial trajectory.

To this end, Illinois has embarked on a transformation of its HHS system. The transformation, which was announced by Governor Bruce Rauner in his 2016 State of the State address, "*puts a strong new focus on prevention and public health; pays for value and outcomes rather than volume and services; makes evidence-based and data-driven decisions; and moves individuals from institutions to community care to keep them more closely connected with their families and communities.*"

Consistent with the Triple Aim, the HHS transformation seeks to improve population health, improve experience of care, and reduce costs. It is grounded in five themes:

- Prevention and population health
- Paying for value, quality, and outcomes
- Rebalancing from institutional to community care
- Data integration and predictive analytics
- Education and self sufficiency

To move the transformation plan from theory to practice, Illinois has assembled a broad cross-agency transformation team from the Governor's Office and 12 state agencies (Exhibit 1).

Exhibit 1: Cross-agency transformation team members

13 ILLINOIS ENTITIES ARE INVESTED IN HHS TRANSFORMATION	
Abbreviation	**Name of entity participating in behavioral health transformation**
GO	Governor's Office

1 Based on SFY 2015 and includes DHFS, IDHS, DCFS, IDoA, IDOC, IDES (Illinois Department of Employment Security), IDPH, IDVA
2 State Fiscal Year 2015 Illinois DHFS claims data
3 From this point forward Medicaid will refer to both Title XIX and Title XXI of the Social Security Act.

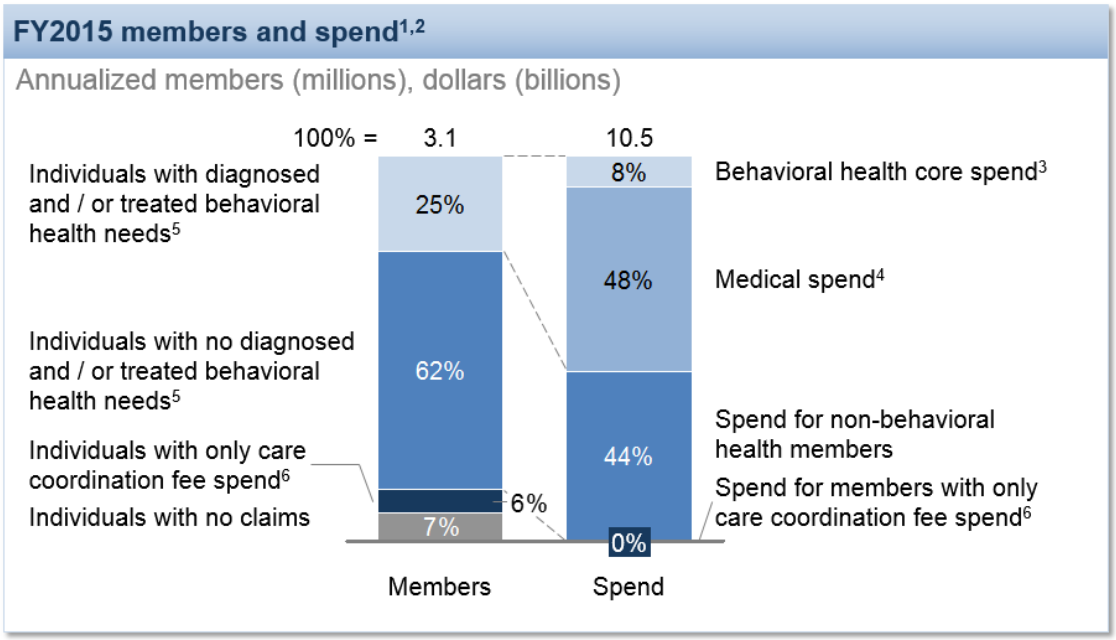
DHFS	Illinois Department of Healthcare and Family Services
DCFS	Illinois Department of Children and Family Services
IDHS	Illinois Department of Human Services
IDJJ	Illinois Department of Juvenile Justice
IDOC	Illinois Department of Corrections
IDoA	Illinois Department on Aging
IDPH	Illinois Department of Public Health
IDVA	Illinois Department of Veterans' Affairs
IHDA	Illinois Housing Development Authority
DoIT	Illinois Department of Innovation and Technology
ISBE	Illinois State Board of Education
ICJIA	Illinois Criminal Justice Information Authority

The initial focus of the transformation effort is on behavioral health (mental health and substance use) and specifically the integration of behavioral and physical health service delivery. Behavioral health was chosen due to the urgency of the issue as well as the potential financial and human impact. Building a nation-leading behavioral health strategy will not only help bend the healthcare cost curve in Illinois but also help turn the tide of the opioid epidemic, reduce violent crime and violent encounters with police, and improve maternal and child health. There is also a large financial payoff in improving behavioral health: Medicaid members with behavioral health needs (referred to henceforth as "behavioral health members") represent 25% of Illinois Medicaid members but account for 56% of all Medicaid spending (Exhibit 2).[4]

4 State Fiscal Year 2015 Illinois DHFS claims data

Exhibit 2: Behavioral health members as proportion of Medicaid population

Medicaid members with diagnosed and/or treated behavioral health needs make up 25% of the population, but 56% of the total spend



1 Annualized members (not unique members) shown here with no exclusions made on population or spend. Annualized member count = Sum of member months/12
2 Most inclusive definition of behavioral health population used here of members who are diagnosed and treated, diagnosed but not treated, and treated but no diagnosis present. Behavioral health core spend defined as all spend with a behavioral health primary diagnosis or behavioral health-specific procedure, revenue, or HIC3 pharmacy code.
3 Behavioral health core spend is defined as spend on behavioral health care for individuals with behavioral health needs
4 Medical spend is defined as all other spend for individuals with behavioral health needs. See appendix for additional methodology notes
5 Behavioral health diagnosis is defined as a behavioral health diagnosis in any of the first 18 diagnosis fields of any claim during the year. Behavioral health treatment is identified on the basis of a claim with a behavioral health primary diagnosis or a behavioral health-specific procedure, revenue, of HIC3 drug code during the year
6 Annualized members with only spend for care coordination fees. Care coordination fee is identified by HCPCS codes - G9002, G9008

SOURCE: FY15 State of Illinois DHFS claims data

The focus on behavioral health has been informed by the State's *Healthy Illinois 2021* plan, which encompasses the State Health Assessment (SHA), the State Innovation Model (SIM) grant awards, and the State Health Improvement Plan (SHIP). Together, these initiatives aim to align plans, processes, and resources to improve the health of Illinois residents. Illinois' two State Innovation Model (SIM) design grant awards from the Center for Medicare and Medicaid Innovation - a Round One award in 2013 and a Round Two award in 2015 – helped the State to create focused and measurable health improvement strategies and identify behavioral health

as a priority. Together, the SHA, SIM, and SHIP work have been foundational to the Illinois' HHS transformation and to the requests in this waiver.

The SIM work was led by the Governor's Office and the Illinois Department of Public Health, with input from key stakeholders including other State agencies, provider associations, community organizations, payers, advocacy groups, and educational institutions. An executive committee and four SIM workgroups (consumer needs, data and technology, physical and behavioral health integration, and quality measure alignment) met monthly over five months to provide recommendations for key strategies of the *Healthy Illinois 2021 Plan*.

These stakeholders identified several priorities for transformation efforts, including the need to reduce siloes in behavioral health care to enable a more efficient system with greater integration of physical and behavioral health. This waiver demonstration proposes critical next steps to accomplish this mission, aiming to achieve six main goals:

1. Rebalance the behavioral health ecosystem, reducing overreliance on institutional care and shifting to community-based care
2. Promote integrated delivery of behavioral and physical health care for behavioral health members with high needs
3. Promote integration of behavioral health and primary care for behavioral health members with lower needs
4. Support development of robust and sustainable behavioral health services that provide both core and preventative care to ensure that members receive the full complement of high-quality treatment they need
5. Invest in support services to address the larger needs of behavioral health members, such as housing and employment services
6. Create an enabling environment to move behavioral health providers toward outcomes- and value-based payments

This 1115 waiver application is only one component of a broader strategy to help achieve the above goals. The State has already started to integrate physical and behavioral health by carving-in behavioral health into the managed care system and developing a set of proposed State Plan Amendments (SPAs) that support integration. The waiver proposals in this application build on this work to lay the foundation for a truly integrated physical and behavioral health system, centered on members, their families, and their communities. The waiver proposals seek to test new ideas that catalyze innovation in integration and value-based payments. They also seek to test a combination of services that may have been pursued in isolation but promise to be more effective together, tailored more precisely to member needs.

Illinois Medicaid is committing to producing federal savings of $1.2 billion over the life of the waiver and re-investing these savings to help achieve the demonstration goals. The State

believes that the benefits and initiatives authorized by this waiver demonstration are fundamental components to bring Illinois' vision to fruition.

Greater detail is provided in the following subsections:

- Section 1.2: Context for Illinois' 1115 waiver demonstration
- Section 1.3: Illinois' waiver demonstration plan
- Section 1.4: Demonstration hypotheses and evaluation approach
- Section 1.5: Demonstration location and timeframe

Section 1.2: Context for 1115 waiver demonstration

Illinois and its Medicaid program have undergone significant changes over the past few years and now approach its behavioral health strategy and this waiver demonstration with a heightened sense of urgency.

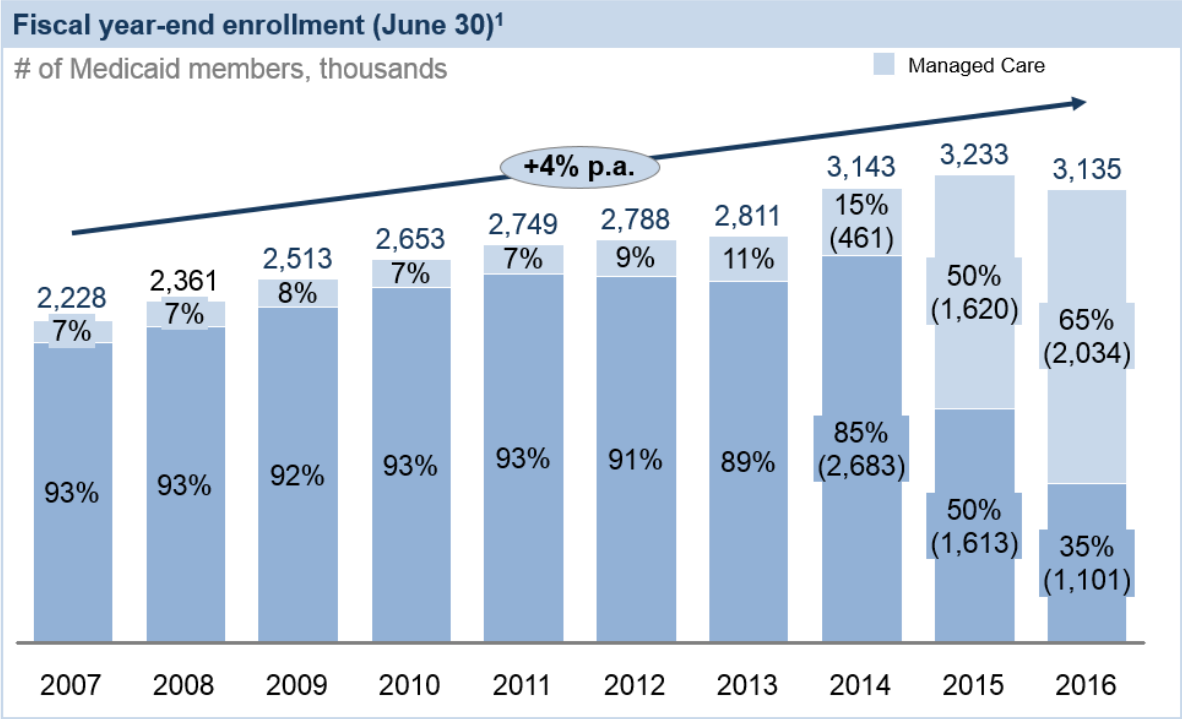
Section 1.2.1: Overview of Medicaid in Illinois

Illinois spends more than $18 billion on the approximately 3.2 million Medicaid members in the State.[5] With Medicaid expansion under the Affordable Care Act (ACA), approximately 600,000 members were added to the Medicaid rolls, shifting Illinois' Medicaid population from mostly children to mostly adults.[6] Furthermore, 65% of Illinois' Medicaid population is now enrolled in capitated managed care, up dramatically from 15% in 2014 (Exhibit 3).[7] This amounts to seismic and purposeful change in the Medicaid landscape in the State that will continue to unfold.

Exhibit 3: Medicaid, MCO enrollment growth

5 State Fiscal Year 2015 Illinois DHFS claims data
6 DHFS eligibility
7 DHFS Bureau of Rate Development and Analysis

Medicaid enrollment has grown ~4% annually since 2007; capitated managed care enrollment has more than quadrupled in the past three years



1 Excludes partial eligibility

SOURCE: Healthcare and Family Services Bureau of Rate Development and Analysis

Adapting to this new reality has been a challenge for both the State government and the State's healthcare delivery system. Since many rules and practices were tailored to a pre-ACA world with limited capitated managed care, Illinois is now "catching up" by updating them. For example, proposed changes to Illinois' administrative rules aim to ease the burden on providers and break down barriers to the integration of behavioral and physical health, such as requiring that all services provided by CMHCs be tied back to a mental health need.

Providers have also faced challenges. In mandatory managed care regions, the primary relationships for providers have shifted from those with the State to ones with managed care organizations (MCOs), a transition that has not been without growing pains (e.g., adapting to the billing practices and systems of multiple MCOs). Providers are working to adapt to a predominantly managed Medicaid environment, and managed care organizations have begun to form partnerships with provider coordination entities to improve care. These partnerships are in their infancy, so there are substantial opportunities to enhance their impact.

The Illinois budget situation has exacerbated challenges in the healthcare delivery system. Because the State only achieved a stop-gap budget on the last day of the 2016 fiscal year (June 30, 2016), the healthcare ecosystem faces uncertainty for the months ahead.

Section 1.2.2: Overview of behavioral health in Illinois

Illinois aspires to nation-leading behavioral health outcomes yet today outcomes vary widely. On some indicators, Illinois performs better than many of its state peers. For example, Illinois ranks 11th among states for rates of youth substance abuse or dependency problems (5.8%)[8] and 14th for drug deaths per 100,000 (11.9).[9] On other measures, the State performs below the national average. Illinois ranks 30th in mental health workforce availability with 844 people per mental health worker compared to the national median of 752 and the 25th percentile of 520.[10] Illinois ranks 32nd and 31st in the nation in pre-term birth and violent crime rates, respectively, both of which have links to behavioral health.[11] Lastly, Illinois ranks 41st in the nation in mental health service coverage for children, with just 45% of children who need services receiving them.[12] Given the State's overall spending on the behavioral health population, these results demonstrate clear room for improvement.

The Illinois behavioral health ecosystem is heavily reliant on deep-end, institutional care rather than upstream, community-based care. Approximately 40% of Illinois Medicaid behavioral health spend is dedicated to inpatient or residential care[13] and utilization of state psychiatric hospitals per 1,000 residents is 44% higher than the national average. This stands in sharp contrast to utilization of lower-cost community care facilities, which is less than half the national average.[14] This over-reliance on institutional care has significant implications for behavioral health members, who may experience additional stress due to removal from their communities and treatment in more restrictive institutional settings.

To understand what drives this high spend and poor outcomes, Illinois has conducted quantitative and qualitative analyses and sought extensive stakeholder input through dozens interviews, multiple town halls, and review of more than 200 written recommendations. In addition, to understand the behavioral health system from a member-centric perspective, the State devised 14 representative member archetypes. The archetypes reflect the diversity of

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8 *America's Health Rankings 2015*, United Health Foundation
9 *Parity or Disparity: The State of Mental Health in America 2015*, Mental Health America
10 Ibid. Ratio includes psychiatrists, psychologists, licensed clinical social workers, counselors, and advanced practice nurses specializing in mental health care.
11 *America's Health Rankings 2015*, United Health Foundation
12 *America's Health Rankings 2015*, United Health Foundation
13 State Fiscal Year 2015 Illinois DHFS claims data.; does not include supplemental payments to hospitals
14 SAMHSA Uniform Reporting Measures, 2014 State Health Measures

Illinois' behavioral health population and illuminate the many clinical and non-clinical factors that can influence behavioral health outcomes. The archetypes are displayed in Exhibit 4

Exhibit 4: Behavioral health member archetypes

The strategy has been informed by pain points experienced by 14 customer archetypes that vary by age, living situation, and behavioral health condition

Archetype	Lenses: Age	Living situation	Behavioral health condition
Jerry	Toddler	In at-risk home	At-risk
Jane	Child	Foster home	ADHD/ODD
Connor	Teenager	Transferring to congregate care	Severe aggression
Brice	Teenager	Urban home	Major depression
Mike	Teenager	Juvenile institution	Bipolar disorder/ alcohol and marijuana abuse
Mia	Teenager	Rural home	Opioid abuse
Jenn	Young Adult	Rural home	Anxiety
Greg	Young Adult	Correctional facility	Schizophrenia
Stephen	Adult	Experiencing homelessness	Actively psychotic/ opioid abuse
Darnell	Adult	Experiencing homelessness	Post-traumatic stress
Ashley	Adult	Permanent supportive housing	Schizophrenia
Tom	Adult	Friend's couch	Alcohol and heroin abuse
William	Adult	Rural home	Alcohol abuse
Cynthia	Aged	Skilled nursing facility	Moderate anxiety and depression

The State is taking a fully multigenerational approach to behavioral health

Through the member archetypes, quantitative and qualitative analyses, and stakeholder input, Illinois has identified six primary pain points (Exhibit 5) the State must address to maximize the effectiveness of its behavioral health system.

Exhibit 5: Key pain points in behavioral health system

SIX PAIN POINTS FOR BEHAVIORAL HEALTH MEMBERS	
Pain point	**Description**
Lack of coordination of behavioral health services	• Currently no designated point of accountability for whole-person needs (medical and behavioral health care) • Services often delivered in siloes, resulting in gaps and interruptions in service, particularly during transitions

	between care settings and during major life changes (such as being released from incarceration; aging out of the Department of Child and Family Services, or DCFS, system; loss of housing) • Lack of coordination results in care deficiencies and sub-optimal care allocation • Evidence: – At 23.5%, Illinois ranks 42nd in the nation in state psychiatric hospital 180-day readmission[15] – Behavioral health population has 80 admissions per 1,000 and 14 readmissions per 1,000[16]
Challenges in identifying and accessing those with the greatest needs	• No evidence-based approach to identify need and target care • Limited funding for identification and prevention services • Un-integrated, disparate access points for key subpopulations such as homeless individuals and parolees • Care tends to be reactive, rather than preventative • Evidence: – More than 40% of core behavioral care spend is inpatient care, indicating failure to assess and intervene early[17]
Insufficient community behavioral health services capacity	• Limited community capacity prohibits behavioral health services from being provided in the most appropriate, lowest-acuity settings possible, such as in members' homes and in less intensive outpatient settings • Community capacity has not expanded to meet the needs of an expanded and more heavily adult Medicaid population • Evidence: – Illinois ranks 30th in the nation in mental health workforce availability[18] – Wait times for new psychiatrist appointments can be as long as 3 months
Limited support services to address "whole-person" needs	• Limited assistance in supportive housing, transport, and job training • Existing services are poorly coordinated • Evidence:

15 *Parity or Disparity: The State of Mental Health in America 2015*, Mental Health America
16 State Fiscal Year 2015 Illinois DHFS claims data
17 Ibid.
18 *Parity or Disparity: The State of Mental Health in America 2015*, Mental Health America

	– ~40,000 individuals in Illinois have housing needs; only 17,500 of those 40,000 are receiving the services they need[19] – Only 29% of adults with known mental health conditions who are served in the community are employed, vs. 39% nationally[20]
Duplication and gaps in behavioral health services across agencies raise costs	• Duplication due to lack of cross-agency procurement strategy for common purchases • Gaps and interruptions in services arise because many programs and services lack a "natural owner" to provide them • Program-centric (rather than member-centric) orientation of behavioral health system leads to duplication and gaps • Evidence: – 42.2% of members served by the Division of Alcoholism and Substance Abuse (DASA) are criminal-justice referrals without direct coordination between entities[21] – Agencies occasionally offer same or similar services without capturing synergies
Deficiencies in data, analytics, and transparency	Illinois has submitted an Implementation Advance Planning Document (IAPD) to address the following pain point: • Information often not shared across state agencies and providers, making it difficult to draw critical insights • Evidence: – No single view of the behavioral health member exists, making it difficult to understand member history and tailor service packages based on what is most likely to drive positive outcomes

Section 1.2.3: Illinois' vision for an integrated behavioral and physical health delivery system

Although the lack of coordination of behavioral health services is one of the largest behavioral health system pain points, Illinois believes merely resolving this pain point and promoting coordination of behavioral health services do not go far enough. Rather, the State aspires to full-scale integration of behavioral and physical health services, ensuring team-based care and

19 Illinois Supportive Housing working group, 2016
20 SAMHSA Uniform Reporting System – 2014 State Mental Health Measures
21 DASA Provider Performance and Outcomes Reports – SFY 2015

seamless communication across and between medical and "social service neighborhoods." Building upon a managed care system that carves behavioral health into the medical program, the State, in collaboration with its managed care partners, aims to enhance true integration of behavioral and physical healthcare through an ambitious integrated behavioral and physical health home program that promotes accountability, rewards team-based integrated care, and shifts away from fee-for-service (FFS) towards a system that pays for value and outcomes. Henceforth, these will be referred to as "integrated health homes" or "IHHs."

Agencies involved in the HHS transformation have collectively defined integration as "the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."

Illinois' vision for integration is ambitious, and the current provider delivery system is not structured to support it. Today, behavioral and physical healthcare providers often operate in siloes and fail to exchange information, let alone collaborate as part of a seamlessly integrated care team.

The development of integrated behavioral and physical health homes and the payment model to sustainably support them will be a significant step in realigning the Illinois delivery system. The State envisions that these IHH providers and teams will have:

- Access to enhanced integration funding to facilitate the creation of these health homes (to be discussed in Section 4.1)
- Reimbursement (e.g., PMPM payments) for care coordination activities that promote whole-person care for eligible populations in need
- Outcomes-based payment models that reward measurable, positive outcomes associated with integrated care (across behavioral and physical health indicators)

Illinois recognizes that these IHHs will not materialize without considerable planning; both further design and development processes are required. The State therefore intends to progress the design of these health homes with significant stakeholder input, building upon and furthering other demonstrations across the country. It also intends to allow flexibility for multiple models to emerge across the State to address the needs of different segments of the population and allow for continued provider innovation.

Further, the State appreciates that different providers are at different stages in their evolutions toward becoming integrated health homes. Therefore, the model will likely follow a phased

approach under which all providers are encouraged to make progress. This approach will also create greater incentives for those providers that are able to move more quickly towards a higher degree of integration. An evolution of Illinois' payment and delivery system can be found in Appendix A.

Section 1.2.4: The Illinois behavioral health aspiration and strategy

Illinois' vision for an integrated behavioral and physical health delivery system is part of a broader and comprehensive behavioral health strategy. In seeking to transform its behavioral health system, the State has solicited input from a wide range of stakeholders representing a diversity of geographic and socioeconomic perspectives. This stakeholder engagement is further discussed in Section 1.2.6.

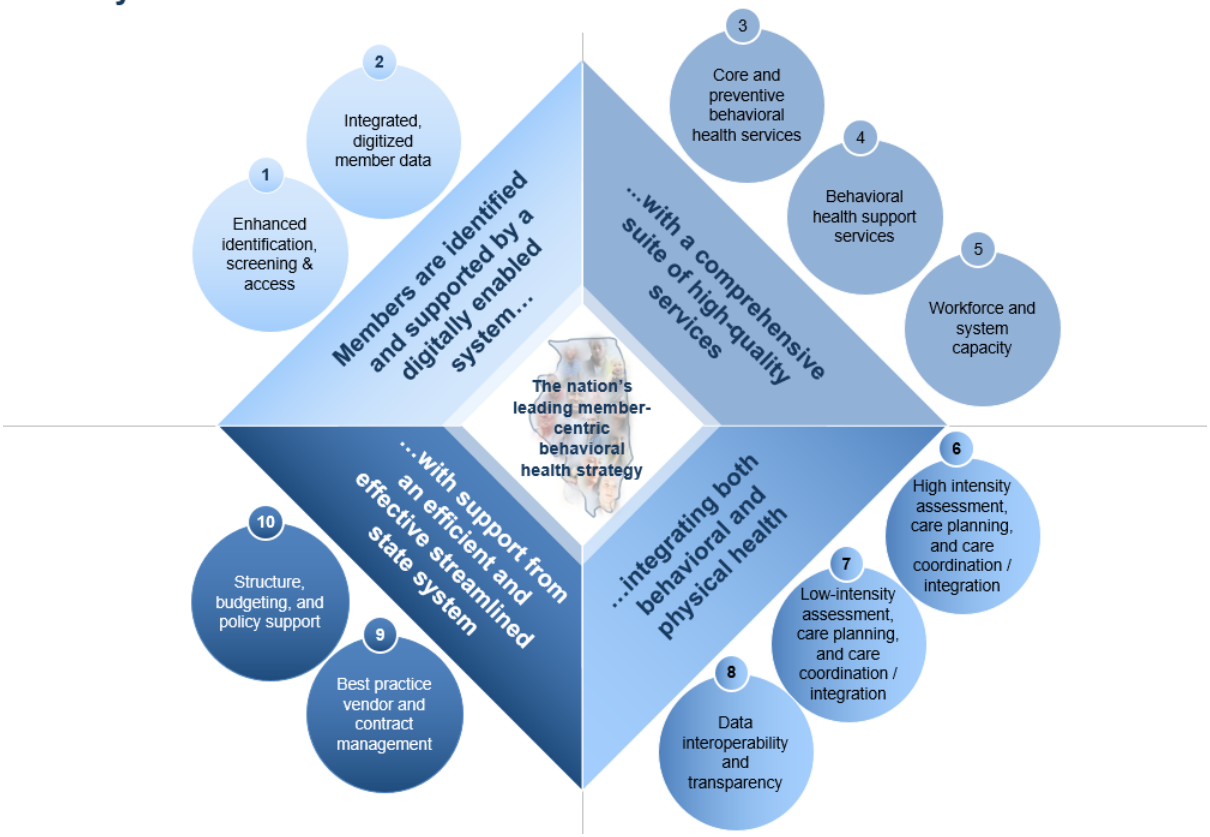
Building on stakeholder input, the State and the stakeholder community envision a future behavioral health system in which:

- Members are identified and supported through a digitally enabled system
- Members have access to a comprehensive suite of high-quality services
- Behavioral and physical health services are integrated
- A streamlined state administrative system provides effective and efficient support

Exhibit 6 depicts these four central approaches and ten initiatives to support them. In the following four subsections, these approaches are described in depth.

Exhibit 6: Four central approaches and ten initiatives of Illinois' behavioral health strategy

Illinois envisions a member-centric behavioral health system enabled by ten key initiatives



Section 1.2.4.1: Members are identified and supported by a digitally enabled system
Today, many behavioral health members fall through the cracks: nearly a quarter of this population receives a behavioral health diagnosis in any given year but does not receive any behavioral health services, and more than 10% receive behavioral health services, largely medications, without a corresponding behavioral health diagnosis.[22] To address this issue, the State first aims to enhance identification, screening, and access by meeting members "where they are" and using uniform screening and assessment tools for earlier diagnosis, more proactive care, and improved provider communications.

22 State Fiscal Year 2015 Illinois DHFS claims data

Second, the State will integrate digitized member data to facilitate unified, non-duplicative approaches to addressing member needs, which will help optimize service allocation and direct services to where they can be most effective. Illinois plans to submit an Implementation Advanced Planning Document (IAPD) to build a 360-degree member view that can provide a comprehensive picture of needs across the HHS system.

Section 1.2.4.2: Members have access to a comprehensive suite of high-quality services
The current behavioral health system concentrates care in institutional settings and lacks sufficient community-based alternatives to deliver care where it can often be more effective and less costly. The State aims to address the over-reliance on institutional care in several ways.

First, Illinois aims to strengthen community-based behavioral health services, both core (dedicated behavioral health services) and preventative (upstream interventions to prevent behavioral health conditions from arising or mitigate their impact through early identification and immediate treatment). It also seeks to optimize its use of higher-acuity services, providing appropriate oversight to ensure that they occupy the appropriate position in the continuum of care, mapping directly to members' needs.

Second, the State seeks to strengthen support services, such as housing and employment assistance, to augment and reinforce core and preventative behavioral health services. Illinois believes supportive services are essential for meeting whole-person needs, enhancing the effectiveness of core services, and enabling members to improve their own outcomes.

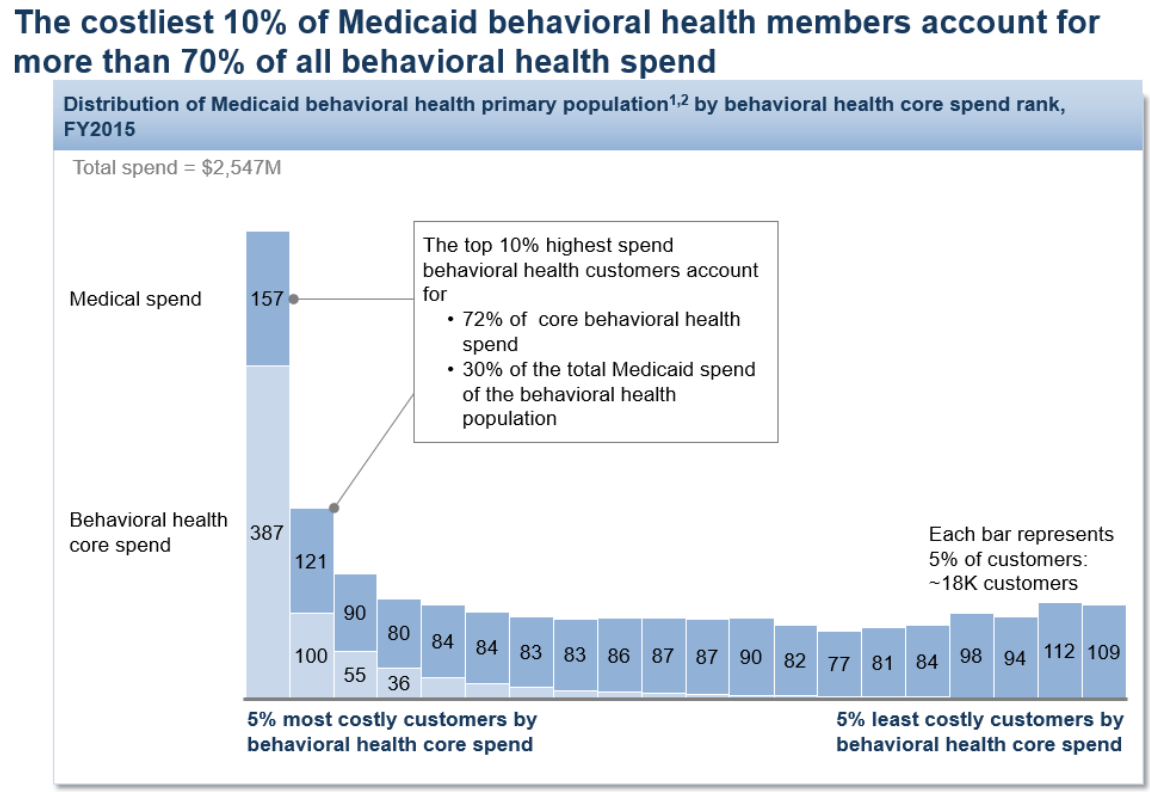
Finally, these services must be delivered by a workforce that is up to the task. To this end, Illinois aims to expand the supply of highly trained mental health professionals and enhance the efficiency and effectiveness of the existing workforce through increased access to training opportunities and system design that encourages professionals to practice at the "top of their license." Illinois envisions technology-enabled services such as tele-psychiatry as a central component of this workforce strategy, particularly for bringing high-quality care to residents in underserved areas of the State.

Section 1.2.4.3: Behavioral and physical health services are integrated
The State sees three pillars in its mission to integrate physical and behavioral health:

1. *High-intensity assessment, care planning, and care coordination and integration*: As outlined in Section 1.2.3, Illinois intends to build a system of integrated health homes to manage members with complex behavioral health needs (e.g., serious mental illness,

substance use disorder (SUD)) and hold providers accountable for outcomes.[23] Illinois will submit an updated SPA for these IHHs, which will align financial incentives around a comprehensive approach to behavioral and physical health services, uniform assessment, evidence-based practices, and wellness promotion. Illinois believes that IHHs targeted at members with the highest needs will have a significant impact on outcomes and healthcare spending because the costliest 10% of Medicaid behavioral health members account for more than 70% of all Medicaid spending on behavioral health in the State (Exhibit 7).[24] These IHHs will ensure that the needs of this highly complex population are met.

Exhibit 7: The costliest 10% of Medicaid behavioral health members



1 Distribution of unique members shown here
2 Primary population defined as Medicaid members with behavioral health needs minus those who have been treated but not diagnosed and those who have been diagnosed but not treated. It also excludes those with dual eligibility or non-continuous eligibility or third-party liability, It also excludes those who died during their inpatient stays

SOURCE: FY15 State of Illinois DHFS claims data

23 Health homes traditionally defined as providers who "integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person." Services include comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow-up, patient and family support, and referrals to community and social support services.

24 State Fiscal Year 2015 Illinois DHFS claims data

2. *Low-intensity assessment, care planning, and care coordination and integration*: Illinois' IHHs will also integrate behavioral health into primary care to serve members with lower behavioral health needs. This integrated approach is expected to have a significant payoff: many members with behavioral health problems also have chronic medical conditions or use primary care as their preferred point of contact. As shown earlier, many members either receive behavioral health services without a formal diagnosis or receive a behavioral diagnosis but no behavioral health services. To address these gaps, Illinois believes it can promote assessment, care planning, care coordination, and integration of physical and behavioral health at the primary care level as part of broader IHHs. These IHHs can be held accountable for outcomes and total cost of care, making whole-person care a necessity. Behavioral health integration into primary care through IHHs is expected to reduce barriers to access to behavioral health for lower-needs members and help ensure they receive services in the most appropriate setting.
3. *Data interoperability and transparency:* Enhanced data interoperability and transparency will be critical to enable full integration of physical and behavioral health. Data interoperability can ensure care team members have the most up-to-date information on a member to inform critical decisions. It can also help providers communicate more easily and more effectively, thus facilitating care integration. Meanwhile, greater transparency will give providers insight into their own performance as well as the performance of peers with whom they collaborate. For example, a primary care provider who suspects a member is on the verge of a behavioral health crisis should know which behavioral care providers are best-suited to serve that member. Furthermore, greater transparency will empower members themselves to make more informed decisions about the care they receive.

Section 1.2.4.4: A streamlined state administrative system provides effective and efficient support

To enhance the efficiency and effectiveness of the State system, Illinois plans to focus on two key areas: vendor/contract management and organizational effectiveness. By ensuring best practices for managing vendors and contracts, with an emphasis on outcomes and continuous improvement, Illinois will ensure system-wide accountability and strengthen relationships between providers, vendors, and the State. Enhancing this function will improve outcomes and enhance cost-effectiveness of state spending.

With the launch of the HHS transformation, Illinois has renewed its focus on organizational effectiveness and capacity building. New agency leadership has been assembled from both the private and public sectors, many of whom have successful records of transformation in other states. The transformation leadership team aims to ensure that the system is designed to achieve behavioral health objectives not only in the short-term, but also on an ongoing basis.

In search of additional efficiency and effectiveness measures, the State will revise outdated administrative rules that hinder the behavioral health system. Rules that were developed for a different time (e.g., Rule 132, which governs mental health, and Rules 2060 and 2090, which cover substance-use disorder) may now inhibit progress toward the outcomes Illinois seeks. For example, these rules may deter integration of behavioral and physical health rather than promote it. This process is expected to enhance behavioral health system capacity and remove structural barriers to integration.

Section 1.2.5: Alignment of ongoing state initiatives

The behavioral health strategy is aligned with a broad set of state efforts. It builds on the SIM work and aims to fulfill the behavioral health goals of the most recent SHIP initiative, which include integrating behavioral and physical health, reducing deaths caused by behavioral health crises, and rebalancing treatment from institutional to community settings. The strategy is also aligned with and expands upon recent state legislation "Public Act 099-0480," which aims to address the opioid crisis.

The State has also submitted a series of six Advance Planning Documents (APDs) on the data and analytics infrastructure to support the behavioral health strategy. These APDs help ensure compliance of Illinois Medicaid programs with new electronic healthcare standards and would update the State's Medicaid Management Information System (MMIS) and Medicaid Statistical Information System (MSIS). The component of the strategy addressing integrated, digitized member data will be pursued through a recently submitted IAPD, which focuses on building a shared interoperability platform that can provide a comprehensive view of each member, including service eligibility, provider interactions, and State agency relationships. This view will help enable physical and behavioral health integration and provide common data where no direct relationships between providers exist today.

Finally, the State's participation in two CMS Medicaid Innovation Accelerator Programs (IAPs) provides access to technical assistance to guide Illinois' pursuit of the core components of its behavioral health strategy. The State's emphasis on supportive services such as housing is strengthened by its participation in "Promoting Community Integration through Long-Term Services and Supports" (on the "State Medicaid-Housing Agency Partnership" track). Additionally, integration is directly supported by the "Physical and Mental Health Integration" IAP.

The research, planning, and stakeholder engagement funded by CMS have served as foundational inputs into the behavioral health strategy and stakeholder support. Each of these efforts fits within the broader HHS transformation as well as the State's behavioral health strategy. This waiver demonstration seeks to add to and build upon this portfolio of efforts and further advance healthcare transformation in Illinois.

Section 1.2.6: Stakeholder engagement

Stakeholder engagement and input have been critical in both informing the State's focus on behavioral health and the design of the strategy detailed above. Throughout the SHA, SIM Rounds One and Two, the creation of the SHIP, and the HHS transformation, more than 2,000 stakeholders collectively emphasized the urgency of behavioral health transformation in Illinois. In HHS transformation town halls, DCFS town halls, and dozens of meetings and surveys, stakeholders shared insights about pain points in the behavioral health system and suggested strategies to address them.

Stakeholders across the State provided detailed input into the SHA process during which 400 organizational leaders were engaged and 11 organizational presentations were held both in person and via webinar. These sessions provided an overview of *Healthy Illinois 2021* and solicited feedback on preliminary priorities; suggestions for additional priorities; examples of successful health improvement work; and perceived statewide assets, barriers, and opportunities. The State also held 11 focus groups with citizens in five counties from different regions across Illinois: Champaign, Cook, Lee, St. Clair, and Sangamon. Each focus group included no more than 15 participants and met for two hours. The limited group size fostered deeper discussions and more actionable recommendations.

During the SIM rounds, the Governor's Office convened four working groups that met regularly (Exhibit 8).

Exhibit 8: SIM workgroups

SIM Workgroup	Purpose
Consumer Needs	To inform SIM recommendations from the perspective of consumers and their families
Data and Technology	To recommend solutions (including those using existing resources) that enhance the secure and timely exchange of actionable clinical behavioral health data consistent with defined standards and to recommend opportunities for provider technical assistance
Physical and Behavioral Health Integration	To provide recommendations to support best practices for payers and providers, enhance care coordination, and develop collaborative practices and service linkages
Quality Measure Alignment	To develop a quality measurement strategy that allows for Statewide, multi-payer measurement and includes appropriate behavioral health measures

Working group members included state agency staff, provider association representatives, behavioral health advocates, behavioral health providers, physical health providers, payers, and consumers from across Illinois. Recommendations by the physical and behavioral health

integration working group, in particular, helped inform both the broad behavioral health strategy and the components of this 1115 waiver.

Most recently, four stakeholder-specific working groups were convened with consumer advocates, community services providers, behavioral health providers, and managed care organizations to obtain focused feedback on the emerging behavioral health strategy and components of this waiver application.

All channels of stakeholder engagement have informed the behavioral health strategy. Some components of the strategy are included and described in this waiver request. Other components are being pursued through other mechanisms (e.g., the IAPD; State Plan Amendments, etc.).

Section 1.3: Waiver demonstration plan

Illinois strongly believes this 1115 waiver is critical to the successful implementation of its behavioral health strategy. The proposed waiver elements seek to test new ideas that lay the foundation for innovation in integration and value-based payments. They also seek to test a combination of services that may have been pursued in isolation but promise to be more effective together.

Illinois believes the strategy, supported by the waiver, will have substantial impact on the lives of Medicaid members with behavioral health conditions, offering them a more comprehensive suite of services delivered in a way that is tailored more precisely to their needs. Additionally, Illinois believes that the strategy will have a positive financial impact over the life of the waiver. The State seeks approval for the initial investments needed to secure these savings and further promote the behavioral health transformation. The federal savings will come from implementing value-generating measures in the early years of the waiver, which would result in substantial savings by the last year of the demonstration.

Under this waiver demonstration, the State asks CMS to invest federal savings in a set of benefits and initiatives to advance its behavioral health strategy, which are outlined in Sections 1.3.2 and 1.3.3. All eligibility groups will continue to receive all State Plan benefits; the additional initiatives will maximize the impact of these benefits. In addition, the State asks CMS to fund a set of Designated State Health Programs (DSHPs) to enable further investment in its behavioral health strategy. The State will continue to fund its share of waiver benefits and initiatives as well as reinvest some of its savings in the behavioral health system through a set of SPAs that the State will submit for approval. The Illinois budget situation makes this demonstration a critical step on the path to offering a comprehensive continuum of behavioral health and supportive services for residents with behavioral health needs.

In aggregate, these measures will help Illinois create a value-based, member-centric payment and delivery system that not only fulfills the behavioral health strategy but also delivers member-centric care to all State-supported Illinois residents.

Section 1.3.1: Demonstration goals

This demonstration, which seeks to provide residents of Illinois with a full complement of well-integrated services, is integral to realizing two foundational components of the State's behavioral health strategy: providing a comprehensive suite of high-quality services and integrating physical and behavioral health.

This demonstration has six overarching goals, as mentioned previously:

1. Rebalance the behavioral health ecosystem, reducing overreliance on institutional care and shifting to community-based care
2. Promote integrated delivery of behavioral and physical health care for behavioral health members with high needs
3. Promote integration of behavioral health and primary care for behavioral health members with lower needs
4. Support development of robust and sustainable behavioral health services that provide both core and preventative care to ensure that members receive the full complement of high-quality treatment they need
5. Invest in support services to address the larger needs of behavioral health members, such as housing and employment services
6. Create an enabling environment to move behavioral health providers toward outcomes- and value-based payments

Goals 1, 2, and 3 are the State's primary objectives - effective integration and coordination and the correct balance of community-based and institutional care are critical to improving population health, improving experience of care, and reducing costs. The State is exploring ways to integrate behavioral and physical health through value-based payment and delivery models, IHHs for behavioral health members with high needs, and integrated primary care and behavioral health services management for behavioral health members with lower needs. This waiver will be essential for enabling Illinois care providers to transition to these models.

Goals 4 and 5 lay the foundation for the first three goals. To promote integration, re-balance the behavioral health system, expand the availability of community care, and reduce overreliance on institutional care, the State must build appropriate core, preventative, and supportive services. Without these services, outcomes will not improve significantly regardless of how well integrated behavioral health is with other healthcare and supportive services. As Illinois seeks to shift from an institutional care model to a more community-based one, a

broader array of services is critical. Therefore, goals 4 and 5 underpin the success of goals 1, 2, and 3.

Together, these five goals will enable significant progress toward achieving goal 6: the shift to outcomes- and value-based payment models. This shift is instrumental for achieving true transformation of Illinois' healthcare delivery system and ensuring the system is restructured with the member at the center. Meeting these goals will improve the quality of behavioral health care across the State and set the stage for payment models that reward providers for outcomes rather than volume.

To meet these six goals, Illinois proposes a set of benefits and initiatives to be tested under this waiver. Illinois will also submit a set of SPAs for services that are inextricably linked and complementary to the behavioral health strategy.

Section 1.3.2: Demonstration benefits

Illinois requests approval to implement a priority set of benefits and initiatives. In keeping with the spirit of 1115 demonstrations, many of the proposed benefits and initiatives are to be conducted in pilot form. The waiver initiatives are described in Section 1.3.3. As will be noted in Section 3, all eligibility groups will continue to receive all State Plan benefits.

The following list includes six benefits that the State seeks to pursue through this waiver demonstration. These benefits are further detailed in Section 3.

- Supportive housing services
- Supported employment services
- Services to ensure successful transitions for justice-involved individuals at the Illinois Department of Corrections (IDOC), Cook County Jail (CCJ), and the Illinois Department of Juvenile Justice (DJJ)
- Redesign of the substance use disorder service continuum
- Optimization of the mental health service continuum
- Additional benefits for children and youth with significant mental health needs

Section 1.3.3: Demonstration initiatives

The State also requests approval to pursue a set of initiatives to complement the benefits and maximize their effectiveness.

The following table (Exhibit 9) is an overview of the additional initiatives that the State seeks to pursue through this demonstration. They are detailed further in Section 4.

Exhibit 9: Overview of demonstration waiver initiatives

DEMONSTRATION WAIVER INITIATIVES		
#	**Initiative**	**Description**
1	Behavioral and physical health integration activities	Investment funds for the State, MCOs, and providers to promote integration of behavioral and physical health (e.g., development of team-based care partnerships between providers, workforce cross-training to ensure competence in both behavioral and physical health)
2	Infant/Early childhood mental health initiatives	Infant/early childhood mental health consultation, an early intervention approach to teach professionals who have frequent contact with young children (e.g., teachers, care providers) ways to improve the social-emotional and behavioral health and development of at-risk children Evidence-based home visiting for families of children born with withdrawal symptoms
3	Workforce-strengthening initiatives	Investment funds for the State and providers to support behavioral health workforce-strengthening initiatives (e.g., creation of a loan repayment program, curriculum redesign to promote integration, continuing education, training to work with justice-involved populations, and telemedicine infrastructure)
4	First episode psychosis (FEP) programs	Funding to start up teams to run programs that address individuals in the initial onset of a psychotic episode, aimed at avoiding the usual trajectory into disability

Section 1.3.4: Savings to enable demonstration benefits and initiatives

The State believes that the rebalancing of behavioral health services and the integration of physical and behavioral healthcare will produce substantial savings to the federal government. To ensure that the demonstration project is budget-neutral, the State will place all of its full-benefit Medicaid population under the waiver and commit to generating federal savings of $1.2 billion over the five-year life of the waiver, a 2% reduction in spending compared to what spending would be without the waiver.

Much of these savings will be generated by the design and implementation of value-based payment and delivery models that will integrate physical and behavioral health. To that end, Illinois intends to pursue IHHs at scale. These IHHs will be pursued through a SPA, but this waiver demonstration seeks to prepare providers to become IHHs through the integration activities described in Section 4.1 as well as a more comprehensive suite of available services through the waiver benefits and proposed SPAs. Collectively, with these value-based payment

models and the support of other initiatives, Illinois will be able to achieve its trend reduction target.

By improving the delivery of behavioral health services across the state and creating an infrastructure for continued improvement, the benefits and initiatives to be funded by this waiver will continue to generate federal and state savings well beyond the five-year demonstration period.

Section 1.3.5: Designated State Health Programs (DSHPs)

Illinois also seeks to fund DSHPs through this waiver demonstration. These DSHPs include state health services provided by a variety of agencies, including the Department of Juvenile Justice (DJJ), the Division of Alcoholism and Substance Abuse (DASA), and the Illinois State Board of Education (ISBE). The DSHPs will enable greater investment by Illinois in its behavioral healthcare system through the initiatives in this waiver as well as through a complementary set of SPAs that the State will submit for approval. These funds will be used to fill critical gaps in current behavioral health services and strengthen the delivery and effectiveness of these services.

Appendix B contains a list of the DSHPs that the State seeks to pursue through this waiver. Providers of services under these programs will not need to change the way they practice for these programs (e.g. will not need to bill Medicaid or become Medicaid-certified providers).

Section 1.4: Demonstration hypotheses and evaluation

The table below (Exhibit 10) presents an overview of the preliminary plan to evaluate the services funded by this waiver. It is subject to change and will be further defined as the program is implemented. The example measures are not final and do not represent an exhaustive list of measures that could be used to test each hypothesis.

Exhibit 10: Demonstration hypotheses, broken down by demonstration goal

PRELIMINARY EVALUATION PLAN		
Hypothesis	**Example measures (not final)**	**Data sources**
Goal 1: Rebalance the behavioral health ecosystem, reducing overreliance on institutional care and shifting to community-based care		
Rebalancing the behavioral health ecosystem will reduce total cost of care and optimize utilization (increasing appropriate utilization and reducing unnecessary utilization)	• Risk-adjusted total cost of care • Inpatient utilization/1,000 • Community mental health utilization/1,000	• Claims data

Helping members to stay in their communities will improve satisfaction	• Health Plan CAHPS scores[25] – Overall rating of health care received in last 6 months – Overall health plan rating	• Health Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey
Goal 2: Promote integrated delivery of behavioral and physical health care for behavioral health members with high needs		
Integration of behavioral and physical health care will improve the quality of care for members with high needs (costliest 10% of members)	• Health Plan CAHPS scores – Percentage of people who rate overall mental or emotional health as very good or excellent (for top 10%) • HEDIS quality measures – Follow-up within 7 days for behavioral health hospitalization – Diabetes screening in members with diabetes and schizophrenia	• Health Plan CAHPS • Claims data • Healthcare Effectiveness Data and Information Set (HEDIS)
Integration will reduce unnecessary utilization and total cost of care for members with high-needs	• Differential in member spend for chronic conditions between behavioral health and non-behavioral health populations • Rate of plan all-cause readmissions (PCR) Mental health inpatient utilization	• Claims data • HEDIS
Goal 3: Promote integration of behavioral health and primary care for behavioral health members with lower needs		
Integration of behavioral health and physical health will improve access to services for members with lower-needs	• Number and percent of diagnosed but untreated individuals with depression, anxiety, and substance use disorder	• Claims data • HEDIS

25 Can substitute with CAHPS Clinician and Group survey results (CG-CAHPS) if available

	• Number of initial behavioral health diagnoses in primary care settings • Antidepressant medication management	
Integration of behavioral health and physical health will reduce unnecessary utilization and total cost of care for lower-needs members	• Risk-adjusted total cost of care • Emergency room visits/1,000 • Hospitalizations/1,000	• Claims data
Integration of behavioral health and physical health will improve quality of care for lower-needs members	• HEDIS quality measures – PHQ-9 scores at follow-up – Percentage of members receiving eye screenings for diabetic retinal disease – Initiation and engagement of substance abuse treatment after diagnosis	• Claims data • HEDIS
Goal 4: Support the development of robust and sustainable behavioral health services that provide both core and preventative care to ensure that members receive the full complement of high-quality treatment they need		
Preventative measures will reduce prevalence of mental health and substance use diagnoses over time	• Prevalence of mental health diagnoses • Prevalence of SUD diagnoses	• Claims data
More robust behavioral health services will decrease the ratio of inpatient vs. outpatient utilization and spend for the behavioral health population	• Ratio of risk-adjusted total cost of care for inpatient care to that for outpatient care • Ratio of inpatient utilization per 1,000 to outpatient utilization per 1,000	• Claims data
Better behavioral health services will increase member satisfaction	• Health Plan CAHPS scores – Ease of getting care and treatment – Overall rating of health care received in last 6 months – Overall health plan rating	• Health Plan CAHPS

Goal 5: Invest in support services to address the larger needs of behavioral health patients, such as housing and employment services		
Supportive services provision will reduce inpatient admissions and lengths of stay	• Inpatient admissions with a primary diagnosis of a behavioral health condition per 1,000 • Members with behavioral health diagnosis in residential mental health facilities (per 1,000) • Average length of stay in residential treatment facilities	• Claims data
Supportive services provision will enhance behavioral health member independence, reducing the total cost of care while also increasing rates of stable living conditions and employment	• Risk-adjusted total cost of care • Employment status of adult mental health members in the community	• Claims data • Substance Abuse and Mental Health Services Administration (SAMHSA)
Goal 6: Create an enabling environment to move behavioral health providers toward outcomes- and value-based payments		
Creating an enabling environment will increase outcomes- and value-based payments	• Percentage of Medicaid spending through outcomes- and value-based payment models • Percentage of eligible providers participating in health home payment model	• Claims data
Outcomes- and value-based payment models will improve outcomes for behavioral health members	• Health Plan CAHPS scores – Percentage of people who rate overall mental or emotional health as very good or excellent • HEDIS quality measures – Follow-up within 7 days for behavioral health hospitalization – Percentage of members getting annual wellness visits	• Health Plan CAHPS • Claims data • HEDIS

To test these hypotheses and evaluate the performance of the demonstration project initiatives, the State will compare measures including but not limited to those listed above before, during, and after the demonstration.

Section 1.5: Demonstration location and timeframe

The demonstration will take place throughout the State of Illinois over the next five years, with the aspiration to start on July 1, 2017.

This demonstration is the first step in Illinois' statewide, cross-agency HHS transformation. It focuses on creating change in the Illinois behavioral healthcare system that is sustainable beyond the life of the waiver. Despite undertaking it during a time of great challenges in the State, Illinois believes that this approach to transformation, based on statewide collaboration and member-centric design in behavioral health, can provide a model for the nation to address a long-neglected health issue. We look forward to our discussions and welcome your feedback.

Section 2: Demonstration Eligibility

Under the demonstration, there is no change to Medicaid eligibility. The standards for eligibility set forth under the State Plan remain in effect.

Section 2.1: Eligibility groups affected by the demonstration

The demonstration will enhance behavioral health benefits and integrate behavioral and physical health benefits, in both fee-for-service and managed care, for all child and adult full-benefit Medicaid beneficiaries. All affected groups derive their eligibility through the Medicaid State Plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan. All Medicaid eligibility standards and methodologies for determining eligibility of these groups remain applicable. Expenditures for all groups (other than those specifically excluded) are subject to the demonstration budget neutrality calculation.

Section 2.2: Eligibility groups excluded from the demonstration

The demonstration does not include the groups or benefits described in 42 C.F.R. § 440.255 (limited services available to certain aliens); or individuals who are eligible only for payment of Medicare premiums and cost-sharing including those enrolled in the Specified Low Income Medicare Beneficiaries; the Qualified Individual (QI) program; or the Qualified Disabled Working Individual (QDWI) program.

Section 3: Demonstration Benefits and Cost-Sharing Requirements

Section 3.1: Demonstration benefits

Under the 1115 waiver, Illinois requests coverage of six groups of benefits. Each benefit is designed to enable Illinois to provide a higher-value, higher-quality behavioral health system. The benefits, however, do not create optimal impact in isolation. They are critical elements in supporting fully integrated behavioral and physical health homes, which will be most effective when they have the right core, preventative, supportive behavioral health services with which to integrate.

Illinois has designed each of benefits based on strong evidence showing improvements in cost and quality of care through similar initiatives across the country. Illinois recognizes the importance, however, of tailoring programs to geographic and population-specific variations and of undergoing continuous data analysis and performance review to monitor and improve the program to optimize outcomes.

In this vein, for many benefits, Illinois has identified pilot target populations most in need of the proposed benefits and for whom the benefits will most likely decrease total cost of care and increase quality of care. As the waiver progresses and the benefits demonstrate significant cost and quality outcomes, benefits will be scaled to reach a broader population where appropriate.

All eligibility groups will continue to receive all State Plan benefits. The benefits described in Exhibit 11 may be available to any individual in any eligibility group who meets the criteria for the target group on a pilot basis.

Exhibit 11: Benefit populations and limits

Section	Benefit	Target group
3.1.1	Supportive housing services	Individuals with serious mental illness (SMI) who are either at risk of institutionalization or homelessness or currently reside in institutions or permanent supportive housing
3.1.2	Supported employment services	Individuals aged 14 years and up with serious and persistent mental illness (SPMI), SUD, or serious emotional disturbance (SED) needing ongoing support to obtain and maintain a job
3.1.3	Services to ensure successful transitions for justice-involved individuals at the Illinois Department of Corrections (IDOC), Cook	Medicaid-eligible IDOC and IDJJ-justice-involved individuals within 30 days of release to the community

	County Jail (CCJ), and the Illinois Department of Juvenile Justice (DJJ)	Cook County detainees not including same-day discharges eligible for managed care not previously enrolled in CountyCare
	Medicaid coverage for extended-release injectable naltrexone MAT services for targeted individuals within 30 days pre-release	Medicaid-eligible individuals incarcerated at the Illinois Department of Corrections (IDOC) and Cook County Jail (CCJ) appropriate for MAT therapy within 30 days of release to the community
3.1.4	Short-term residential treatment in an institution for mental diseases (IMD) treating substance use disorder	Individuals with SUD in need of short-term residential treatment as part of a continuum of care
	Substance use disorder case management	Individuals with substance use disorders receiving any ASAM treatment level of care but not receiving case management from other sources (e.g., IHHs)
	Withdrawal management	Individuals with substance use disorders who meet the medical necessity ASAM criteria for withdrawal management
	Recovery coaching for substance use disorder	Individuals who have already initiated recovery and are seeking support for long-term recovery
3.1.5	Short-term residential treatment in a mental health IMD	Individuals with mental health disorders in need of short-term residential treatment as part of a continuum of care
	Crisis beds	Individuals who require psychiatric treatment but without sufficiently high or acute needs to require inpatient stay
3.1.6	Intensive in-home services	Families and children with high behavioral health needs and/or SED at risk of transition to higher level of care Limited to children aged 3-21
	Respite care	Families and children with high behavioral health needs and/or SED at risk of transition to higher level of care Limited to children aged 3-21

The following subsections describe each benefit outlined in Exhibit 11, providing more detailed benefit descriptions, rationales, lists of included elements, and delivery structures. While

described as individual benefits for the sake of clarity, these asks form part of a robust HHS continuum designed to deliver key services in an integrated way to meet the needs of behavioral health members and support them and their families to live healthy lives in the lowest-intensity setting suitable for their needs.

Section 3.1.1: Supportive housing services

For many individuals with behavioral health conditions, housing instability can be the most significant barrier to health care access, leading to excessive use of emergency department care, inpatient treatment, and crisis services. In Illinois, an estimated 46% of adults using emergency shelters or living on the street have a chronic substance abuse problem and/or serious mental illness.[26] For these individuals, supportive housing offers a lifeline: a stable living situation that serves as a base from which they can access services and pursue their own efforts to improve their behavioral health.

By coupling stable housing and pre-tenancy and tenancy supports and services with behavioral and physical health services, the chances of mental health recovery and reduced alcohol and drug use among persons with mental illness and/or SUD experiencing homelessness or housing instability greatly improve.

Illinois recognizes the value of developing and funding supportive housing services in helping members avoid inappropriate re-institutionalization and costly inpatient and acute services, and it currently funds a limited array of supportive housing services through a mix of federal grants and state general revenue funds from state agencies. However, it currently has no defined Medicaid service package to support individuals to find, obtain, and retain supportive housing.

To design the supportive housing benefit package, Illinois takes guidance from the June 2015 CMS Informational Bulletin, “Coverage for Housing-Related Activities and Services for Individuals with Disabilities,” to “assist states in designing Medicaid benefits” and to “clarify the circumstances under which Medicaid reimburses for certain housing-related activities.” To facilitate development of services in this area across the states, CMS offered a competitive Medicaid Innovation Accelerator Program (IAP) intensive technical assistance opportunity to eight states, including Illinois, to explore how best to incorporate pre-tenancy and tenancy support services within the Medicaid program. This IAP technical assistance has shaped the following waiver ask as well as the broader strategic approach to covering housing support services under Medicaid in Illinois.

Through the 1115 waiver, Illinois seeks to pilot a funding and delivery model for pre-tenancy services and tenancy support services for individuals with high behavioral health needs who are at risk of homelessness or inappropriate institutionalization. There are currently no 1915c

26 U.S. Department of Housing and Urban Development, Office of Community Planning and Development, 2011

waivers serving the Illinois behavioral health population. The 1115 waiver offers the best option to ensure provision of services to this vulnerable population.

Illinois envisions the supportive housing service package created through this waiver as critical to enabling IHHs to truly take accountability for members and serve them with a "whole-person" approach. Direct supportive housing service provision and the linkage to supportive housing services will be some of the critical activities of an integrated health home.

Details on the pilot's proposed delivery system, services, and eligible members are outlined in Exhibit 12.

Exhibit 12: Supportive housing services details

SUPPORTIVE HOUSING SERVICES	

Service details	**Pre-tenancy services** support an individual's ability to prepare for and transition to housing.
	
	Category: Person-Centered Assessment
	• Screening and assessment of housing preferences/barriers related to successful tenancy
	  – Working with an individual to assess the type of housing, location, and other factors that could meet their needs that they prefer
	  – Identifying possible housing transition and retention barriers, such as accessibility needs, criminal background, language requirements, ability to pay rent (including SSI/SSDI eligibility and benefits), tenancy problems that have led to prior housing loss and needed supports (including Medicaid/Medicare eligibility and benefits)
	• Developing an individualized housing support plan based on assessment
	  – Identifying the types of housing-related services and supports an individual will need based on the assessment
	  – Defining short- and long-term measurable goals, interventions to address identified barriers/needs, and roles and responsibilities for the tenant and support staff
	• Developing an individualized housing support crisis plan
	  – Identifying situations and behavioral risk factors that could jeopardize housing placement and appropriate early interventions to prevent or address crisis and related roles and responsibilities
	
	Category: Housing Search Services
	• Assisting with rent subsidy application/certification and housing application process

	– Assisting individuals with obtaining, completing, and submitting applications to secure rental assistance and apply for housing (e.g., apartment rental applications), accommodating any language needs through services which include translation and/or interpretation – Assisting individuals to collect required documentation to apply and be eligible for housing, including personal identification, proof of income, and credit history – Requesting a reasonable accommodation or modification related from a landlord/property manager for individuals with disabilities (e.g., waiving restriction on pets for service animals, requesting a first floor apartment or installation of automatic door openers) – • Assisting with housing search – Assisting in search, including reviews of housing resources (e.g., newspapers, rental databases), accompanying individual on inspection of potential housing, and helping make selection) **<u>Category: Move-In Preparation Services</u>** • Identifying resources to cover start-up expenses, moving costs, and other one-time expenses – Assisting individuals to identify expenses related to move-in and start-up, such as security and utility deposits, covering unpaid utility bills, purchasing adaptive aids and environmental modifications, moving costs, purchases of furniture/furnishings and supplies, and identifying financial and other resources to facilitate move-in • Community transition/household set-up services – Assistance with security deposit if necessary; set-up fees for utilities or service access, including telephone, electricity, heating and water; essential household furnishings and moving expenses, including furniture, window coverings, food preparation items and bed/bath linens. The housing support plan development process should determine what set-up services qualify as reasonable and necessary; community set-up services should be provided only when the person is unable to meet such expenses or when these services cannot be obtained from other sources • Ensuring housing unit is safe and ready for move in

	– Conducting or facilitating an inspection to ensure that housing meets standards for federal, state, or other rental assistance programs and related quality/safety standards • Assisting in arranging for and supporting move-in – Assisting individuals to schedule move-in activities, such as movers, utilities, change of address, and helping individuals purchase furniture, furnishings, and household supplies **Tenancy Support Services** assist qualified individuals in maintaining tenancy once housing is secured. These services are made available to individuals with identified risks for housing instability and eviction. Ongoing housing-related services promote housing success, foster community integration and inclusion, and help members develop natural support networks. **<u>Category: Relations with property management and community members</u>** • Education/training on the roles, rights, and responsibilities of tenants and landlords – Includes periodic review of leases and related documents that establish the rights and responsibilities of the tenant and landlord and ongoing training regarding the consequences of not meeting lease obligations • Coaching on developing/maintaining relationships with landlords/property managers – Coaching and assisting individuals to advocate for themselves with the landlord/property manager, to maintain positive relationships, and to foster successful tenancy • Continuing training on being a good tenant and lease compliance – Ongoing support, coaching, motivational interviewing, and links to behavioral interventions to help an individual be a good tenant. Includes ongoing support to master household management and life skills (e.g., laundry, maintaining a clean apartment, minimizing fire and other safety hazards, money management including budgeting and paying rent and utilities) **<u>Category: Housing Retention Services</u>** • Providing support in order to maximize housing retention – Working with individuals to manage and reduce behaviors that jeopardize housing, such as late rent payments or other lease violations, like use of illicit substances,

	excessive noise, problems with cleanliness, not seeking treatment for the exacerbation of mental health symptoms, etc. – Providing or coordinating necessary crisis or other interventions as necessary • Providing advocacy/linkage with community resources to prevent eviction – Assisting individuals to secure a reasonable accommodation, to engage legal services, or to apply for resources to pay rent or utility arrears to prevent eviction • Assisting with the housing recertification process – Identifying and helping to secure necessary paperwork for completing a housing recertification – Assisting in completing applications in a timely manner to avoid loss of housing • Coordinating with tenants to review/update/modify housing support and crisis plans – Regularly reviewing and updating housing and crisis support plans to reflect current needs and address new or recurring barriers to housing retention
Service delivery	Services will be provided to eligible members as authorized by their payers (MCO or FFS). Service units will be proportionally allocated to each FFS and MCO, based on applicable populations.
Eligible members	Individuals with serious mental illness (SMI) or SUD. Additionally, these individuals and their families must also be at risk of homelessness or the individual must be at risk of inappropriate institutionalization or homelessness or currently reside in an institution or permanent supportive housing.

Section 3.1.2: Supported employment services

Stable employment, like stable housing, plays a critical role in helping individuals with behavioral health issues prevent hospitalizations and support their journey to recovery. Stable employment has been shown to aid recovery, reduce the likelihood of crisis reoccurrence, and lead to better overall health outcomes for individuals with mental illness. In addition, employment services have been found to reduce community mental health treatment costs, psychiatric hospitalization days, and emergency room usage.

In Illinois, 22% of individuals served by community mental health programs are employed, this is slightly above the national average of 19%. However, 48% of the individuals served are unemployed, and the remaining 30% are not in the labor force.[27] For these unemployed individuals, services to help obtain and maintain employment may improve outcomes.

27 SAMHSA Uniform Reporting System, 2015

A growing body of research supports the Individual Placement and Support (IPS) employment approach. IPS supported employment services provide intensive ongoing support to obtain and maintain a job or to find self-employment outside sheltered workshops and other non-competitive situations for individuals needing assistance due to their mental health challenges. IPS supported employment services are integrated with mental health services, chemical dependency services, and clinical/support services.

Illinois has more mental health patients participating in IPS-supported job programs (2.8%) than the national average (1.8%). However, compared to the number of individuals with mental illness who desire work, this coverage remains far too low. This waiver seeks to expand existing IPS supported employment services to address a greater percentage of the 78% of members served by community mental health centers (CMHCs) who are unemployed or out of the workforce.

Currently, 51 IPS teams in Illinois are supported by braided funding through the Division of Mental Health (DMH) and the Division of Rehabilitation Services (DRS). However, Illinois has identified some core challenges to the implementation of the IPS model, including a lack of collaboration across a fragmented system.

Through the 1115 waiver, Illinois seeks to pilot a funding and delivery model of supported employment for a targeted group of members with high mental health needs that unifies the current fragmented system. The delivery model will be designed to be seamlessly unified with the IHHs as Illinois envisions supported employment services to be a critical activity offered by (either directly or through a coordinated referral) the IHH.

Details on the pilot's proposed delivery system, services, and eligible members are outlined in Exhibit 13.

Exhibit 13: Supported employment services details

SUPPORTED EMPLOYMENT SERVICES	
Service details	IPS supported employment services provide ongoing supports to participants who, because of their mental health conditions, need intensive ongoing support to obtain and maintain a job in competitive or customized employment in an integrated work setting. • An average of 20 hours of service per month are provided, based on the needs of the individual and his/her phase of placement and employment (on a limited basis, additional hours can be authorized for members with demonstrated need for more intensive services) • IPS services may also include support to establish or maintain self-employment, including home-based self-employment

	• Supported employment services are individualized and may include any combination of the following services:
	  – Vocational/job-related discovery or assessment, person-centered employment planning, job placement, extensive job development with and without the presence of the member, identifying employer needs and developing collaborative relationships to make sure they are addressed in ways to facilitate both employee and employer success
	  – Assessing potential and actual natural supports in the workplace, partnership building and negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, development of natural supports, benefits support, transportation, asset development and career advancement services
	  – Other workplace support services, including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting (these services may be made within the waiver or under the authority of State Plan mental health services)
	
	IPS supported employment services are provided in conjunction with mental health services and may include:
	
	• An assessment of work history, skills, training, education, cognitive ability, linguistic skills and career goals
	• Ensuring accurate information about how employment will affect income and disability supports
	• Preparation skills, such as résumé development, interview skills, and disclosure discussions
	• Helping create and update individualized job and career development plans, listing member strengths, abilities, preferences, and goals
	• Assistance in locating employment opportunities that are consistent with the member's strengths, abilities, preferences, and goals
	• Finding integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required
	• Coaching, mentoring, and encouraging the use of illness self-management tools and strategies utilized in the work setting to increase positive presentation to potential employers and to increase job sustainability

	• Exploration of community-based resources to increase job placement likelihood (interview clothing, transportation assistance, GED courses/educational programs) and assistance accessing such resources • Helping members prepare for performance evaluations, increasing their self-advocacy skills, advancing soft-skills development, and assisting with career advancement through links to certificate-granting programs • Assistance in properly terminating employment where desired and/or necessary to increase likelihood of re-employment
Service delivery	Medicaid funds under the 1115 waiver would enable providers to employ a service team consisting of IPS staff and clinical staff (in both mental health and substance abuse). All clinical and medical services provided would be billed separately from the per capita fee. The providers would receive outcomes-based rates per participant that will be determined by defined milestones. Example milestones include: • Completion of individual assessment of employment interests, skills, preferences, strengths, and challenges • Preparation for employment (e.g., development of résumé, attendance at available work-related skill-building activities, enrollment into an educational program) • Completing steps in job search process (e.g., development of a job search plan, number of job search appointments maintained, number of face-to-face employer contacts made within first three months of enrollment, number of interviews completed) • Job placement (e.g., payment after five days on the job) • Job retention (e.g., payments at 15, 45 and 90 days, 6 months and 12 months on the job; increase in the number of hours/week employed)
Eligible members	Working-age (14 years and older) Medicaid enrollees who, because of their mental health challenges, need intensive ongoing support to obtain and maintain a job in a competitive work environment or in self-employment that pays more than minimum wage. Members who meet the following criteria may be eligible: • Serious and persistent mental illness or serious emotional disturbance • Express a desire to be employed

Section 3.1.3: Services to ensure successful transitions for justice-involved individuals at the Illinois Department of Corrections (IDOC), Cook County Jail (CCJ), and the Illinois Department of Juvenile Justice (DJJ)

Each year, approximately 25,000 people are released from IDOC correctional facilities and 60,000 individuals are released from CCJ not including same-day discharges. Many of these individuals have behavioral health conditions: national estimates suggest 56% of state correctional populations are dealing with mental health issues[28], DOC estimates approximately 80% of its population has SUD, and the Cook County Health and Hospital system (CCHHS) estimates that approximately one-third of these individuals have some sort of mental illness. Approximately 1,000 youth in DJJ custody are released each year and the vast majority of the DJJ population has some sort of behavioral health diagnosis. More than 95% of youth in facilities has at least one behavioral health diagnosis and nearly 50% have three or more behavioral health diagnoses.[29]

SUDs are a particularly severe problem among the justice-involved population. According to the Illinois Department of Corrections, 9,237 inmates, who comprise 19 percent of the prison population, were incarcerated for violations of the Controlled Substance Act or the Cannabis Control Act in 2014. Another 7,782 Illinois parolees, or 28 percent of the total 2014 parolee population, were on parole for violations of those Acts.[30] Furthermore, the opioid epidemic has hit the justice-involved population particularly hard. In one Illinois facility, the Sheridan Correctional Center, heroin and other opiates were reported as the primary substances for 22% of the inmates.[31] Overall, in state fiscal year 2015, IDOC reported that 1,413 individuals entered a DOC correctional facility with a SUD involving heroin or other opioids as the primary substance and an additional 366 individuals entered DOC with a SUD diagnosis with heroin/other opioids as a secondary substance (IDOC).

The justice-involved population has historically had high rates of mental health and substance use disorders. What is unprecedented is the ability of Medicaid programs to address these issues. IDOC estimates that due to the Affordable Care Act, about 90% of its population is eligible for Medicaid. The ACA Medicaid expansion offers Illinois the first opportunities to comprehensively connect justice-involved individuals with Medicaid services. The magnitude of both the need for Medicaid services and the lack of coordination within this system is large, and offering the proper mental health and SUD services and pre-release linkages could potentially reduce costs and improve outcomes both within the behavioral health system and within the justice system.

Today in Illinois mental health and SUD needs often go unaddressed after release. Transitions to the community are disjointed, and there is limited oversight to connect former inmates to

28 Urban Institute, 2015
29 Illinois Department of Juvenile Justice Monthly Report, July 2016
30 Illinois Department of Corrections, Fiscal year 2014 Annual Report
31 Illinois Criminal Justice Information Authority, 2011

necessary SUD and mental health treatment services upon release. These flawed transitions can have dire consequences for the health of these individuals and can lead to further criminal activity and recidivism.

- National research has shown that a former inmate's risk of dying from a drug overdose is 129 times greater in the two weeks following release from prison than for the general public[32]
- As of 2011, former IDOC inmates had the fifth-highest recidivism rate in the nation: 51.7%, compared with a national average of 43.3%[33]
- IDOC estimates that approximately 1,000 recidivists each year have serious mental illness

Pre-release planning and effective hand-off procedures are needed to improve health outcomes for this population, address gaps in care, and reduce recidivism. To ensure that the IDOC, CCJ, and DJJ populations are linked to the appropriate services upon release and have access to the SUD and mental health treatment they need, IDOC, DJJ, DHFS, CCJ, and CCHHS are pursuing initiatives to restructure intake, pre-discharge, and discharge processes to ensure all Medicaid-eligible individuals are enrolled upon release.

Through the 1115 waiver, Illinois seeks to further these initiatives and ensure a seamless transition for justice-involved individuals back into their communities. In particular, Illinois intends to ensure this population is linked to and has relationships with their integrated health homes pre-release.

To do this, Illinois requests:

- **Medicaid coverage for behavioral health screening and, if indicated, assessment, 30 days prior to release:** These services would be administered by trained clinical staff inside the correctional facility
- **Medicaid coverage for identifying Illinois licensed and/or certified behavioral health providers to be accountable for these individuals post-release:** This will only be needed for fee-for-service providers, as MCOs will be responsible for the managed care population
- **Medicaid coverage for outpatient behavioral health (both mental health and SUD) services provided to justice-involved individuals 30 days prior to release.** These services would be administered by either the contracted in-facility provider or, where feasible, by Illinois licensed and/or certified providers who will also be accountable for these individuals post-release (often via telemedicine). These visits would provide a foundation for improved mental health and SUD treatment before transition to the community

32 Binswanger, I.A., Stern, M.F., Deyo, R.A., Heagerty, P.J., Cheadle, A., Elmore, J.G., & Koepsell, T.D. (2007). Release from prison a high risk of death for former inmates. New England Journal of Medicine, 356

33 Pew Center for States, 2011

- **Pilot Medicaid coverage for extended-release, injectable naltrexone medication-assisted treatment (MAT) services for targeted justice-involved individuals at IDOC and CCJ within 30 days pre-release:** Individuals with SUD will receive pre-release MAT education, MAT readiness assessment, counseling, and relapse/overdose prevention education. In addition, those appropriate may participate in a pilot to receive medication assisted treatment administered in the form of extended release injectable naltrexone to be continued after release in the community.
- **Waiver authority to allow justice-involved individuals to defer redeterminations for eligibility until after release:** This would ensure continued access to services during a period in which previously justice-involved individuals remain highly vulnerable to recidivism. By remaining Medicaid-eligible while incarcerated, these individuals are more likely to receive the care they need as they transition back into their communities. Redetermination would be delayed until 180 days post-release
- **Waiver authority to allow Illinois to auto-assign IDOC and IDJJ justice-involved individuals to an MCO at the earliest possible point:** Because the default enrollment process in health plans can take more than a month to become effective, auto-assignment needs to occur as early as possible
- **For the CCJ population, waiver authority to allow automatic and passive enrollment in CountyCare, a full-service MCO owned and operated by CCHHS:** Exceptions would be made for individuals who opt for another plan within 30 days or were enrolled in a different health plan at the time of incarceration and released in fewer than 60 days; these individuals can return to their original plans under the State's "quick reinstatement" policy.

Details of the proposed delivery system, services, and eligible members for pre-release services are outlined in Exhibit 14. Details of the proposed delivery system, services, and eligible members for pilot MAT services are outlined in Exhibit 15.

Exhibit 14: Details for transition services for IDOC- and CCJ justice-involved individuals

SERVICES FOR IDOC, DJJ, AND CCJ JUSTICE-INVOLVED POPULATIONS PRE-RELEASE	
Service details	The 1115 waiver requests Illinois to allow Medicaid coverage for behavioral health screenings and assessments administered in the 30 days prior to release from IDOC, DJJ, or CCJ facilities. It also requests that appropriately licensed and certified providers be permitted to bill Medicaid upon release for one outpatient behavioral health visit within 30 days before release for each justice-involved individual transitioning from IDOC, DJJ, and CCJ. • Services offered will not differ from behavioral health services offered under the State Plan (e.g., assessment, counseling, treatment, case management) • Services may be provided by the appropriate professional in person or via telemedicine and may be provided by both the

	contracted SUD/mental health provider within the facility, or, when possible, by the same providers who will be taking responsibility for that individual post-release; in either circumstance, a smooth transition to accountable providers post-release must be assured • Identifying providers who will be accountable post-release will be the responsibility of MCOs (or the State for the fee-for-service population)
Service delivery	Screening and assessment will take place within correctional facilities to ensure behavioral health needs are fully recognized prior to release. If need for a behavioral health provider on the outside is clinically indicated, identification of the post-release accountable provider will follow. Provider reimbursement will be requested upon release and will be contingent upon demonstration of full and proper linkage to the behavioral health system (individual must have a care plan, a follow-up appointment within 2 weeks of release, and proof of medication dispensing)
Eligible members	All Medicaid-eligible inmates who are within 30 days of release

Exhibit 15: Details for MAT services for IDOC and DJJ justice-involved individuals

MAT SERVICES FOR IDOC AND CCJ JUSTICE-INVOLVED POPULATIONS PRE-RELEASE	
Service details	The 1115 waiver requests Illinois to allow Medicaid coverage for medication-assisted treatment in the form of extended-release, injectable naltrexone administered within 30 days of release from pilot IDOC and CCJ facilities. Opioid-agonist maintenance therapies (e.g., methadone, buprenorphine) for opioid use disorders are effective treatments, but use is often discouraged among the justice-involved population due to concern over diversion of medication. Extended-release injectable naltrexone, approved by the Food and Drug Administration in 2010 for the prevention of relapse to opioid disorders, however, has no known misuse or diversion potential and thus may be preferred within the correctional system. Most critically, because injectable naltrexone has an extended release, it may protect former inmates from overdose death within the critical one month post-release period. Furthermore, the controlled environment of the correctional facility is an appropriate setting to initiate extended release naltrexone as justice-involved individuals with opioid use disorders have a higher likelihood of

	abstaining from opioids for the required length of time prior to initiating treatment. The MAT treatment offered in-facility will not differ from the services currently offered under the State Plan. Pre-release MAT services may be provided by the appropriate professional in person or via telemedicine and may be provided by both the contracted SUD/mental health provider within the facility, or, when possible, by the same providers who will be taking responsibility for that individual post-release
Service delivery	Provider reimbursement for medication assisted treatment will be requested upon release and will be contingent upon demonstration of full and proper linkage to an outpatient MAT provider The Pre-release injectable naltrexone pilot will be offered to ~200 individuals statewide. Over the 5 years of the waiver, as these services demonstrate significant cost and quality outcomes, services will be scaled to reach a broader population.
Eligible members	Medicaid-eligible inmates of IDOC and CCJ appropriate for medication maintenance therapy who are within 30 days of release on a pilot basis

Section 3.1.4: Redesign of substance use disorder service continuum

The nation, including Illinois, is experiencing a rapidly growing SUD crisis.

- In 2011, 928,000 Illinois residents ages 12 years or older met the DSM-IV criteria for a SUD[34]; of these 928,000 individuals:
  - Approximately 259,000 needed but did not receive treatment for SUD[35]
  - Approximately 731,000 individuals needed but did not receive treatment for alcohol abuse[36]
- In 2015, there were 43,591 unduplicated admissions to Illinois Division of Alcoholism and Substance Abuse (DASA)-funded treatment services, representing less than 5% of the Illinois over-12 population with SUD
- 29% of patients admitted to DASA-funded services in 2015 indicated opiates were their primary substance of abuse, a 32.8% increase from 2002

[34] National Survey on Drug Use and Health

[35] State Fiscal Year 2015 Illinois DHFS claims data

36 This estimate is based on a somewhat broader definition of treatment need than past-year DSM-IV substance-related disorder; another, partially overlapping group of 731,000 Illinois residents 12 years and older needed but did not receive treatment for alcohol use in the past year

While Illinois has a strong track record of providing an expansive range of SUD treatment services for these individuals, its system, like those found across the rest of the nation, lacks strong coordination with the broader physical and mental health system. Furthermore, the services that are provided today are not adequately matched to the level of acuity of the member's needs, resulting in dependence on high-cost, deep-end residential treatment rather than integration with community-based prevention, treatment, and recovery.

Through the design and development of IHHs, other elements of its broader behavioral health transformation, and through the relevant asks in this 1115 waiver, the State of Illinois will not only ensure individuals with substance use disorders have access to the full continuum of necessary services, both in the community and within inpatient facilities, but will also ensure these services are provided within a fully coordinated, integrated delivery model that incentivizes providers to care for individuals at the right time in the lowest-acuity setting possible.

To transition to this fully integrated and coordinated substance use system Illinois intends to develop:

- An integrated system in which providers and their teams take ownership for both physical and behavioral health
- Increased data transparency and outcome-based payment models to measure and reward high-quality care
- A comprehensive evidence-based service continuum
- Appropriate standards of care
- Benefit management and program integrity safeguards to ensure appropriate utilization
- A robust network development plan
- Initiatives that address and reduce the opioid use epidemic

Each of the above elements are described in the following subsections.

Section 3.1.4.1: Integrated physical and behavioral health delivery system
As described in Section 1.2.3 IHHs will incentivize a single care delivery model that wraps around the members, ensures access to the appropriate suite of services provided in the lowest-acuity setting, and is provided by a coordinated behavioral and physical health team.

Section 3.1.4.2: Data transparency and outcome-based payment
Illinois has already taken steps toward data transparency with respect to SUD. The Illinois Division of Alcoholism and Substance Abuse (DASA) collects a set of National Outcomes Measures, developed by SAMHSA, on all members to track progress on a set of six goals:

- Increase the percentage of members reporting employment (or enrollment in school)
- Decrease the percentage of members arrested
- Decrease the percentage of members who report being homeless

- Increase the percentage of members reporting abstinence from alcohol
- Increase the percentage of members reporting abstinence from illegal drugs
- Increase the percentage of members experiencing "social connectedness" (measured as by participation in self-help groups)

Additionally, DASA has taken steps toward utilizing collected data to shift from paying for volume to paying for performance. The performance-based contracting goals are intended to improve the extent to which members are engaged in the initial phase of treatment, retained in treatment, and are linked to less intensive levels of service following completion of a SUD treatment program.

Marrying this system with the development of IHHs will enable providers to look beyond substance use and social indicators toward full integration, taking "paying for performance" to the next level and leveraging the power of teams to improve whole-person and whole-family outcomes.

Section 3.1.4.3: Comprehensive evidence-based design

An integrated physical and behavioral health system to prevent and treat individuals with SUD is critical, and the availability of a continuum of services with which to coordinate is equally critical.

Today, the Illinois Medicaid program offers many but not all of the American Society of Addiction Medicine (ASAM) treatment levels of care. Through this 1115 waiver and a set of SPAs, Illinois seeks to expand the SUD treatment continuum benefit.

Through this 1115 waiver, Illinois requests Medicaid coverage for:

- Treatment within licensed ASAM level III.5 residential treatment services with more than 16 beds for up to 30 days for members enrolled in fee-for-service
- Treatment within licensed ASAM level III.5 residential treatment services with more than 16 beds for 16 to 30 days for members enrolled in managed care
- SUD case management for targeted populations on pilot basis
- Withdrawal management (level III.2) for targeted populations on pilot basis
- Recovery coaching for targeted populations on pilot basis

Through a SPA, Illinois will expand the SUD treatment continuum to also include MAT.

Exhibit 16 displays the full spectrum of ASAM and non-ASAM services available today and how this treatment continuum will expand as a result of the 1115 waiver and proposed SPAs. It is critical to note that this expansion will occur not only within the context of a seismic shift toward a coordinated, integrated care delivery system with outcomes-based payment incentives but will also be coupled with clear standards of appropriate care, program integrity safeguards, and benefit management (as described in Sections 3.1.4.4 and 3.1.4.5).

Exhibit 16: ASAM services

ASAM LEVEL OF CARE	SERVICE TITLE	BRIEF DESCRIPTION	CURRENT MEDICAID SERVICE	FUTURE MEDICAID SERVICE	AUTHORITY
N/A	SBIRT	Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs	No (Limited provision under SAMHSA grant to Federally Qualified Health Centers, or FQHCs)	Yes	Integrated Health Homes
N/A	Recovery coaching	Non-clinical support to help individuals sustain recovery over time	No	Yes	1115 waiver (pilot with targeted populations)
N/A	SUD case management	Activities designed to augment clinical services for a patient in treatment that include providing and coordinating ancillary services to support treatment and improve clinical outcomes	No	Yes	1115 waiver (pilot with targeted populations)
N/A	Medication-assisted treatment (MAT) -Opioid Treatment (Methadone)	Physician-supervised opioid agonist medication (daily or several times weekly) and counseling to maintain multidimensional stability for those with severe opiate use disorder	No	Yes	SPA
I	Outpatient services	Organized outpatient treatment services (fewer than 9 hours per week delivered in a variety of settings), including professionally directed screening, assessment, and counseling, and	Yes	Yes	Current State Plan

		ongoing recovery and disease management services			
II	Intensive outpatient/ partial hospitalization	Structured program delivering 9 or more hours per week of clinically intensive programming with a planned roster of individualized therapies	Yes	Yes	Current State Plan
III.1	Clinically Managed Low-Intensity Residential Services	Supportive living environment (halfway house) with 24-hour staff and integration with clinical services; at least 5 hours of low-intensity treatment per week (Halfway House)	No - GRF funded	No	State GRF as funded today
III.5	Clinically Managed High Intensity Residential Services	Residential treatment for adults or adolescents, providing at least 25 hours per week of high-intensity clinical services	Only the treatment portion of the stay and only for those programs in compliance with the IMD exclusion. No coverage for domiciliary costs	Yes (up to 30 days)	1115 waiver and managed care contract authority to provide in lieu of services for up to 15 days
III.2	Withdrawal Management – Clinically Managed Residential	Patients with moderate withdrawal needs, who require 24-hour support to complete withdrawal management and increase likelihood of continuing recovery	No	Yes	1115 waiver (pilot with targeted populations)

III.7	Withdrawal Management – Medically Monitored	Patients with severe withdrawal needs, requiring 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical/ nursing monitoring	Yes	Yes	Current State Plan

Illinois proposes under the 1115 waiver to cover level III.5 or higher IMD services for all Medicaid-eligible individuals for up to 30 days but SUD case management, withdrawal management, and recovery coaching services for a targeted group on a pilot basis. Exhibits 17 and 18 describe the SUD case management and withdrawal management services, as well as proposed delivery systems and eligible members. Exhibit 19 describes the details for recovery coaching for individuals initiating recovery from substance use disorder.

Exhibit 17: SUD case management service details

SUD CASE MANAGEMENT	
Service description	SUD case management helps members handle aspects of their lives that are not necessarily related to a SUD but that might influence whether the patient remains in treatment or has successful treatment outcomes. Areas of needed assistance addressed by case management services include: • Health needs • Arrangement of transportation of members (not providing transportation) • High quality early care • Management of family situations, living conditions, and school or work situations Case management services are individualized for patients in treatment, reflecting particular needs identified in the assessment process and those developed within the treatment plan. Examples include: • Inter- and intra-provider record review • Internal and/or external multidisciplinary clinical staffing • Telephone calls, letters, and other attempts to engage family members or “significant others” in the member’s treatment • Telephone calls, letters, and home visits to members to keep them engaged in treatment • Assistance with budgeting, meal planning, and housekeeping • Letters, telephone calls, and meetings with employers on behalf of a member • Assistance for members and their families in obtaining Medicaid, Social Security, cash grants, and WIC • Link Cards and other entitlements that they may need • Assistance for members and their families in obtaining medical, dental, mental health, educational, recreational,

	vocational, and social services as specified in the treatment plan
Delivery system	Authorized by a DASA treatment license in outpatient or residential setting or an approved off-site location
Eligible members	Medicaid-eligible members receiving any ASAM treatment level of care who are not receiving case management services through any other provider on pilot basis

Exhibit 18: Withdrawal management service details

WITHDRAWAL MANAGEMENT (LEVEL III.2)	
Service description	Withdrawal or "clinically managed detoxification" (level III.2) services are those provided in a non-medical or social detoxification setting. This level of care emphasizes peer and social support and is intended for members whose intoxication and/or withdrawal is sufficient to warrant 24-hour support. Services provided under level III.2 are administered by appropriately trained personnel and include 24-hour monitoring, observation, and support in a supervised environment for a member to achieve initial recovery from the effects of alcohol or another drug. This level is referred to as "social detoxification" because of its emphasis on peer and social support. It also can be used for members whose intoxication or withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support, but do not require medically monitored inpatient detoxification.
Delivery system	Performed in a DASA-licensed residential treatment setting
Eligible members	Medicaid-eligible members with SUD who meet the medical necessity ASAM criteria for withdrawal management on a pilot basis

Exhibit 19: SUD recovery coaching service details

SUD RECOVERY COACHING	
Service description	Recovery coaching aims to help members recovering from SUD sustain recovery over time. It focuses on non-clinical issues and utilizes evidence-based practices such as strengths-based case management, motivational interviewing, and contingency management. Issues addressed through coaching include but are not limited to proceeding through drug court; dealing with probation officers; and helping find resources for harm reduction, family support and education, and support groups, among other services. Recovery coaching can not only help members in addiction treatment acquire the resources and skills they need to sustain recovery over

	time but can also prevent members with SUD from requiring more intensive and expensive care.
Delivery system	Recovery coaching will be provided by a "recovery coach" who does not diagnose or treat directly and instead focuses on non-clinical issues to assist members to sustain recovery. The coaches will be required to go through formal training and may be required to have "lived experience." The coaches may practice in a wide range of settings including primary care practices, emergency departments, Federally Qualified Health Centers (FQHCs), CMHCs, schools, recovery community centers, faith and community-based organizations, recovery homes, jails and prisons, probation and parole programs, and other social service centers. Peer recovery services are delivered across the recovery process, from prior to treatment to post-treatment (or sometimes in lieu of treatment).
Eligible members	Limited pilot of Medicaid eligible adults ages 18+ who have already initiated recovery and are seeking support for long-term recovery from addiction to alcohol and/or other drugs on a pilot basis

Section 3.1.4.4: Appropriate standards of care, benefit management, and program integrity safeguards

Defining appropriate standards of care will be critical to the successful implementation of the future substance use benefit package Illinois envisions. Illinois currently uses and will continue to use the ASAM Patient Placement Criteria standards. All providers are and will continue to be required to demonstrate compliance with these criteria and be periodically checked via on-site reviews.

In addition, to ensure the added services are utilized in an appropriate manner, Illinois will implement an independent third-party pre-authorization service for SUD assessment, level-of-care, and length-of-stay recommendations. This third party will pre-authorize services and perform chart audits and random site visits, among other functions, to ensure the fidelity of Illinois' substance use model. Illinois recognizes the importance of such an unbiased review of compliance, especially as it seeks Medicaid funding for the SUD treatment continuum to cover ASAM level III.5 in an IMD. It anticipates this type of third-party pre-authorization process to be performed by MCOs or other appropriate entities for members not in managed care. Additionally, in order to ensure that expansion of level III.5 or higher IMD services does not exceed the identified need, the State will implement with appropriate utilization controls..

Further, to ensure the proposed benefit package is provided to individuals in accordance with clinical and other standards contained in administrative rule, DASA will conduct post-payment audits annually for each Medicaid-certified provider, based upon a subset of licensure rules.

Any funds found to have been paid in a non-compliant manner will be recouped and if necessary, sanctions will be imposed on the license or Medicaid certification.

Section 3.1.4.5: Network development plan

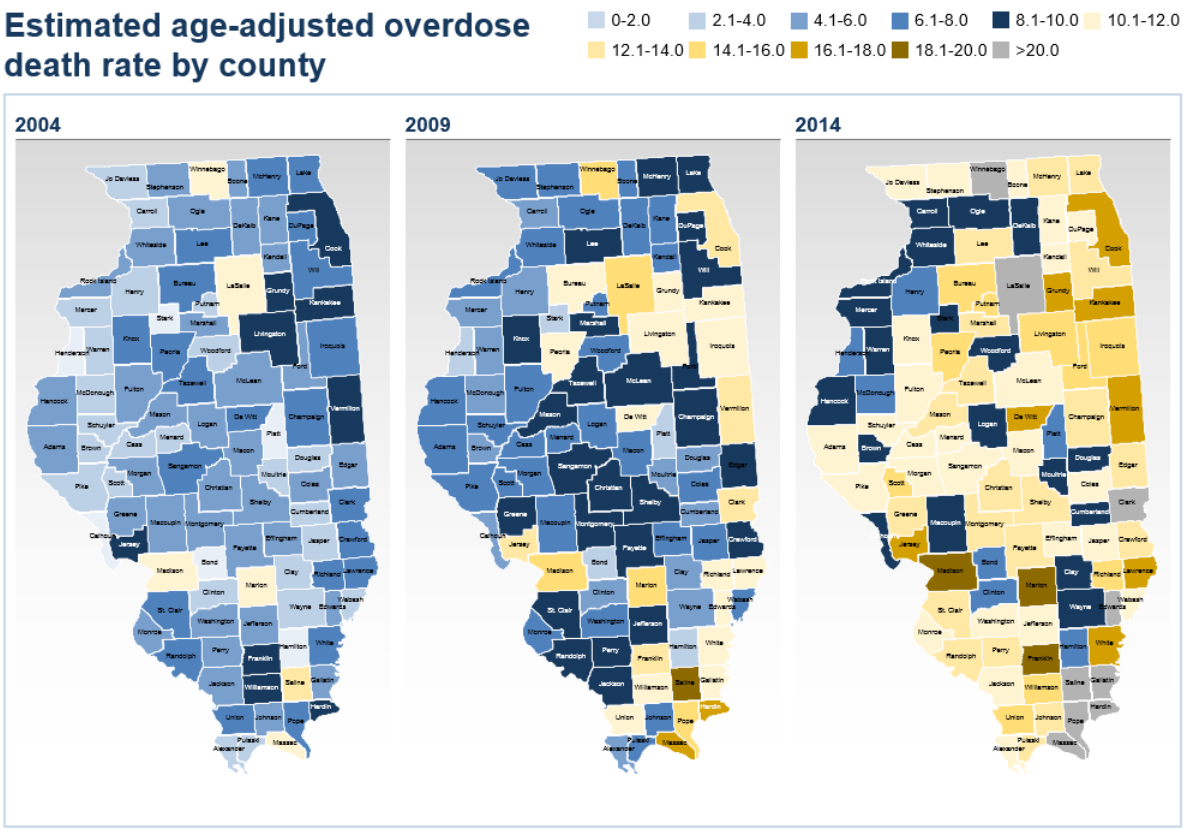
Also critical to successful implementation of the proposed future substance use benefit package in Exhibit 16 is a strong network development plan. To ensure providers are prepared to deliver the ASAM services, DASA will enhance its licensing and credentialing requirements regarding the ASAM criteria and providers' ability to follow this evidence-based protocol. In addition, providers will be required to undergo annual trainings unique to their professional credentials and additional trainings for providers wishing to perform new services to ensure they fully understand the ASAM evidence-based protocols and other regulatory requirements.

Section 3.1.4.6: Strategies to address prescription drug abuse and opioid use disorder (OUD)

Illinois, like the rest of the nation, is facing a rapidly growing opioid epidemic.

- Between 2008 and 2014, deaths in Illinois from opioid overdoses nearly tripled, and the proportion of drug overdose deaths attributable to opioids jumped from 31% to 68%
- 29% of patients who were admitted to DASA-funded services in 2015 indicated opiates as their primary substance, a 32.8% increase in such admissions from 2002
- Illinois treatment admissions for heroin are significantly higher than the nation as a whole. Nationally, heroin treatment admissions comprised 16.4% of total state-funded treatment in 2012, while Illinois heroin treatment admissions accounted for 25.3% of all IDHS/DASA-supported treatment admissions. In 2012, the percentage of treatment admissions for heroin in the Chicago metropolitan area was more than twice the national average (35.1% vs. 16.4%)
- Across the state, age-adjusted overdose death rates have increased significantly over the past decade (Exhibit 20)

Exhibit 20: Age-adjusted death rates by overdose over the past ten years



SOURCE: CDC: Drug Poisoning Mortality County Trends

According to the Centers for Disease Control and Prevention, over 8,200 people died nationally from heroin overdoses in 2013. In Illinois, 2,135 drug-related overdose deaths were reported from January 1, 2014 to October 31, 2015, according to the Illinois Department of Public Health. Heroin accounted for 59.3% (1,266) of these drug overdose deaths. Other opioids accounted for an additional 36.9% (788) of these fatalities.

To combat the opioid crisis, in 2016 Illinois enacted a groundbreaking piece of legislation entitled "Public Act 099-0480." The act comprehensively addresses the opioid crisis by:

- Expanding the availability of opiate overdose reversal drugs, such as naloxone. The Act allows pharmacies to dispense them, school nurses to administer them, and requires all police and fire agencies and emergency medical technicians to carry the drugs and be trained on how to administer them
- Upgrading the prescription monitoring program and data reporting system. The Act improves the current EHR system interface with the prescription monitoring program and requires coroners, medical examiners, and other health care professionals to report all cases of drug overdose to the Department of Public Health
- Amending existing drug court programs to keep more users in treatment and less in jail

- Establishing a medication take-back program to collect and dispose of unused medications
- Establishing drug education programs in schools, mandating public awareness campaigns on the dangers of unused prescription medications

Finally, the Act mandates that all FDA-approved forms of medication-assisted treatment prescribed for the treatment of SUD be included under the medical assistance program. As a result, Medication Assisted Treatment using methadone (MAT) will qualify as a covered Medicaid service, effective January 1, 2017, and will substantially increase access to services for individuals on the road to recovery.

Section 3.1.5: Optimization of the mental health service continuum

Through the creation of IHHs and an expanded community service package, Illinois intends to dramatically reduce the inappropriate utilization of inpatient, institutional, and residential mental health services. However, Illinois also recognizes that, when appropriate, these deep-end settings are a critical element of the full mental health service continuum.

To promote appropriate utilization of high-acuity services and ensure that all Medicaid members have access to a full range of behavioral health services, Illinois requests Medicaid coverage for three additional benefits:

- **Stays in IMDs of up to 30 days for members enrolled in fee-for-service** to enable Medicaid coverage for appropriate, short-term residential stays that focus on stabilization and transition to community care
- **Stays in IMDs of 16 to 30 days for members enrolled in managed care**, days 1 to 15 will be covered in lieu of services in accordance with CMS managed care rules
- **Crisis beds** to create a diversion service setting for individuals experiencing a crisis who cannot be maintained in the community but who also do not require inpatient mental health care

Section 3.1.5.1: Stays in IMDs of up to 30 days for members enrolled in fee-for-service and 16 to 30 days for managed care

The federal IMD exclusion represents a significant barrier to ensuring availability of a full spectrum of behavioral health services. In Illinois today the IMD exclusion undermines access to appropriate services for individuals in crisis and vulnerable populations with mental illness diagnoses.

While Medicaid beneficiaries can receive physical health services in a wide range of inpatient facilities, individuals with mental health conditions may encounter barriers to accessing inpatient mental health services, even when inpatient treatment is most appropriate. Therefore, the IMD exclusion unnecessarily restricts and complicates care for individuals with mental health needs. In addition, the IMD exclusion drives up otherwise avoidable system costs such as inappropriate use of expensive emergency room services. CMS' recent managed care

rule acknowledges this in part by allowing capitation payments to managed care organizations (MCOs) for enrollees who are patients in an IMD for 15 days or less, lending credence to the argument that IMD services can be paid in lieu of more costly hospital based services – a rationale Illinois supports.

Through the 1115 waiver, Illinois seeks to test provision of crisis intervention and acute stabilization services within IMD facilities for stays of up to 30 days for all Medicaid members including those deemed unfit to stand trial (UST) (four of Illinois' state psychiatric hospitals serve this UST population). Illinois intends to ensure that individuals who are admitted to IMDs for shorter stays are admitted as part of a seamless and appropriate continuum of care, fully coordinated with that individual's IHH.

Illinois believes that the addition of this IMD benefit, within the context of a transformation to a system of IHHs that take accountability for providing whole-person care and are complemented by new community-based behavioral health and supportive services, will increase rates of long-term recovery and maintenance of behavioral health members in the community while improving outcomes and lowering costs.

Section 3.1.5.2: Crisis beds

Under the 1115 waiver, Illinois seeks coverage under Medicaid for the treatment and room and board costs of short-stay residential care for both children and adults. These crisis beds will be used exclusively as diversion/step-up beds for individuals that meet medical necessity requirements and are in need of stabilization due to crisis but do not have needs acute or high enough to require an inpatient stay.

These beds will offer a stable environment, structure, and support to facilitate symptom stabilization and respite for family members. Providers offering crisis beds will participate as needed in crisis assessment, individual treatment planning, family needs assessment, development of safety plans and longer-term individual plans of care, and the coordination of linkages to appropriate community resources. These providers may also facilitate transportation between the stabilization site and other service sites and maintain continuous communication and coordination with the IHH's care coordinator and mobile crisis response service team.

Staffing for these beds will involve direct care by a MHP (mental health professional) or RSA (rehabilitative services associate) and supervision provided by a QMHP (qualified mental health professional) or LPHA (licensed practitioner of the healing arts). Members will have 24/7 access to psychiatric consultation and nursing/medical staff.

Section 3.1.6: Additional benefits for children and youth with behavioral health conditions and/or serious emotional disturbance

Children with behavioral health conditions and SED, especially those who are transitioning back to their communities from out-of-home care, are often at risk of requiring intensive inpatient or residential care. To prevent this disruption and maintain more children in their home and communities, the State proposes to offer at-risk children with serious behavioral health conditions and/or SED a set of additional benefits as described in the 2013 CMS guidance, "Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions." The vast majority of the benefits in the CMS guidance that are not described in this waiver are being pursued through SPAs.

Under the 1115, Illinois proposes piloting two additional key benefits for children: intensive in-home services and respite care. These benefits have been tested in other major initiatives, including the SAMHSA Children's Mental Health Initiative and the CMS Psychiatric Residential Treatment Facilities (PRTF) demonstration program, showing cost savings and significant improvements in quality of life for children and their families.

In addition, intensive in-home services and respite care will serve as critical services for IHHs to leverage when appropriate to maintain their members with high behavioral health needs and/or SED in the community and avert the need for higher-acuity care.

Section 3.1.6.1: Intensive in-home care

Intensive in-home services are interventions provided in the home to stabilize behaviors that may lead to crisis, prevent the need for inpatient hospitalization, and prevent the need to move from residences into out-of-home living arrangements. Services offered through the intensive in-home care pilot will include both home-based clinical and support services. Home-based clinical services are face-to-face, individual, strengths-based therapeutic interventions driven by a clinical intervention plan focused on symptom reduction. Home-based support services are intended to support both the child and his/her family in implementing therapeutic interventions, skill development, and behavioral techniques that focus on symptom reduction. Specifically, supports include teaching methods for social, emotional, and behavioral development, self-help, coping with stress, and parenting.

These intensive in-home services will be time-limited as families gradually learn to stabilize their learning environments. Further details of the proposed delivery system, services, and eligible members are outlined in Exhibit 21.

Exhibit 21: Intensive in-home services details

INTENSIVE IN-HOME SERVICES	
Service details	Intensive in-home services are therapeutic interventions delivered to children and families in their homes and other community settings to improve youth and family functioning and to prevent out-of-home placement in inpatient or residential treatment settings. Service components include: • Individual and family therapy

	• Skills training • Behavioral interventions
Service delivery	Services are expected to be delivered in the child's home and offered at the time of day when they are most needed and when the family is most receptive to them. Services are expected to be culturally competent and linguistically appropriate. These services will be authorized for an initial 60-day period with potential for authorization for an additional two 30-day renewals. Both home-based clinical services and home-based support services must be provided for a minimum of one hour per week.
Eligible members	Children (3 to 21 years old) with high behavioral health needs at risk of transition to a higher level of care on a pilot basis

Section 3.1.6.2: Respite care

Intensive in-home services alone may not provide a sufficient continuum of support to meet the needs of the child and family and keep the child in the least restrictive environment possible. For this reason, to adequately reduce caregiver stress, sometimes a short break from the home environment for the child or family may be needed. Respite services can help to relieve stress and ultimately maintain individuals in the community after a short time away. As described in the 2013 CMS guidance, respite services "provide safe and supportive environments on a short-term basis for children with mental health conditions when their families need relief."

Currently, respite care is offered through select, population-based HCBS waivers across the State as well as through a State-funded demonstration. Through the 1115 waiver, Illinois seeks to pilot the respite program with a targeted group of children with high needs and families across the State.

Details on the proposed delivery system, services, and eligible members for respite care are outlined in Exhibit 22.

Exhibit 22: Respite care service details

RESPITE CARE	
Service details	Respite care is a set of individualized time-limited services that provide families scheduled relief to help prevent stressful situations, including avoiding a crisis or escalation within the home. • Services can be delivered in or out of the home as long as they take place in community-based settings • Services must be provided on a scheduled basis and planned as part of a child's individualized care plan and therefore are not to be utilized as emergency child care

	• Services will be culturally competent and aligned with the family's beliefs and preferences • Services shall not exceed seven hours per event, 21 hours per month, or 130 hours annually • Services are not standalone and must be offered in conjunction with other treatment services
Service delivery	Medicaid funds under the 1115 waiver would be used by the State to contract with an entity approved by the Department of Healthcare and family Services who would administer Medicaid dollars for respite care
Eligible members	High-needs children and youths (3 to 21 years old) who have a serious emotional disturbance and/or complex behavioral health conditions and are at risk of transition to a higher level of care on a pilot basis

Section 3.2: Cost-sharing requirements

There is no cost-sharing for any benefit provided under the waiver; copayments, coinsurance, and/or deductibles for any of the above benefits. State Plan benefits will continue to be applied in accordance with the State Plan.

Section 4: Other Waiver Initiatives

Under the 1115 waiver, Illinois requests coverage of four initiatives to maximize the impact of the benefits enumerated in Section 3 and create the systemic changes necessary to pave the way for integration and value-based payments.

First, the State recognizes of importance of aligning system transformation efforts with broader population and preventative health reform. Just as supportive housing, supported employment, respite care, and lower-acuity crisis alternatives are vital components of the behavioral health continuum of care, so are prevention services. To build this continuum of care, Illinois requests support through the 1115 waiver for select infant and early childhood mental health initiatives.

Second, to prepare the State and providers to successfully implement IHHs, Illinois requests support through the 1115 waiver for Medicaid funding for select behavioral and physical health integration activities. This funding will provide payers and providers resources to develop the infrastructure, technology, and provider capabilities required to implement health homes.

Thirdly, to promote an Illinois workforce that is sufficiently sized, diversified, culturally competent and trained to provide the services requested in this waiver and prepared to function within a value-based payment system, Illinois requests through the 1115 waiver Medicaid funding a set of workforce-strengthening initiatives. These initiatives range from support for loan forgiveness to funding for telemedicine infrastructure.

Lastly, to ensure first episodes of psychosis can be addressed and managed as early and effectively as possible, Illinois requests Medicaid funding to expand the reach of first episode psychosis programs by supporting the creation of teams to address this critical inflection point in members' lives.

Section 4.1: Behavioral and physical health integration activities

In Illinois, as in other states, behavioral health is a key driver of healthcare utilization and Medicaid spending. As previously noted, although Illinois Medicaid members with behavioral health conditions make up 25% of the Medicaid population, they account for 56% of Medicaid spending when factoring in both behavioral and medical costs.

While individuals with behavioral health conditions have some of the greatest needs, the Illinois healthcare system is often too fragmented to serve them in an ideal fashion. For behavioral health members with high needs, the complexity of accessing physical and behavioral health services separately can be prohibitive. There are also many behavioral health conditions that can and should be addressed within primary care settings, but members often encounter primary care providers who lack experience in treating behavioral health conditions or engaging behavioral health members in their own care. Behavioral health members often have difficulty adhering to medication regimens, managing appointments, or finding transportation to appointments or to pick up medications.

The integration of behavioral and physical health is essential to fully address the needs of these members. Furthermore, integrating care for these hard-to-serve members can also play a pivotal role in bending the Medicaid cost curve. This is illustrated by the cost differential between behavioral health and non-behavioral health members with similar conditions: Illinois Medicaid members with diagnosed and treated behavioral health conditions are approximately 3.5 times as likely (59%) as other members (17%) to have a chronic medical condition, and their annual treatment costs are nearly twice as high (not risk-adjusted) as those of non-behavioral health members with the same conditions (Exhibit 23).[37]

Exhibit 23: Chronic conditions in Medicaid behavioral health members

Behavioral health Medicaid members are 3.5x as likely to have a chronic condition and almost 2x the spend of the non-behavioral health population

Chronic medical condition prevalence and cost in non-behavioral health population vs. behavioral health primary population[5]

	Non-behavioral health population[1]	Average PMPM spend[2], $	Behavioral health primary population[1]	Average PMPM spend[3], $	Percent difference in PMPM
No chronic condition	83%	101	41%	186	84%
Asthma	7%	268	15%	732	173%
Hypertension	6%	408	23%	986	141%
Hyperlipidemia	4%	327	15%	926	183%
Diabetes	3%	470	10%	1,219	160%
COPD	2%	331	10%	1,102	233%
Arthritis	2%	418	11%	976	133%
Chronic Kidney Disease	1%	1,171	4%	2,368	102%
Ischemic Heart Disease	1%	639	4%	1,659	160%
Heart Failure	0%	1,389	2%	2,653	91%
Cancer[4]	0%	879	1%	1,796	104%
Stroke	0%	1,799	2%	2,267	26%
Osteoporosis	0%	915	1%	1,567	71%
Atrial Fibrillation	0%	992	1%	2,563	158%
Alzheimer's disease	0%	1,052	1%	2,164	106%
	Total population[1] = 1,642,415		Total population[1] = 357,785		

1 Valid population after non-Medicaid and business exclusions
2 Represents total spend incurred by members of the non-behavioral health population
3 Represents cost of medical treatments for members of the behavioral health primary population
4 Includes breast, colorectal, lung, and prostate cancers
5 Excludes members with no claims or only PMPM coordination payments
SOURCE: FY15 State of Illinois DHFS claims data

Illinois has made substantial progress toward integration by carving in behavioral health during the transition to managed care. In addition, the State is migrating children who receive services from the DCFS—a population that tends to have behavioral health needs—to a specialized managed care product. While the State believes these to be important starting points, it believes more progress needs to be made in partnership with its MCOs, to more deeply integrate behavioral and physical health care.

37 State Fiscal Year 2015 Illinois DHFS claims data

As described in Section 1.2.3, to achieve its vision for integration, Illinois intends to design and implement IHHs. Authorized through a SPA, these IHHs will align incentives and reward providers for furnishing high-value, high-quality care that is fully coordinated across behavioral and physical health settings. Illinois believes this delivery system is equally necessary in both mandatory and voluntary managed care counties.

In IHHs, providers will treat the whole member including physical and behavioral needs. Providers will proactively identify and target high-needs members as well as screen those at risk of developing SUD and work to ensure they receive the appropriate follow-up care. Physical and behavioral health providers will collaborate closely; share information; deliver care in a multi-disciplinary, team-based model; and co-develop treatment plans. This integrated care team will jointly consider diagnosis and treatment with the member's socioeconomic, mental, and physical health needs; coordinate transitions in care (e.g., after incarceration, between residential and outpatient recovery treatment); and make referrals utilizing data on outcomes and cost.

Increased access will be critical to enable individuals to access care "where they are" (e.g., in schools). In addition, community and support service connectivity will extend beyond pamphlets in the office. Providers will actively connect members to appropriate social services and community-based prevention programs for which they are eligible.

To make these changes, provider operating models under the IHHs will shift from those that focus primarily on managing member flow and volume toward those that optimize staff mix, leverage technology, and enable all providers to practice at the tops of their licenses. In addition, providers and payers will consistently share and review performance data to leverage best practices, monitor quality improvements, and prioritize outreach efforts.

While Illinois firmly believes that this IHH model will transform the State's healthcare delivery system, it acknowledges that not all actors can make this transition alone. Indeed, this transition requires a fundamental shift in operating models from one that is siloed and throughput-based to one that is integrated and value-based. Support is needed to make this difficult shift. Therefore, through this 1115 waiver, Illinois seeks Medicaid funding to assist health system actors in their transition to integrated care. Support will come in two forms:

- Support for the State and MCOs to enable IHH design, development, and implementation
- Support for providers to offer resources that facilitate development of IHHs and enable success as health homes

Indexed heavily in the first three years of the waiver, this integration support enables the State and MCOs to invest in the people, facilities, processes, and technology needed to promote IHHs. For providers, it acts as both a catalyst to incentivize them to become health homes and a resource to provide support required to succeed in early life as a health home.

To be eligible for integration funds, providers may be required to submit a formal letter of intent to the State stating that they will become IHHs for their Medicaid members. Examples of initiatives that could be funded by support to payers and providers are outlined in Exhibit 24. These will be refined in collaboration with stakeholders on approval of the waiver.

Exhibit 24: Integration activities service details

SUPPORT FOR BEHAVIORAL AND PHYSICAL HEALTH INTEGRATION	
Transition support for the State and MCOs	
Prepare the workforce for integration	Activities to be undertaken by the State in partnership with MCOs to help providers succeed as IHHs: • Design a curriculum that contributes to the healthcare workforce to promote knowledge of and capabilities for practicing integrated care from day one • Teach integration-specific skills and best practices • Build operational competence in offering integrated physical and behavioral health care • Ensure that integration activities and materials address proficiency in the area of cultural sensitivity and competency Training and technical support will be targeted by provider type and topic areas, which may include: • For IHH leaders: workforce management and recruiting, patient access strategies (e.g., hours, scheduling), business support • For physical health providers: continuing education in managing basic behavioral health conditions (e.g. DATA 2000 waiver trainings) and developing processes to recognize and ensure members obtain appropriate support for more serious conditions • For behavioral health providers: continuing education in managing basic physical health conditions, as appropriate based on member circumstances, and developing processes to recognize and ensure members obtain appropriate support for more serious conditions • For clinical care coordinators: clinical workflows to manage members admitted to higher levels of care, methods to manage member engagement • For case managers: patient and family education and support, planning for community engagement and resource utilization, clinical workflow management • For police officers: crisis intervention training • For volunteers and untrained individuals: mental health first aid training

Assess provider readiness to become integrated health homes	The State, in partnership with MCOs, will develop an IHH readiness assessment tool to evaluate processes that providers have in place and ability to perform integrated activities: • Providers must demonstrate sufficient competence in integrating physical and behavioral health to assure Illinois Medicaid that eligible members can be attributed to their IHHs • Comparisons across administrations of the readiness tool allow for evaluation of readiness improvement and progression as IHHs • Tool will be used to identify best practices to share, thus improving value over time
Transition support for providers	
Accelerate partnerships between behavioral and physical health providers	• Support providers to build integrated care teams and become IHHs. For example to: – Build care compacts or collaborative care agreements to formalize relationships with other providers to meet requirements of IHHs – Hold collaborative training sessions several times per year to provide ongoing education and idea exchanges on how to best integrate behavioral and physical health – Administer ongoing training modules • Leverage learnings from the DocAssist program to ensure primary care providers receive the virtual psychiatric and clinical guidance they need when managing behavioral health conditions, particularly for those structurally incapable of cementing such relationships (e.g., due to distance from other providers) • Create care coordination links between outpatient clinics and office-based MAT services to establish a continuum of care so that members of different acuity/stability can be referred to appropriate levels of care
Launch disease-specific pilots	• Disease-specific integration pilots to build a foundation for behavioral and physical health collaboration (and collaboration among relevant providers). Possible pilot collaborations include: – Pre- and post-partum depression and physical health (obstetrician, mental health provider or mental health professional, and primary care physician) – Diabetes and depression (endocrinologist, MHP, PCP) – Non-opioid collaborative therapy (physical therapy, CBT, weight-loss therapy for osteoarthritis, etc.) to manage chronic pain
Create processes for tracking of data	• Help providers develop and implement data collection and reporting mechanisms and standards to: – Track utilization of integrated services

to inform quality improvement strategies	– Track healthcare outcomes of individuals treated in integrated service settings – Help providers conduct quality improvement analyses to capture lessons learned, find opportunities to build scale, and identify challenges to broader expansion of integrated care

Section 4.2: Infant/early childhood mental health initiatives

Social-emotional development during early childhood is the foundation for success in learning and in life, and it is correlated with improved long-term health and educational outcomes. Social-emotional development can be disrupted by a variety of health and environmental factors, including family or community violence, traumatic experiences, a child's mental health issues, poverty, and mental health and substance abuse issues of caregivers. On the other hand, strong partnerships between families, providers, programs, and systems can promote and support healthy social-emotional development for infants and young children, helping them reach their full potential. According to the Centers for Disease Control and Prevention, "Assuring safe, stable, nurturing relationships and environments for children has a positive impact on a broad range of health problems and the development of skills that will help children meet their full potential."[38]

To nurture healthy child-parent relationships, it is imperative to increase the capacity of the adults in children's lives. Two tested ways to do this are through evidence-based home visiting (EBHV) programs and Infant/Early Childhood Mental Health Consultation (I/ECMHC).

Illinois has long believed home visiting and I/ECMHC to be effective and efficient strategies. Illinois has already invested heavily in EBHV, programs that pair families experiencing risk factors with trained professionals who provide information and support to improve the comprehensive health of children and their families by supporting parents' ability to provide a safe, supportive, and healthy early learning environment. The programs improve the life trajectories of not only families and children at risk for poor health but also those at risk of poor educational, economic, and social outcomes.

Currently, EBHV services are offered in Illinois through a variety of initiatives including the federal Maternal, Infant, and Early Childhood Visiting (MIECHV) program, Healthy Families Illinois, Parents Too Soon, Early Childhood Block Grant (ECBG) - Prevention Initiative, and Early Head Start. Despite the diverse set of programs, it is estimated that EBHV reaches only 10% of eligible children and families.[39] I/ECMHC services are offered as part of each EBHV program as well as through child care, Head Start, Preschool for All, Preschool Development/Expansion Grant, child welfare, and the Early Intervention program.

38 *Children benefit when parents have safe, stable, nurturing relationships,* CDC National Center for Injury Prevention and Control: Division of Violence Prevention

39 Association of State and Tribal Home Visiting Initiatives, Illinois Fact Sheet, Spring 2016

Illinois has yet to pursue I/ECMHC at scale. I/ECMHC teams multi-disciplinary early childhood mental health professionals with people who work with young children to build caregiver skills and capacity to effectively promote children's social-emotional development, health, and well-being. Many studies have shown that access to EBHV programs and I/ECMHC can improve health outcomes as well as social outcomes. The programs improve child-parent relationships, decrease caregiver stress, facilitate the development of positive social skills, reduce preschool expulsions, and lead to better teacher-child interactions. Intervening early and engaging families may also be able to prevent severe disruptions later in a child's life (e.g., suspension or expulsion from school, mental health issues, and involvement with the criminal justice system).[40]

Through the 1115 waiver, Illinois seeks to test early childhood models that are integrated into the State's behavioral health delivery system. Through the 1115 waiver Illinois seeks to:

- Pilot an early childhood mental health consultation model
- Pilot an early childhood home visiting program for a targeted group of at-risk children and families

The EBHV Program will be targeted toward families of children born with withdrawal symptoms. Opioid use and dependence during pregnancy is a growing public health concern, and neonates experiencing withdrawal benefit from not only high-quality care upon arrival, but also on a comprehensive discharge plan that addresses the whole-person and family. This discharge plan should address maternal substance abuse treatment, creating a safe environment for the mother and baby, and ensuring parenting and community supports are available. Under the 1115 waiver, Illinois proposes that families of all Medicaid-eligible neonates suffering from withdrawal be linked to a home visiting program to help advise the parents on their children's health and development and support them to gain skills to help their children thrive.

Details of the proposed delivery system, services, provider qualifications, and eligible members are outlined in Exhibit 25.

Exhibit 25: Early childhood mental health intervention service details

INFANT/EARLY CHILDHOOD MENTAL HEALTH INITIATIVES	
Service details	**Infant/Early Childhood Mental Health Consultation (I/ECMHC)** is a multi-level early intervention approach that teams early childhood mental health professionals with people who work with young children and their families. Its goal is to build their capacity and skills to promote social-emotional development, and behavioral health and well-being of children

40 Perry, D., Brennan, E., Bradley, J., & Allen, M. D. (2006, July). The evidence base on mental health consultation in early childhood settings: Child and family outcomes. Paper presented at Developing Local Systems of Care for Children and Adolescents with Emotional Disturbances and their Families, Orlando, FL.

	I/ECMHC services may be provided to child care, preschool, home visiting, child welfare, Early Intervention, and Head Start/Early Head Start programs I/ECMHC builds the capacity of teachers, home visitors, pediatricians, child welfare workers, and other adults who work with young children and families through a variety of services: • Case/program consultation • Reflective consultation with staff and supervisors • Support and consultation for program directors and administrators to implement effective strategies to support social--emotional development and enhance program quality • Identification of effective strategies and training for staff working with specific children as well as the classroom/program as a whole • Co-facilitation of parent or caregiver support groups • Identification of need for additional services (particularly health and mental health services) and referral • Design of training in response to observed need within a program or classroom **Home visiting programs** provide families with regular, planned home visits to help parents learn how to improve their family's health and provide better opportunities for their children. Home visits may include: • Supporting preventative health and prenatal practices • Assisting mothers on how best to breastfeed and care for their babies • Helping parents understand child development milestones and behaviors, • Promoting parents' use of praise and other positive parenting techniques, and • Working with mothers to set goals for the future, continue their education, and find employment and child care solutions
Service delivery	Medicaid funds under the 1115 waiver would be used by the State to contract with a set of providers to deliver I/ECMHC and home visiting services. I/ECMHC pilot programs must target highest-need areas. Therefore, a majority of pilot sites will be required to be located in highest-need areas as defined by income, rate of violent crime, and a set of early childhood

	indicators to be determined. Geographic diversity of pilots will also be required to test efficacy in rural areas. Home visiting services will be non-duplicative and coordinated with existing programs targeted at this population including, but not limited to, DHS' High Risk Infant Follow-up program (HRIF) and any DCFS programming.

Eligible members	Providers of services to children and families who work with:
	
	• Children who are:
	  – Medicaid-eligible
	  – Less than five years old
	  – At risk of needing future social, emotional, behavioral, or health intervention
	• Pregnant women who are Medicaid-eligible
	• Parents of Medicaid-eligible children identified as eligible members

Section 4.3: Workforce-strengthening initiatives

A state's behavioral health outcomes are only as good as the workforce that provides it. Overall, the national healthcare workforce is aging and not adequately trained to meet growing demand for integrated physical and behavioral health care. Illinois has a shortage of physicians, which is particularly severe for certain population groups:

- 28.5% of Illinois residents live in areas that have been designated primary care Health Professional Shortage Areas (HPSAs); the national median is 18.6%[41]
- Illinois meets the national average in number of active primary care physicians per 100,000 residents (approximately 104.8)[42]
- Only 73.2% of Illinois physicians reported that they were accepting new Medicaid patients in 2013[43]
- Illinois is projected to need more than 100,000 new healthcare workers by 2020[44]

This workforce shortage is felt acutely by the behavioral health system. Like other states, Illinois has a need for more specialists including child and adolescent psychiatrists, advanced practice nurses (APNs), physician assistants, occupational therapists, licensed clinical social workers, and other behavioral health care workers. As Illinois seeks to integrate behavioral and physical health, many members of the workforce will require additional training. Addressing these

41 Illinois Health Care Workforce Report & Recommendations, from the Illinois Health Care Reform Implementation Council Workgroup on Workforce. January 2014

42 HPSA information from the Health Resources and Services Administration (HRSA); population data from ACS. Accessed through the Benchmark State Profile Report for Illinois provided by CMM

43 Centers for Disease Control, 2015

44 State of Illinois Industry Employment Projections

workforce needs will be critical to the success of the other initiatives in the waiver demonstration. A robust and highly skilled workforce is critical for delivering on the integrated behavioral and physical health vision Illinois has developed.

Under the 1115 waiver, Illinois requests Medicaid funding to enhance its existing behavioral health workforce while building the behavioral health workforce of the future. In the near-term, this will enable existing providers to better serve behavioral health members with a team-based, integrated approach. In the long term, it will enhance the behavioral health workforce supply, particularly in underserved areas, and ensure that all providers are proficient in the practice of integrated care.

The 1115 support for workforce initiatives will be split into two elements:

- **Support for workforce development:** to attract, train, and retain behavioral healthcare workers that are culturally competent, racially/ethnically, and linguistically diverse
- **Support for workforce optimization:** to train providers to be culturally and linguistically competent and to be equipped to address whole-person care for those in need

Support for workforce development
Support for workforce development will initially be used to develop and refine the State's workforce development strategy focusing on:

- Conducting a comprehensive needs assessment
- Designing a strategy that builds capacity for current needs and anticipates future behavioral health workforce requirements
- Ensuring attractive incentives for the behavioral health workforce that keep pace with market conditions
- Designing programs for loan repayment/forgiveness and education investments for behavioral health workers

Later, support for workforce development will be directed toward funding execution of these programs.

Support for workforce optimization
Initially, support for workforce optimization will be used for:

- Designing a strategy to incent providers to serve Medicaid beneficiaries in underserved areas
- Conducting a telemedicine needs assessment across the State, funding and initiating rollout of telemedicine infrastructure, and training providers in use of telemedicine
- Developing a training curriculum for providers who require support to learn how to best partner with MCOs

Design a strategy to recruit and retain a workforce that is linguistically and racially/ethnically diverse

Later, support for workforce optimization will be directed toward direct funding of this strategy as well as continued rollout, training, and maintenance of telemedicine infrastructure.

Details of the proposed workforce initiatives to be funded through these two streams are outlined in Exhibit 26.

Exhibit 26: Workforce initiative service details

SUPPORT FOR WORKFORCE INITIATIVES	
Workforce development	
Loan repayment/ forgiveness program	Create a loan repayment assistance program to healthcare workers who commit to serving Medicaid populations in rural areas or other underserved places: • Loan repayment assistance could be provided for a wide range of professionals including psychiatrists, licensed clinical social workers, occupational therapists, community health workers, and direct care workers • Bonus payment pools for critical-access and safety-net hospitals that establish tuition repayment programs to attract and retain behavioral health workers • Candidates for repayment would need to commit to a number of years of full-time employment following graduation This program could be administered by the Illinois Department of Public Health, which currently administers the Illinois National Health Service Corps State Loan Repayment Program
Workforce optimization	
Telemedicine infrastructure	Payments to fund the infrastructure required for the provision of virtual care via telemedicine. Funding may be used to: • Conduct a telemedicine needs assessment across the State • Purchase and install telemedicine infrastructure in areas of need • Train providers in use of telemedicine
Linking community services to Medicaid and managed care	Funds used to develop training, technical assistance, and learning collaboratives for smaller community providers in need of support to work effectively with Medicaid and MCOs.

Section 4.4: First episode psychosis (FEP) programs

Approximately 100,000 individuals across the United States experience their first episodes of psychosis each year.[45] Most of these individuals are between 15 and 25 years of age. Based on Illinois' population, these statistics imply that more than 3,800 individuals in the State will experience a first episode of psychosis each year. These individuals are in critical need of intensive, specialized support. Historically, individuals diagnosed with Schizophrenia Spectrum Disorders experience significant impairment in most or all areas of functioning--social, academic, and vocational—and many wind up with permanent disabilities, resulting in tremendous personal, social, and fiscal costs.

First Episode Psychosis (FEP) programs are targeted at individuals in the initial onset of a psychotic episode. These programs have been shown to significantly improve chances of clinical and social recovery, thus stopping the usual trajectory into disability.

Illinois has not yet implemented any FEP program but is in the process of training providers and developing the necessary infrastructure to fund 13 teams statewide. These teams will include a clinical team lead, a psychiatrist or APN, two therapists, an IPS (supported employment/education) specialist, and a case manager. To be eligible for the FEP program, individuals will need to be between the ages of 12 and 40 years and experiencing an initial episode of psychosis or pre-psychosis

As part of this 1115 waiver, Illinois requests Medicaid coverage to expand the reach of the first episode psychosis initiative. This expansion will leverage the learnings from the FEP program discussed above and shift the provider payment structure to one that is outcomes-based.

45 McGrath J., Saha S., Chant D., & Welham J. (2008). Schizophrenia: a concise overview of incidence, prevalence, and mortality. Epidemiologic Reviews, 30, 67-76.

Section 5: List of Proposed Waivers and Expenditure Authorities

The State requests the following waivers:

1. Statewideness, § 1902(a)(1)

To the extent necessary to permit any limited service benefit (e.g., extended-release, injectable naltrexone MAT services within 30 days pre-release, transitional services for justice-involved individuals at CCJ)

2. Comparability, § 1902(a)(10)(B)

To the extent necessary to limit certain benefits as set forth in the Demonstration Application

3. Eligibility redetermination (42 C.F.R. 435.916)

To the extent necessary to extend the period of redetermination for individuals who are incarcerated until 180 days after release or discharge

4. Freedom of Choice, § 1902(a)(23)(A)

To the extent necessary to enable the State to assign justice-involved individuals to a managed care plan so that services may begin promptly upon discharge

The State requests federal financial participation in the following costs not otherwise matchable (CNOMs):

1. Supportive Housing Services

Expenditures for services to support an individual's ability to prepare for and transition to housing and maintain tenancy once housing is secured

2. Supported Employment Services

Expenditures for services to support an individual who, because of serious mental illness, need ongoing support to obtain and maintain employment

3. Transition Pre-Release Services

Expenditures for assessment, treatment, and coordination of focused services for justice-involved individuals 30 days prior to release to improve linkages with community behavioral health treatment

4. Medicaid coverage for extended-release injectable naltrexone MAT services for targeted individuals within 30 days pre-release

Expenditures for extended-release, injectable naltrexone MAT services for justice-involved individuals appropriate for such services 30 days prior to release

5. Short-Term Residential Treatment in a Substance Use Disorder IMD

Expenditures for services for individuals who, as part of a continuum of care, are receiving residential substance use disorder treatment in facilities that meet the definition of an Institution for Mental Disease for 30 days or less

6. Substance Use Disorder Case Management

Expenditures to provide substance use disorder case management to individuals not otherwise receiving case management

7. Withdrawal Management

Expenditures to provide substance use disorder withdrawal management

8. Substance Use Disorder Recovery Coaching

Expenditures to provide recovery coaching services to individuals who have entered treatment for substance use disorder

9. Short-Term Residential Treatment in a Mental Health IMD

Expenditures for services for individuals who, as part of a continuum of care, are receiving inpatient mental health treatment in facilities that meet the definition of an Institution for Mental Disease for 30 days or less

10. Crisis Beds

Expenditures to provide subacute inpatient treatment

11. Intensive In-Home Services

Expenditures to provide intensive in-home services to families and children with high behavioral health needs at risk of transition to a higher level of care

12. Respite Care

Expenditures to provide respite care to children and caregivers of children with serious emotional disturbance and/or complex mental health issues

13. Behavioral Health and Physical Health Integration Activities

Expenditures to support the infrastructure and activities required (e.g., workforce preparation, provider readiness assessment, partnership development between providers, launch of disease specific pilots, etc.) to integrate behavioral and physical health, reduce fragmentation of service, reduce total cost of care, improve behavioral and physical health outcomes, and promote patient centered care

14. Infant/Early Childhood Mental Health Initiatives

Expenditures for I/ECMH professionals to build the capacity of staff and caregivers working with children and families in order to promote children's social emotional development, health, and well-being and address mental health needs.

Expenditures to provide home visiting services to families of children born with withdrawal symptoms.

15. Workforce Development and Workforce Optimization

Expenditures to develop and implement development of a robust and racially/ethnically and linguistically diverse behavioral health workforce, including loan repayment/forgiveness and education programs and expenditures to develop and implement behavioral health workforce optimization, including telemedicine infrastructure and improving linkages between community service providers and managed care organizations

16. First Episode Psychosis

Expenditures to expand the First Episode Psychosis program

17. Designated State Health Programs

Expenditures for costs of designated programs which are otherwise state-funded

Section 6: Demonstration Financing and Budget Neutrality

Illinois understands that when submitting a Section 1115 demonstration waiver, states are required to include an initial view illustrating that they expect the demonstration to be budget neutral. The test for budget neutrality will be applied according to the terms and conditions for the demonstration that are agreed to by the State and CMS, will be measured periodically throughout the approval period, and evaluated at the conclusion of the demonstration based on per member per month (PMPM) costs.

Based on CMS guidance, a budget neutrality workbook will be provided to include historical enrollment, trends, and expenditures. Base year per-capita costs are total costs divided by total member months in order to calculate a yearly average PMPM cost for each of the five years captured in the historical data. Base year PMPM costs are derived by trending the historical PMPM forward, taking into account State Plan Ammendments.

To ensure budget neutrality, Illinois Medicaid will achieve cost savings from a range of sources including:

- Comprehensive management of members, particularly previously uninsured young adults, who experience SMI and SUD
- Deflecting members with behavioral health conditions away from high-cost institutional services when unnecessary, ensuring proper management under community-based services
- Stabilizing behavioral health conditions and co-morbid medical conditions to avoid long-term Medicaid eligibility for some individuals. For others, the outcome of the early intervention will result in conditions that are easier to manage and less costly than disability-related Medicaid
- Designing a value-based payment and delivery system that ensures provider responsibility for delivering the right care, in the right place, at the right time, at the right cost

Though not part of the budget neutrality model, the State also expects the demonstration to have a significant positive impact on the ability of enrolled individuals to become and remain employed (or continue their education) and avoid the correctional system, thereby reducing reliance on other publicly supported programs as well.

Exhibit 27: Budget neutrality overview

Historical member months and expenditures						
	HY01	**HY02**	**HY03**	**HY04**	**HY05**	**Total**
Member months	31,104,323	32,145,779	32,362,517	34,318,516	37,862,717	167,793,852
Expenditures	$12,540,460,017	$13,031,726,157	$14,207,325,984	$14,667,679,798	$16,757,846,285	$71,205,038,241

Demonstration member months and expenditures						
	DY01	**DY02**	**DY03**	**DY04**	**DY05**	**Total**
Member months	37,750,583	37,715,421	37,681,379	37,648,466	37,616,689	188,412,538
Expenditures						
Without waiver	$18,576,508,609	$18,897,139,817	$19,239,445,018	$19,604,095,912	$19,984,282,470	$96,301,471,827
With waiver	$18,452,538,364	$18,644,845,445	$18,849,218,411	$19,065,795,271	$19,290,173,701	$94,302,571,192
Variance	$ 123,970,245	$ 252,294,372	$ 390,226,607	$ 538,300,642	$ 694,108,769	$ 1,998,900,635
Total CNOMs	$ 185,682,531	$ 260,281,368	$ 195,449,380	$ 180,181,551	$ 180,066,901	$ 1,001,661,731
Total DSHPs	$ 199,201,835	$ 199,201,835	$ 199,201,835	$ 199,201,835	$ 199,201,835	$ 996,009,175
Net change	$ (260,914,121)	$ (207,188,831)	$ (4,424,609)	$ 158,917,256	$ 314,840,033	$ 1,229,728

Illinois requests to invest the federal share of this variance in the benefits and initiatives described above. To finance the non-federal share of the demonstration, Illinois intends to use the state share of savings to be realized through the demonstration as well as general fund dollars generated through approved designated state health programs (DSHP). DSHP protocol guidelines from CMS indicate 3 approval categories. Illinois is currently assessing options for programs that we anticipate will qualify as the primary source of non-federal funding.

Section 7: Stakeholder engagement and public notice

Section 7.1: Stakeholder engagement and public notice overview

As part of the stakeholder engagement process required within the development of this Section 1115 Demonstration Waiver, Illinois sought consultation with stakeholders including state, county, and local officials and health care providers, health care payers, patients, and their families. The State gathered this input during the public comment period from August 26, 2016 until October 2, 2016 at 5 p.m. (Central) in accordance with the requirements under 42 C.F.R 431.408. Illinois certifies that it has provided public notice about the Demonstration Proposal in the following ways:

Date	Notice or document	Link
08/18/2016	Notice of delay of public hearing on HFS website	https://www.illinois.gov/hfs/SiteCollectionDocuments/081816_Notice_of_Public_Hearing_Correction2.pdf
08/19/2016	Notice of Public hearing in the Illinois state registry	http://www.cyberdriveillinois.com/departments/index/register/register_volume40_issue34.pdf#page=155
08/24/2016	Notice of public hearing on HFS website, including details for each public hearing session	https://www.illinois.gov/hfs/SiteCollectionDocuments/08.24.16NoticePH1115waiver.pdf
08/26/2016	Notice of public information on HFS website regarding 1115 Demonstration proposal and public hearings	https://www.illinois.gov/hfs/SiteCollectionDocuments/082616PN1115waiverLongFormCLEAN.pdf
08/26/2016	Submission of draft 1115 Demonstration Proposal on HFS website	https://www.illinois.gov/hfs/SiteCollectionDocuments/20160826%201115%20Waiver%20for%20Public%20Comment%20vF.pdf
09/02/2016	Public notice regarding updated draft waiver application on HFS website	https://www.illinois.gov/hfs/SiteCollectionDocuments/Notice_of_Public_Information_Waiver_090216rev.pdf
09/07/2016	Reminder of public hearing and teleconference information	https://www.illinois.gov/hfs/SiteCollectionDocuments/090716PublicHearing1115waiverTelecom.pdf

Illinois accepted written comments and questions regarding the Demonstration Proposal until October 2, 2016 via e-mail and postal mail, and also provided copies of the Demonstration Proposal at the below address:

Illinois Department of Healthcare and Family Services
Division of Medical Programs

Bureau of Program and Policy Coordination
201 South Grand Avenue East
Springfield, IL 62794
Email address: hfs.bpra@illinois.gov

Illinois also certifies that it held 2 public hearings at least 20 days prior to the submission of the Demonstration Proposal to CMS. During these hearings, participants were provided an overview of the Demonstration Proposal and an opportunity to provide comments. For the Chicago session, teleconferencing equipment was made available to allow participants to submit comments or questions by phone. The hearings were held at the following locations and times:

Thursday, September 8, 2016
10:30 AM to 1:00 PM
Howlett Auditorium
Michael J. Howlett Building
501 South Second Street
Springfield, IL 62756

Friday, September 9, 2016
10:30 AM to 1:00 PM
Assembly Hall Auditorium
James R. Thompson Center
100 W. Randolph Street
Chicago, IL 60601

During each hearing, participants were provided with an overview of the Demonstration Proposal, and given the opportunity to provide comments. Approximately 100 people attended the Springfield hearing and a total of 10 participants provided comments on the Demonstration Proposal. During the Chicago hearing, approximately 185 people were present in person and 134 by phone. Out of these, 25 participants provided comments on the Demonstration Proposal in person, and no comments were submitted by phone.

The state also held a joint hearing with a joint House and Senate Committee to discuss the 1115 waiver. The hearing was held on September 20, 2016 at 10.30 A.M. and was held in the Michael A. Bilandic building on 160 N. LaSalle St, Chicago. Details of the hearing can be found on the Illinois General Assembly website at http://www.ilga.gov/senate/committees/hearing.asp?hearingid=14064&CommitteeID=1575

On September 29, 2016, the Directors of HFS and DCFS presented the 1115 waiver at the Kennedy Forum's Leadership Council meeting. This meeting took place from 8:00 to 10:00 A.M. at Loyola University Chicago.

Illinois received comments from more than 100 commenters which are summarized in Appendix C. For each comment or groups of similar comments, the state has provided a

response. During the approval process and upon approval from CMS, the State will continue to seek stakeholder input and will conduct a robust engagement process to spread awareness about these system improvements.

Additionally, the State also held workgroup sessions with 4 different stakeholder groups to discuss various topics of the Demonstration Proposal. Working groups were held twice for each stakeholder group, which included consumer advocates, community service organizations, providers and Manager Care Organizations. Workgroup participants and invitees included:

Community service providers	Consumer advocates	Providers	Managed care organizations
• Aunt Martha's • Autism Speaks • Autonomy Works • Association of Social Workers • Catholic Charities • CBHA • Chaddock • Chicago Children's Advocacy Center • Child and Family Connections of Central Illinois • Children's Home and Aid • Cornerstone and Supportive Housing • FHN • HRDI • Illinois Alcoholism and Drug Dependency Association • Illinois Association of Public Health Administrators • Illinois Joining Forces • Illinois Partners for Human Services	• AIDS Foundation of Chicago • Brain Injury Association of Illinois • Cook County Public Guardian • Equip for equality • Everthrive • FCAN • Former foster youth • Health & Disability Advocates • Health and Medicine Policy Research Group • Healthy Schools Campaign • Heartland Alliance • Illinois Children's Mental Health Partnership • Illinois Collaboration on Youth • Illinois Foster and Adoptive Parent Association • Illinois Network Centers for Independent Living	• Alliance for Living • Ann & Robert H. Lurie Children's Hospital of Chicago • Barton Healthcare • CBHA • Child Care Association of Illinois • Community Counseling Centers of Chicago • CDDACS • Cook County HHS • Evanston Vet Center • Grand Prairie Services Behavioral Healthcare • Health Care Council of Illinois (HCCI) • IARF • IHA • IHCA • Illinois Chapter of the American Academy of Pediatrics • Illinois Health and Hospital Association	IAMHP on behalf of: • Aetna • BlueCross and BlueShield of Illinois • Cigna Healthspring • CountyCare Health Plan • FHN • Harmony • Health Alliance Connect • Humana • Illinicare Health • Meridian Health Plan • Molina Healthcare • Next Level Health

• Illinois Public Health Association • Jewish Federation (Jewish United Fund of Metro Chicago) • Loyola University • Lutheran Social Services • Metropolitan Family Services • National Association of Social Workers o Illinois Chapter • Revelation Golf • SIU Healthcare Psychiatry • Supportive Housing Providers Association • Thresholds • Youth Outreach Services	• Illinois Public Health Association • Illinois Public Health Institute • Kennedy Forum • McManus Consulting • NAMI • Safe Haven • Supportive Housing Providers Association • The Alliance • The Arc of Illinois • The Illinois Council on Developmental Disabilities • The Ounce of Prevention Fund • Voices for Illinois Children	• Illinois Justice Project • IPHCA (Crusader Health and Esperanza) • John Howard Association • Leading Age • Little City • Lutheran Social Services • Memorial Behavioral Health • One Hope United • Present St. Mary & St. Elizabeth Medical Center • Pediatrics Uptown clinic • Rosecrance Health Network • Sinnissippi • Touchette Regional Hospital, Centreville • UCAN	

Finally, Illinois certifies that the state has conducted tribal consultation in accordance with section 42 CFR 431.408(b). On August 24 and 26, 2016, the state reached out to the American Indian Health Service of Chicago for comments on the proposed Demonstration Waiver. Illinois did not receive any comments or concern from the organization

Section 7.2: Summary of waiver changes made as a result of stakeholder engagement and public comment process

Appendix C summarizes the 1,086 comments from more than 100 individual contributors received from Illinois stakeholders during the public comment period (August 26, 2016 - October 2, 2016), as well as the State's responses to these comments.

The contributors included members of the provider, community services, law enforcement, payer and advocate communities - and the State acknowledges, with thanks, these

organizations and individuals that have been deeply involved in the development of this waiver application. The State received a tremendous amount of support from the stakeholder community, as well as recommendations to enhance the Demonstration and areas to consider in the implementation of the initiatives. A number of adjustments to the draft waiver application were made in response to, and incorporating, feedback from stakeholders in this comment period. Select (but not exhaustive) examples include:

- **Supportive housing services:** Expanded member eligibility beyond SMI to include SUD as well and clarified the family-centric approach the State is proposing i.e., that if individuals qualify their immediate family can receive supportive housing services as well
- **Supported employment services:** Limited to members with SMI since members with SUD without co-occurring mental illness do not need this high-fidelity model
- **Services to ensure successful transitions for justice-involved individuals at the Illinois Department of Corrections (IDOC), Cook County Jail (CCJ), and the Illinois Department of Juvenile Justice (DJJ):** Expanded to DJJ population and expanded Vivitrol pilot to CCJ
- **Redesign of substance use disorder service continuum**: Removed certificate of need process for level III.5 facilities to avoid creating any barriers to access while ensuring appropriate utilization controls
- **Additional benefits for children and youth with behavioral health conditions and/or serious emotional disturbance:** Expanded Respite care and intensive in-home benefits for children through extended age range to 3-21 from 5-21
- **Infant/early childhood mental health initiatives:** Added home visiting for families of babies born with drug withdrawal syndrome
- **Workforce-strengthening initiatives:** Expanded concept of "technical assistance" to include linking community service providers to managed care to linking them to Medicaid more broadly
- **First episode psychosis (FEP) programs:** Expanded causes of episodes beyond schizophrenia spectrum to include any mental illness-induced psychosis or pre-psychosis. Expanded age range down to 12 from 14 years old

Many of the comments request additional detail for each Demonstration initiative which the State will define in collaboration with CMS. The State will consider stakeholder input in this process.

Appendix C lays out in more detail the specific comments and State responses. It does not note each expression of support, but only includes suggestions, recommendations, and questions from the stakeholder community. A list of public commenters can be found on the HFS website.

Section 8: Demonstration administration

The contact information for the State's point of contact for the Demonstration Waiver application is below.

Name and Title: Teresa Hursey, Acting Medicaid Administrator
Telephone Number: (217) 782-2570
Email Address: Teresa.Hursey@illinois.gov

Appendix

Appendix A: Evolution of Illinois' behavioral health ecosystem

Evolution of Illinois' behavioral health ecosystem (1/2)

	2014	2016	2018	2020+
Behavioral health member	▪ Array of individualized, patchwork services that must be sought out ▪ Reluctance to present due to stigma	▪ Continued patchwork services that must be sought ▪ Increasingly difficult to access due to budgetary constraints	▪ Changing behavior in accordance with rapidly growing service array and improving integration	▪ Accept comprehensive set of seamlessly integrated services centered around members and families ▪ Behavioral health as part of life
State	▪ Siloed agencies ▪ Stakeholder-driven	▪ Siloes beginning to break down ▪ Stakeholder input into state vision-setting	▪ Agencies collaborating on Transformation priorities ▪ Stakeholders meaningfully contributing to decision-making	▪ Seamless cross-departmental collaboration ▪ Evidence-based, state-led policy making, championed by stakeholders
MCOs	▪ Payment intermediary ▪ Any willing payer ▪ Subject to limited performance tracking and management	▪ MCOs transitioning to active purchaser ▪ Patchy focus on physical and behavioral health ▪ Subject to basic performance tracking and management	▪ Mature purchasers focused on quality and value ▪ Aligned on rules and outcomes ▪ Responsive to rapidly growing state performance management function	▪ Innovative partners competing with one another to deliver quality and value ▪ Aligned on and executing state-facilitated delivery system vision addressing all health needs ▪ Compliant with robust performance management function
Payment model	▪ Fee-for-service and no real pay for outcomes	▪ Considering transition to value-based payment ▪ Rates perceived by behavioral health providers as insufficient to cover costs	▪ Value-based payment model(s) focused on integration of physical and behavioral health; MCO buy-in ▪ Reimbursement tied to performance	▪ >80% of Medicaid payments through value-based models that fully drive integration of physical and behavioral health, rewarding outcomes

Evolution of Illinois' behavioral health ecosystem (2/2)

	2014	2016	2018	2020+
Provider delivery model	▪ Over-indexed on institutional care ▪ Behavioral health providers siloed, sub-scale, and unintegrated ▪ Primary care landscape fragmented, weak coordination, and limited behavioral health service provision ▪ Acute providers focused on throughput and propped up by supplemental payments ▪ No quality and cost transparency	▪ Continued over-reliance on institutional care ▪ Continued fragmentation of behavioral health and PCP landscape ▪ Limited coordination in FFS; MCOs may be doing some ▪ Acute providers unchanged ▪ Extremely limited quality and cost transparency	▪ Greater amount of service delivery occurring in the community ▪ Integrated behavioral and physical health delivery model in place for behavioral health members ▪ PCPs increasingly able to address low-severity behavioral health needs ▪ Acute providers starting to integrate with others ▪ Recognition of and plan for enhanced quality and cost transparency	▪ Well-resourced, highly efficient, with appropriate mix of institutional and community-based care ▪ Robust integrated behavioral and physical health delivery model in place for both higher- and lower-needs behavioral health members ▪ Co-location of physical and behavioral health providers, where appropriate ▪ Coordination with other provider types remains critical ▪ Robust quality and cost transparency for consumers, providers, and MCOs
Supportive services model	▪ Limited availability of and coordination with supportive services (e.g. supported housing, supportive employment, life skills training, transportation supports)	▪ Limited availability of and coordination with supportive services	▪ Meaningful investments initiated in supportive services ▪ State, MCOs, and providers each playing appropriate role	▪ Robust array of supportive services well-coordinated with broader service continuum ▪ State, MCOs, and providers each playing appropriate role

Appendix B: Proposed Designated State Health Programs (DSHPs)

Agency	Service	Description
Division of Alcoholism and Substance Abuse	Problem gambling services	Targeted outpatient group and individual services for adults experiencing compulsive gambling disorders
Division of Developmental Disabilities	Child Care Institution (CCI)	Structured environment for children and adolescents who cannot reside in their own home
Division of Developmental Disabilities	Family Assistance Program	Assistance to families to help provide care at home for children with serious mental disabilities including financial assistance to help meet the special service needs and unusual expenses connected with having a severely disabled child living in the home
Division of Developmental Disabilities	Respite Program- group	Respite services either in the form of intensive or non-intensive support services for individuals with developmental disabilities to maintain these individuals in their homes including supervision and care for children and adults in a group setting for a portion of the day
Division of Developmental Disabilities	Respite Program- in-home / residential	Intensive or non-intensive support services to help maintain individuals in their homes and provides short-term stays for individuals in a residential setting
Division of Developmental Disabilities	Case Management and Support Coordination	Assistance to provide prior authorization for all individuals for whom there is a reasonable basis to suspect the presence of a developmental disability who request Medicaid-funded services or nursing facility services; includes assessments, education and referrals
Division of Developmental Disabilities	Independent Service Coordination (ISC) Program	Education, referral, and linkage services for children and adults with developmental disabilities; general ISC functions include: intake, education, goal setting, referral and linkage to both generic and specialized services, and transportation to facilitate referrals, linkage, and planning

Division of Developmental Disabilities	BOGARD Service Coordination	Provides a range of services including assessments and reassessments of needs and goals, coordination of the individual service plan, specialized service facilitation an brokering for persons in nursing facilities, development of natural support networks, and performance of activities to maintain or improve availability, accessibility, and quality of services.
Division of Developmental Disabilities	Other Support Services	Ongoing and new special projects to address the varying needs of the participants served by the Division of DD
Division of Developmental Disabilities	Bogard Specialized Services	Aggressive, accountable, competent, and knowledgeable interactions that are habilitative in nature and directed toward meeting the individual's wants and needs
Division of Developmental Disabilities	Day Services	Structured individualized program of community habilitation activities for individuals for whom the more traditional day program is not appropriate
Division of Developmental Disabilities	Regular work/sheltered employment	Long-term employment in a sheltered environment for individuals whose functional levels require supervision but are not precluded from future movement into a Supported Employment position or a competitive employment position
Department of Public Health	Expenses of Adverse Reporting, Patient Safety and the Adverse Pregnancy Outcome Reporting System (APORS) in Support of Infant Mortality Reduction	Collection system for information on infants born with birth defects or other abnormal conditions and conducts surveillance on birth defects to guide public health policy in the reduction of adverse pregnancy outcomes and identify and refer children who require special services to correct and prevent developmental problems and other disabling conditions
Department of Public Health	Grants for Vision and Hearing Screening Programs	Mandated screenings at specific age and grade levels done by technicians/nurses trained and certified by the Department; screenings result in approximately 1 million children screened annually for both vision and hearing

Department of Public Health	Expenses Incurred for the Rapid Investigation and Control of Disease or Injury	Grants for the rapid investigation and control of disease or injury
Department of Public Health	Expenses of Environmental Health Surveillance and Prevention Activities, Including Mercury Hazards and West Nile Virus	Grants for Environmental Health Surveillance and Prevention Activities, Including Mercury Hazards and West Nile Virus
Department of Public Health	Expenses for Expanded Lab Capacity and Enhanced Statewide Communication Capabilities Associated with Homeland Security	Grants for Expanded Lab Capacity and Enhanced Statewide Communication Capabilities Associated with Homeland Security
Department of Public Health	Grants for Immunizations and Outreach Activities	Grants for Immunizations and Outreach Activities
Department of Public Health	Operating Expenses to Provide Clinical and Environmental Public Health Laboratory Services	Grants for Clinical and Environmental Public Health Laboratory Services
Department of Public Health	Expenses for Promotion of Women's Health	Service to answer questions about health related issues free of charge; open for all women in Illinois and operates 8:00 am - 4:30 pm on workdays
Department of Veterans' Affairs	Illinois Warriors Assistance Program	Confidential assistance for returning Illinois veterans and their families to help with the emotional challenges of transitioning back into their daily lives
Department of Veterans' Affairs	Veteran's Service Officers (VSOs)	Assistance to veterans in navigating the complex web of services and benefits available
Department of Veterans' Affairs	VetCare	Comprehensive, affordable healthcare for Illinois' uninsured veterans
Illinois Board of Education	Adolescent health	Financial support and resources through the Division of Adolescent and School Health (DASH) to improve adolescent health -- specifically, sexual health -- through education in Illinois schools

Illinois Board of Education	Healthy Community Incentive Fund	Enables school districts to take a lead role in cross-sector partnerships as centers of collective impact and develop partnerships with local governmental entities, education organizations, faith-based organizations, civic organizations, and philanthropic groups
Illinois Board of Education	Substance Abuse and Mental Health Services	Builds and expands the capacity of state educational agencies to increase awareness of mental health issues among school-aged youth, train school personnel and other adults, and connect children, youth, and families who may have behavioral health issues with appropriate services
Illinois Board of Education	Evidence-based Home Visiting (EBHV)	Pairs families experiencing risk factors with trained professionals who provide information and support to improve the comprehensive health of children and their families by supporting parents' ability to provide a safe, supportive, and healthy early learning environment
Department of Health and Family Services	Individual Care Grant program	Services for children with a serious emotional disturbance under the age of 18 to assist in obtaining the appropriate level of treatment services required to improve their condition
Department of Child and Family Services	Department of Child and family Services institutional/group home care	Costs associated with residential and group home programs for DCFS involved youth
Department of Corrections	Department of Corrections in facility mental health treatment	Mental health services provided to justice-involved individuals including outpatient services, crisis intervention, and enhanced inpatient treatment
Department of Corrections	Department of Corrections in facility substance use disorder treatment	SUD treatment provided to justice-involved individuals including DASA licensed outpatient treatment, screening, and pre and post release case management
Department of Juvenile Justice	Department of Juvenile Justice in facility mental health treatment	In-facility mental health treatment for juvenile justice populations that utilizes screening and assessment tools to identify needs and provide a continuum of care that includes individual therapy, group therapy, family therapy, and pet therapy

Department of Juvenile Justice	Department of Juvenile Justice in facility substance use disorder treatment	In-facility substance use disorder treatment for juvenile justice populations provided by the "Wells Center." The staff utilizes a cognitive behavioral and strength based approach to extinguish behaviors that are toxic and ineffective and encourage behaviors that are effective and positive so that the individual can stay drug free on return to the community; Includes intake assessment

Appendix C: Public Comments and State Response

The below section summarizes the comments received by the public as well as the State's responses and changes to the Demonstration Project. The State received a tremendous amount of support from the stakeholder community, a community that has been deeply involved in the development of this waiver application. Rather than addressing all showings of support, the following section only includes suggestions, recommendations, and questions from the stakeholder community. Many of the comments request additional detail which the State hopes to define in collaboration with CMS.

C.1: COMMENTS AND RESPONSES FOR SECTION 3.1: SUPPORTIVE HOUSING SERVICES

Comment: Multiple commenters encouraged the State to broadly define the populations eligible for supportive housing services. These recommendations include individuals who:

- Have a primary diagnosis of SUD
- Have a history of being justice-involved or who are at risk of justice involvement
- Are currently eligible for Rule 132 services
- Meet the Federal HUD definition of "chronically homeless" in order to align with HUD Notice CPD-16-11 Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless in Permanent Supportive Housing
- Meet a broad definition of homelessness or risk of homelessness
- Meet a broadly defined level of serious mental illness based not only on specific diagnostic criteria but also on functioning and need
- Are defined by the State as super utilizers of Medicaid
- Have an intellectual and developmental disability and might otherwise select an intermediate care facility under the State Plan
- Are at risk of being in or currently are in an institutional setting (nursing home, ICF, IMO, state psychiatric hospital)
- Are current supportive housing tenants in programs that receive state funding for populations described above
- Individuals experiencing homelessness with an addiction serious enough to require an episode of residential treatment
- Are families who have children with mental health needs
- Have an intellectual or developmental disability and might otherwise select an intermediate care facility

Response: The State hereby clarifies that it will consider either SMI or a primary diagnosis of SUD as eligible for the supportive housing services pilot. Additionally, these individuals and their families must be at risk of homelessness or the individual must be at risk of inappropriate institutionalization or currently reside in an institution or permanent supportive housing.

Comment: Multiple commenters recommended a per diem rate structure for pre-tenancy and tenancy support services.

Response: As the State further defines the operational details for the supportive housing services pilot, it will consider this comment.

Comment: Multiple commenters recommended the State invest in rental subsidies/a rental subsidy pool with one commenter requesting a State commitment to do so.

Response: The State does not believe the 1115 waiver is an appropriate place to make any sort of official commitment to rental subsidies. It does, however, agree that supportive housing services shall be accompanied by similar levels of rental subsidies and supportive housing unit availability. The Department of Healthcare and Family Services (HFS) is working closely with the Illinois Housing Development Authority (IDHA) and the Department of Human Services (DHS) to ensure consistency across these initiatives while maximizing availability and impact of supportive housing services.

Comment: Multiple commenters suggested that increased rate differentials for service settings are needed to support and encourage increased availability of home based services and supports as well as encourage providers to serve those most difficult to serve.

Response: The State notes that this is out of scope for the 1115 waiver.

Comment: One commenter questioned how supportive housing services will work under managed care and encouraged the State to work with providers and MCOs together on how this is implemented through managed care.

Response: As the State works through the operational details of this benefit more guidance will be available.

Comment: One commenter recommended Illinois include linkage to/application for certain federal benefits (e.g., expedited Supplemental Security Income (SSI) applications (SOAR Applications)), as a covered activity under Medicaid Targeted Case Management to enable an income source for housing for Medicaid enrollees who are disabled by their serious mental illness.

Response: The State is appreciative of this comment and will consider this as IHHs are further defined.

Comment: One commenter requested that health care coordinators be given an opportunity to deliver some or all of the supported employment services.

Response: As the State works through the operational details of these benefits it will consider this comment.

Comment: One commenter suggested that MCOs should work with community organizations to ensure requirements for contracting with them for tenancy services are not overly burdensome.

Response: As the State further defines the operational details for supportive housing and continues to collaborate with MCOs on broader system improvements, it will consider this comment.

Comment: One commenter suggested using the Department of Health and Human Services (HHS) definition of "homelessness" to determine supportive housing eligibility rather than the Department of Housing and Urban Development (HUD) definition.

Response: As the State works through the operational details of this benefit, it will consider this comment.

Comment: One commenter urged the State to exercise caution about the maintenance of community supports for people with mental illness who are placed in IMDs, since they need to be able to keep what housing supports are already in place.

Response: As the State further defines the operational details for supportive housing it will consider this comment.

Comment: Multiple commenters encouraged the State to fund a pilot project utilizing the "Housing First" concept in supportive housing for the target group, while exercising caution where "Housing First" has been linked with Assertive Community Treatment.

Response: As the State further defines the operational details for supportive housing, it will consider this comment.

Comment: Multiple commenters highlighted the importance of continuity of supportive housing services irrespective of specific MCO enrollment, and suggested both an administrative intermediary between supportive housing providers and MCOs as well as limiting reauthorization to once per year at most.

Response: As the State further defines the operational details for the supportive housing services pilot, it will consider this comment.

Comment: One commenter suggested that benefits for individuals with mental health needs should include comprehensive assessments of their family's needs.

Response: The State thanks the commenter for this suggestion. The State has submitted State Plan Amendments for the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment and Adult Needs and Strengths Assessment (ANSA) and will consider any refinements to these SPAs as they are rolled out.

Comment: One commenter recommended the State increase the amount of mental health supportive housing.

Response: The State notes that section 3.1 of the waiver is a benefit for supportive housing services.

Comment: One commenter suggested the State add references to how the Supportive Housing Services Benefit will help fulfill the goals of the waiver to other sections of the proposal.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested that incentives for supporting individuals with complex needs should be set.

Response: As the State further defines the operational details for the supportive housing services pilot, it will consider this comment.

Comment: Multiple commenters requested additional details on the supportive housing services pilot including:

- What is the age range for this service?
- How does this service impact DCFS and youth aging out of care?
- Will this service accommodate families, especially families with dependent children?
- Does this apply to incarcerated individuals?

Response: The State clarifies that it will consider either SMI or a primary diagnosis of SUD as eligible for the supportive housing services pilot. These individuals must also be at risk of inappropriate institutionalization or homelessness or currently reside in an institution or permanent supportive housing. To the extent that these populations meet these criteria, they will be eligible for the supportive housing services pilot. Full operational details of the pilot are still being determined.

Comment: One commenter suggested the definition of 'institution' should include but not be limited to nursing homes, intermediate care facilities, institutes of mental disease, state psychiatric hospitals and correctional facilities.

Response: The State appreciates the suggestion and will consider this comment when working through terms and conditions.

Comment: One commenter suggested the State should prioritize supportive housing and employment programs, along with the consideration of other housing models that aid in the long-term recovery of an individual with a serious mental illness.

Response: The State believes the waiver does just this.

Comment: One commenter suggested the waiver should ensure a housing continuum of care that incorporates existing services developed by community-based mental health

providers to meet specific needs in communities across the State (supervised, supported, and crisis residential, as well as supportive housing).

Response: The State aims to ensure an integrated, non-duplicative continuum of care.

Comment: One commenter suggested that each housing support and housing crisis plan follow a similar format.

Response: The State appreciates the suggestion and will consider this comment when working through the operational details.

Comment: One commenter suggested that transportation services to and from appointments or training sessions that help people maintain housing and skills required for autonomous living be included in the list of supportive housing services.

Response: The State notes that Medicaid already covers transportation for Medicaid services.

Comment: One commenter requested additional detail on the authorization process for supportive housing services.

Response: The State would provide such details in the waiver terms and conditions.

Comment: One commenter asked about the plan for increasing units of supportive housing.

Response: The State agrees that supportive housing services must be accompanied by similar levels of rental subsidies and supportive housing unit availability. The Department of Healthcare and Family Services (HFS) is working closely with the Illinois Housing Development Authority (IDHA) and the Department of Human Services (DHS) to ensure consistency across these initiatives while maximizing availability and impact of supportive housing services.

Comment: One commenter noted that supportive housing should be targeted at those that suffer chronic long-term homelessness instead of short-term beds.

Response: The State notes that supportive housing is not intended to serve as short-term beds.

Comment: One commenter questioned the statistic in the waiver that notes that approximately "40,000 individuals in Illinois have housing needs, approximately 25% of whom have serious mental illness (SMI); only 17,500 of those 40,000 are receiving the services they need." Specifically, the commenter is concerned that 25% of the 40,000 would be 10,000 indicating excess supply of services at 17,500.

Response: The State notes that this statistic is not only for the SMI population but rather that the number of individuals with supportive housing needs is approximately 40,000. The State is using the statistic to indicate the need for supportive housing services more

broadly, though this waiver is focused on SMI and SUD. The statistic certainly does not indicate that there is excess supply of services.

Comment: One commenter suggested that any certified agency should be able to access tenancy support dollars, regardless of their ability to bill Medicaid.

Response: As the State further defines the operational details for supportive housing, it will consider this comment.

Comment: One commenter noted that the Supportive Housing Working Group statistic refers to Williams consent decree population (all of whom have SMI), noting that 25% of this population is in need of PSH and not necessarily 25% of all those in need of Permanent Supportive Housing (PSH).

Response: The State appreciates the comment and has adjusted the draft accordingly.

Comment: One commenter requested that the State remove the responsibility of DHS or its providers to ensure the housing unit is safe and ready for move in, noting that there already exists an inspection process that meets federal, state or other rental assistance standards. The commenter suggests altering this section to remove the burden on the DHS provider to conduct inspections and insert language to improve coordination with the subsidy provider's inspection process.

Response: The State thanks the commenter for this suggestion.

C.2: COMMENTS AND RESPONSES FOR SECTION 3.2: SUPPORTED EMPLOYMENT

Comment: Multiple commenters suggested that increased rate differentials for service settings are needed to support and encourage increased availability of home based services and supports as well as encourage providers to serve those most difficult to serve.

Response: The State notes that this is out of scope for the 1115 waiver.

Comment: Multiple commenters urged the State to design program requirements consistent with the Dartmouth Psychiatric Research Center model with the following principles:

- Focus on Competitive Employment
- Eligibility Based on Client Choice
- Integration of Rehabilitation and Mental Health Services
- Attention to Worker Preferences
- Systematic Job Development
- Time-Unlimited and Individualized Support

Response: The State intends to consider the Dartmouth Psychiatric Research Center as it further defines operational details.

Comment: One commenter encouraged the State to broadly define the populations eligible for supported employment services including those who have a history of being justice-involved or who are at risk of justice involvement.

Response: The State hereby clarifies that it will consider the following members eligible for supported employment services:

- Working-age (14 years and older) Medicaid enrollees
- Serious and persistent mental illness or serious emotional disturbance
- Express a desire to be employed

Comment: One commenter recommended that the State work with providers on developing a rate structure for supported employment, how these services will be coordinated through managed care, and on metrics and methods of data collection that will be needed to understand and evaluate the impact employment has on recovery and wellness for the population with significant MHSU conditions.

Response: As the State works through the operational details of this benefit, it will consider this comment.

Comment: One commenter requested that health care coordinators be given an opportunity to deliver some or all of the supported employment services.

Response: As the State works through the operational details of these benefits, it will consider this comment.

Comment: One commenter hopes that the waiver services will allow for services more tailored to what the individual with SUD needs to become employed.

Response: The IPS model in the waiver has been updated to focus on members with SMI and SED (though they may have co-occurring SUD). Employment supports for individuals with SUD without co-occurring mental illness is provided by DASA through the Access to Treatment grant. In the system the State envisions, IHHs would understand who provides these services and be able to refer members in need.

Comment: One commenter requested that the supported employment model be refined to more directly address the needs of the family, for example, by referencing linkages to high quality early care and education programs.

Response: The State thanks the commenter for this suggestion.

Comment: Multiple commenters suggested that IPS providers be integrated with mental health care teams in order incentivize a comprehensive and person-centered approach to services being provided.

Response: The State agrees with this ambition and will consider this as it further defines operational details for this pilot and the integrated health home model.

Comment: One commenter asked a number of questions with respect to this pilot including:

- What is the definition of "serious and persistent mental illness?"
- This services extends down to 14 years of age. What is the profile of a 14-17 year old at risk of being in an institution?
- Is financial literacy a component of supported employment?
- Will there be family support for those under 21? How will transportation and work hour issues be resolved for youth?

Response: The State appreciates the commenter's questions and notes that such details will be worked through in the waiver terms and conditions.

Comment: One commenter believes that the waiver states that supported employment services will only be for those within Integrated Health Homes (IHHs) recommended that all individuals with SMI, SUD or SED be eligible for this service.

Response: The State has updated the IPS model in the waiver to focus on members with SMI and SED (though they may have co-occurring SUD) as the model is designed for those populations. The State further notes that it states in the waiver that the IPS model will be integrated with IHHs but it does not state that only those in health homes will be eligible.

Comment: One commenter believes that the 20 hour limit is unrealistic for most members with SMI and recommended the hours be increased to 30 hours per month with the ability to request additional hours.

Response: The State points the commenter to the language in the waiver that states "An average of 20 hours of service per month are provided, based on the needs of the individual and his/her phase of placement and employment (on a limited basis, additional hours can be authorized for members with demonstrated need for more intensive services)."

Comment: One commenter requested additional details on the methodology for the outcome based rates and recommended that the outcome based rate be tiered to factor in those participants who are harder to place due to their illnesses and additional supports required.

Response: The State notes that such details will be worked through in the waiver terms and conditions.

Comment: One commenter asked that with the language "Ensuring accurate information about how employment will affect incomes and disability supports" if the formula for return to work is changing.

Response: The State notes that it is simply defining the model here.

Comment: One commenter wrote that there is a "need to consider whether the current exclusionary criteria for IPS contract criteria limits the intent of 1115's use of SEP".

Response: The State thanks the commenter for this suggestion.

Comment: One commenter urged the State to utilize Medicaid state plan fiscal authorities such as the Medicaid Rehab Option and Targeted Case Management along with the 1115 waiver to ensure we are able to fully support all of the principles of the Dartmouth IPS model.

Response: The State thanks the commenter for this recommendation.

Comment: One commenter asked for clarification on whether Supported Employment will only be accessible through the use of the IPS model with the current 51 IPS teams and asked that the State consider a graduated model over the 5 year period to allow current SEP providers who are not yet implementing the model to access the waiver while beginning the IPS implementation and fidelity process with the expectation of full implementation by a certain year.

Response: The State notes that such details will be worked through in the waiver terms and conditions.

C.3: COMMENTS AND RESPONSES FOR SECTION 3.3: TRANSITIONAL SERVICES

Comment: Multiple commenters recommended the State treat the transitions experienced by the justice-involved population in the same manner as those of other members transitioning from an institution to the community, prompting a higher care coordination rate.

Response: The State expects there to be tiers of coordination rates within the integrated health home model but intends to flesh out these details over time and with the support and input of the stakeholder community.

Comment: Multiple commenters requested clarification as to why Naltrexone was specifically selected for the use of opioid treatment drugs and wondered if it would make sense to add other products.

Response: Injectable naltrexone (Vivitrol) is preferred in pre-release criminal justice settings because there is virtually no risk of diversion, which makes storage and administration much safer for correctional staff than other agents. Vivitrol has no opioid-like effects whereas agonist treatments (e.g., methadone, buprenorphine) produce opioid effects similar to heroin and can be abused and diverted without strict oversight and controls. At this time, this pilot is therefore limited to Vivitrol.

Comment: Multiple commenters requested clarification on the responsibility of MCOs for identifying providers in the community who will be responsible for an individual's care upon release into the community. Commenters also urged the State to build on current interventions and ensure that providers with history working within the justice system, not just MCOs, are leveraged to effectively operationalize the transitional services benefit.

Response: The State believes that MCOs are accountable for the whole member and therefore expects that the MCOs either facilitate this linkage themselves or collaborates with the appropriate community partner and the correctional facilities and their staff, to do so.

Comment: Multiple commenters submitted comments with suggestions on operational details of the transitional services benefit. These suggestions included adding detail around the potential parenting role of re-integration services as a two generational intervention, including assistance to apply for SSI and housing assistance, ensuring DMH, HFS, and/or community based organizations, not DOC staff, conduct screening, assessments, and referrals, and allowing assistance/assignment to a MCO to be done by a community-based provider not MCO staff.

Response: Operational details like this for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: Multiple commenters suggested expanding the eligibility of pre-release injectable Naltrexone beyond IDOC.

Response: The State thanks the commenter for this suggestion - the State has chosen to expand this pilot to CCJ as well.

Comment: Multiple commenters suggested expanding the eligibility of transitional services beyond Cook County Jail to allow intergovernmental agreements with interested counties to allow their financial participation in paying for the jail services that are provided.

Response: At this time this pilot is limited to Cook County Jail. As the pilot proves effective by driving better outcomes and improved cost-effectiveness, the State will have the option to re-evaluate the benefit and expand the pilot further.

Comment: Multiple commenters urged that counterpart services be included for Illinois Department of Juvenile Justice and the Cook County and other Juvenile Temporary Detention Centers, while other commenters stressed the importance of addressing the mental and behavioral health needs of youth, including those "dually-involved" youth, to reduce the long-term population trends in DOC.

Response: The State appreciates this comment and has updated the waiver to extend this pilot to the Illinois Department of Juvenile Justice population as well. As this pilot proves effective by driving better outcomes and improved cost-effectiveness, the State will have the option to re-evaluate the benefit and further expand the pilot.

Comment: Multiple commenters urged the State to build on current interventions and ensure that providers with history working within the justice system, not just MCOs, are leveraged to effectively operationalize the transitional services benefit. Commenters expressed skepticism that MCOs would be able to perform this function.

Response: The State believes that MCOs are accountable for the whole member and therefore expects the MCOs to either facilitate this linkage themselves or collaborate with correctional facilities to do so.

Comment: One commenter pointed out a concern of having no coverage for inpatient opiate detoxification.

Response: The proposed withdrawal management services do include residential detoxification services.

Comment: One commenter recommended expanding intensive case management to all persons leaving prison or jail for the first 90 days upon release.

Response: Upon release, these individuals are expected to be in IHHs that will provide case management.

Comment: One commenter recommended giving DMH responsibility and oversight of behavioral health services provided in State corrections and county jails in order to ensure

comprehensive oversight of behavioral health services in Illinois, both inside and outside correctional facilities.

Response: Operational details like this for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: One commenter requested that pre-release services should be made available to all those exiting DOC or jails, not just those who are leaving under supervision such as parole or probation.

Response: All individuals leaving DOC, DJJ, or CCJ who meet eligibility criteria may be eligible for the transitional services pilot program, not just those leaving under supervision.

Comment: Multiple commenters suggested expanding pre-release services beyond 30 days.

Response: At this time this pilot is limited to 30 days. The state plans to rigorously evaluate the pilot update design as required to enhance effectiveness.

Comment: Multiple commenters suggested the MAT pilot utilizing injectable naltrexone be expanded to include patients with schizophrenia who are being discharged, utilizing a long-acting injectable anti-psychotic medication.

Response: The State thanks the commenters for this suggestion but notes that the pilot is limited to MAT utilizing injectable naltrexone.

Comment: One commenter urged the State to consider the guidelines for transition and re-entry formulated by SAMHSA's Gains Center for Behavioral Health and Justice Transformation. The commenter notes that these guidelines would include universal screening as early in the booking process as possible and continuing thereafter; follow-up of positive screens with comprehensive assessments to assure appropriate program placement and service delivery; development of individualized treatment and service plans based on the screening and assessment process; identification of appropriate post-release interventions within the critical early period following release; facilitation of continuity of care and supervision post-release; and, use of a system of incentives and sanctions to promote post-release participation in treatment, with clear protocols on managing technical violations of community supervision conditions.

Response: The State thanks the commenter for this suggestion and will consider this as it further defines the operational details for this waiver benefit.

Comment: One commenters urged IDOC collaboration with other State agencies to implement 305 ILCS 5/1-8.5 and 730 ILCS 5/3-14-1 which provides that re-entering men and women have the opportunity to apply for Medicaid at least 45 days prior to release and allow for the suspension rather than termination of existing Medicaid coverage.

Response: The State thanks the commenter for this suggestion and is currently working on a process to ensure that individuals entering IDOC have the opportunity to apply for Medicaid.

Comment: Multiple commenters noted that pre-release services should include assistance applying for appropriate benefits such as Supplemental Security Income, housing assistance, and ensuring continuity of Medicaid coverage.

Response: The State thanks the commenters for this suggestion and will consider it as it further defines the operational details of this waiver benefit.

Comment: Multiple commenters suggested that the State acknowledge that the 19-24 year old population are still adolescent in development and appropriate services must be available.

Response: The State thanks the commenters for this comment.

Comment: One commenter suggested adding language that states the re-entry and SUD populations also need a better connection to supportive housing.

Response: The State thanks the commenter for this suggestion and will consider it as it further defines the operational details of this waiver benefit.

Comment: Multiple commenters requested additional details on what accountable providers will be held accountable for.

Response: Operational details like this for each benefit and initiative are being worked through and more information would be available in the waiver terms and conditions.

Comment: One commenter believes that it is not practical to hold providers accountable for linkage to the behavioral health system because there are currently insufficient community services to provide care for ex-offenders.

Response: The State appreciates the commenter's point. The State does not believe that because there are gaps in the system that greater accountability cannot be installed but understands that provider expectations must consider system realities.

Comment: One commenter believes that the goal of this transformation should be to encourage investments and support the enhancement and development of the appropriate care networks for all plans and provider groups. We believe that requiring the Cook County justice-involved population to be default assigned to CCHHS does not support that goal, and is not in the best interests of the program.

Response: The State thanks the commenter for this comment and notes that this population can opt for a different plan.

Comment: One commenter made a number of recommendations for the MAT pilot - that the pilot include an equal percentage of women, including how the program will be evaluated and if successful, how it will be expanded to cover more people.

Response: The State thanks the commenter for these suggestions.

Comment: One commenter recommended that IDOC justice-involved individuals who are chosen for the pilot and decide to withdraw once they are released should be given the option of other MATs (e.g., methadone and buprenorphine) while continuing in the pilot.

Response: The State notes that the pilot is for the pre-release period and post-release the members will return to standard Medicaid benefits including the MAT to be covered under the State Plan.

Comment: One commenter asked if the individuals eligible for CCJ Waiver services are individuals who are completing their jail sentence.

Response: The State points the commenter to language in the waiver "For the CCJ population, waiver authority to allow automatic and passive enrollment in CountyCare, a full-service MCO owned and operated by CCHHS: Exceptions would be made for individuals who opt for another plan within 30 days or were enrolled in a different health plan at the time of incarceration and released in fewer than 60 days; these individuals can return to their original plans under the State's "quick reinstatement" policy."

Comment: One commenter suggested that DOC/CCJ staff must improve their working relationship with community-based providers to ensure the success of these new benefits. Collaboration on release plans, efforts to discharge returning citizens during provider business hours, sharing of accurate release dates, and assisting community providers to meet returning citizens upon their release are necessary to prevent those discharged from falling through the cracks and continuing the cycle of recidivism.

Response: The State appreciates this suggestion and will consider it as it further defines the operational details of this benefit.

Comment: One commenter noted that IDOC needs to further develop how MCOs engage with identified inmates 30-60 days prior to release.

Response: The State agrees that greater operational detail must be worked out.

Comment: One commenter suggested the auto-assignment should not be applied for members of the 1115 waiver.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested targeted case management, early Medication Assisted Treatment and Peer Support Services be included for the SUD justice involved population.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter asked the State to include Probuphine as part of the proposed criminal justice medication assisted pilot.

Response: The State thanks the commenter for this suggestion.

C.4: COMMENTS AND RESPONSES FOR SECTION 3.4: REDESIGN OF SUBSTANCE USE DISORDER SERVICE CONTINUUM

Comment: Multiple commenters recommended increasing the IMD length, from 30 days to 60 or 90 days.

Response: The State is requesting 30 days at this time. It intends to monitor this benefit closely and, if it proves effective, a longer request could be considered in the future.

Comment: Multiple commenters submitted comments with suggestions on operational details of the SUD service continuum benefit. Suggestions included linking those receiving case management and recovery coaching to family supports, utilizing standards of care and program integrity measures that are not burdensome, utilizing performance measures that appropriately incentivize providers (e.g., not abstinence), developing longer term outcomes and payment structures that make sense for these services (e.g., SUD case management has no real existing baseline of data for outcomes), and allowing innovations in service delivery (e.g., remove DASA rule that these services can be no more than 20 percent anticipated revenue).

Response: Operational details like these for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: Multiple commenters urged the State to include justice-involved individuals with SUD in the pilot population that receives access to substance use case management through the 1115 waiver.

Response: The SUD case management described in the waiver is intended for those not receiving case management elsewhere. It is anticipated that justice-involved individuals with SUD will be in integrated health homes and therefore, SUD case management would be duplicative. However, operational details like this for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: One commenter asked if their triage center would be covered under the IMD exclusion waiver or as crisis beds.

Response: The classification of specific services is not the purview of the 1115 waiver.

Comment: One commenter asked why the State was only requesting level III.5 coverage for 15-30 days rather than 0-30 days.

Response: The State believes that the recently released managed care rules allow States to pay for 0-15 day stays in level III.5 facilities. The State will clarify this with the Centers for Medicare and Medicaid Services.

Comment: One commenter believes that limiting SUD case management services to circumstances where SUD clients “are not receiving case management services through any other provider” makes sense on paper, but not in practice. Clients may have another

case manager if they are court-referred or a managed care case manager if they are enrolled. The commenter believes these clients have so many immediate needs that cannot be attended to by individual entities and suggests as an alternative that the State reform reimbursement rates to include these costs.

Response: Given the multitude of needs these clients have, they would be ideal candidates for IHHs. The SUD case management benefit is focused on cases that are not receiving case management elsewhere.

Comment: One commenter expressed concern with the way the waiver distinguishes between MH and SUD services, "most notably a repeated desire to reduce inpatient/residential services."

Response: The waiver intends to describe the re-design and optimization of both the SUD and MH care continuums. The State appreciates the distinction between the two and did not intend to lump the two together.

Comment: Multiple commenters expressed concern that no domiciliary costs for residential treatment were covered and that only the treatment portion of the stay is covered for those programs in compliance with the IMD exclusion.

Response: Under the waiver, both residential and treatment costs would be covered for programs in compliance with the IMD exclusion.

Comment: Multiple commenters recommended SUD case management, withdrawal management, and recovery coaching be immediately brought to scale.

Response: While State believes these services are vital, at this time a limited demonstration is being conducted in the Medicaid population. As this demonstration proves effective by driving better outcomes and improved cost-effectiveness, the State will have the option to re-evaluate the benefit and expand the pilot further.

Comment: Multiple commenters cited residential treatment as a critical part of the SUD treatment service continuum.

Response: The State agrees with the commenters.

Comment: One commenter noted their belief that the Specialized Mental Health Rehabilitation Facilities (SMHRFs) provide only short-stay crisis stabilization and not long-term residential services. The commenter also argued that in areas of the State without SMHRFs, community-based providers should be funded to fill this need.

Response: The State thanks the commenter for this suggestion.

Comment: Multiple commenters requested the certificate of need language for level III.5 facilities be removed.

Response: The State has removed this language from the waiver application.

Comment: Multiple commenters expressed opposition to the use of MCOs for the pre-authorization process, arguing that it creates a conflict of interest in reimbursing providers.

Response: The State thanks the commenters for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter requested replacing the word "treatment" with "any ASAM level of care" in section 3.1.4.2

Response: The State thanks the commenter for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter suggested the waiver should ensure any employment support services are provided as a treatment intervention and do not tie eligibility for services to successful obtainment and retention of employment.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter noted that consistent with state law, the 1115 waiver should mandate ASAM for all SUD services.

Response: The State thanks the commenter for this comment.

Comment: Multiple commenters noted that 99-480 expressly extends protections to the Public Aid Code. "Notwithstanding any other provision of this Code to the contrary, on or after July 1, 2015, all FDA approved forms of medication assisted treatment prescribed for the treatment of alcohol dependence or treatment of opioid dependence shall be covered under both fee-for-service and managed care medical assistance programs for persons who are otherwise eligible for medical assistance under this Article and shall not be subject to any (1) utilization control, other than those established under ASAM patient placement criteria, (2) prior authorization mandate, or (3) lifetime restriction limit mandate." Thus, the waiver and state plan amendments should not be limited to expansion of methadone or injectable naltrexone – all FDA approved forms of MAT should be included.

Response: Details on the MAT State Plan Amendment are beyond the scope of this waiver. The injectable naltrexone is a pilot for justice-involved individuals before release from facilities.

Comment: One commenter noted that in 305 ILCS 5/5-16.8, 99-480 adds to the list of required health benefits for the Illinois medical assistance program those adopted in 370c and 370c.1 of the Insurance Code. This means HFS must comply with the parity provisions and the minimum benefits each calendar year of at least 45 days of inpatient treatment (including residential), 60 visits for outpatient (including individual and group therapy),

acute treatment services/withdrawal management and clinical stabilization services as well as no lifetime limits on inpatient or outpatient treatment.

Response: The State thanks the commenter for this comment.

Comment: One commenter suggested the authorizations for residential treatment in IMDs should extend to all Medicaid beneficiaries.

Response: The State thanks the commenter for this comment.

Comment: One commenter suggested that no pre-authorization should be required for:

- The first 24 hours of treatment unless immediate authorization can be given
- OP and IOP (ASAM Level I and Level II services)
- Medicated assisted treatment as mandated by 99-480

Response: The State thanks the commenter for this comment.

Comment: One commenter recommended that any continued stay reviews required for residential, day treatment or medically monitored detox should be approved or denied by the respective MCOs within 24 hours of the request. Other continued stays for Level I and Level II services should be approved or denied by the respective MCO within 48 hours.

Response: The State thanks the commenter for this comment.

Comment: One commenter recommended that the State go one step further and allow residential facilities with greater than 16 beds to be Medicaid certified.

Response: The State thanks the commenter for this comment.

Comment: One commenter recommended that the State should also support and pursue a long-term strategy of expressly excluding SUD facilities from the definition of IMDs (either by CMS clarification, Presidential Executive Order or clarification in federal law).

Response: The State thanks the commenter for this comment.

Comment: One commenter urged the State to resist a system that is primarily adult focused and specifically named and conscientiously include services for the 12-18 year old population and age appropriate services for the emerging adult population of 18-25 year olds.

Response: The State thanks the commenter for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: Multiple commenters suggested lowering the age from 18 for age appropriate recovery coach services.

Response: The State thanks the commenters for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter noted that confidentially for youth utilizing services must be ensured.

Response: The State thanks the commenter for this comment.

Comment: One commenter requested that pilot site target populations be clearly defined and done in consultation with community stakeholders.

Response: The State thanks the commenter for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter requested additional details on how a strong network of substance abuse providers will actually be created and sustained.

Response: Operational details like these for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: One commenter suggested that 'motivational interviewing' is a key skill that must be a part of the training for recovery coaching.

Response: The State thanks the commenter for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter suggested that the confidentiality limitations imposed by 42 CFR Part 2 impedes the ability to have SUD expert clinicians working within primary care settings to address the SUD needs of all patients and encouraged the State to highlight this.

Response: The State thanks the commenter for this comment.

Comment: One commenter suggested that the injectable naltrexone pilot be immediately expanded statewide due to studies showing its outcomes.

Response: At this time, this is a limited pilot for the justice-involved population. Should the pilot in this population prove effective, the State can re-evaluate it and consider further expansion.

Comment: One commenter asked how many SUD rehab stays would be covered.
Response: Operational details like these for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: One commenter recommended that patients with SUD should also be able to access step down programs after residential stays including partial hospitalization programs and intensive outpatient programs.

Response: The State thanks the commenter for this comment.

Comment: One commenter requested clarity on the pre-authorization services including:

- What entity will provide these pre-authorization services and audits?
- Will MCOs also be required to have third party authorization and audits or would they be doing their own pre-authorization services?
- What will be the timing required for the third party to respond to pre-authorization requests?
- Will the funding for these services be based on shared savings from the services?
- Why is this being required for only SUD services and not mental health services?
- Could the service use electronic prior authorization which allows for better tracking of the pre-authorization?

Response: Operational details like these for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: One commenter recommended that psychiatrists have input regarding the post-payment audit program.

Response: The State thanks the commenter for this comment.

Comment: One commenter notes that in order to treat members at the "right time in the lowest acuity setting" 1) capacity will need to be increased to make sure individuals seeking care are able to access services in a timely manner rather than sit on waiting lists, 2) the State must increase substance use treatment support services which have been proven to reduce costs and improve outcomes, and 3) there is an overabundance of research that show certain populations with SUDs have better outcomes when place in appropriate settings.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter recommended that all Medicaid eligible individuals seeking SUD treatment be eligible for SUD IMD, Recovery Coaching and Case Management services that are being proposed in the waiver.

Response: These benefits are being pursued as limited demonstrations. As this demonstration proves effective by driving better outcomes and improved cost-effectiveness, the State will have the option to re-evaluate the benefit and expand the pilot further.

Comment: One commenter made recommendations on the third-party pre-authorization process including:

- Any preauthorization service would need to accommodate intakes at 24/7 facilities;
- Developing a utilization management process reduces duplication of work and does not increase administrative burdens;

- Random site visits and chart audits in addition to the annual DASA post-payment review and BALC review is audit heavy for providers;
- The third-party pre-authorization process should be transparent and a record of authorizations and denials should be posted by HFS on a monthly basis; and,
- A RFP and RFI process for the third-party pre-authorization entity in FFS regions.

Response: The State thanks the commenter for this comment and will consider it as operational details are further defined.

Comment: One commenter requested that if DASA will conduct post-payment audits annually for each Medicaid-certified provider based upon a subset of licensure rules, that the State identify the subset of licensure rules or when will they be made available for viewing.

Response: Operational details like these for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: One commenter requested that there be stakeholder input prior to the development of the enhancement of the licensing and credentialing requirements.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter noted a shortage of level III.5 facilities in their area.

Response: The State thanks the commenter for this comment and will consider it as operational details are further defined.

Comment: Multiple commenters requested clarity on whether the recovery coaches will be credentialed providers.

Response: Operational details like these for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: One commenter expressed opposition to a pre-authorization process believing that auditing can adequately function to ensure that providers are appropriately authorizing only medically necessary services for people with an SUD.

Response: The State thanks the commenter for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter suggested expanding access to Medication-Assisted Treatment (MAT) and integrated care for individuals with an opioid use disorder and made the following recommendations:

- Improve accessibility and utilization of MAT services using the Hazelden Betty Ford Foundation COR-12 approach;

- Increase community collaboration, partnership, and recovery oriented approaches by establishing both statewide and community-based steering committees focused upon COR-12, embedded in a Recovery Oriented System of Care (ROSC);
- Improve the screening and referral process for individuals with opioid use disorders utilizing the SBIRT model; and,
- Build capacity for psychiatry and integrated treatment, including the addition of robust Intensive Outpatient (IOP) services at regional locations.

Response: The State thanks the commenter for this suggestion. The State intends on expanding access to MAT through a SPA. It will also consider these recommendations.

Comment: One commenter suggested ways to promote outcomes and rates of recovery among individuals with opioid use disorders including:

- Strive to connect 100% of participants with evidence-based treatment and recovery supports across the continuum of care;
- Follow COR-12 philosophy and phase system, providing on-going monitoring, structure, support and accountability for each consumers' chosen treatment pathway throughout the course of program participation;
- Provide the opportunity for Recovery Supports that include stable, safe, recovery oriented housing, peer-support services, case management and other related services, not just recovery coaching; and,
- Encourage and increase innovative and cutting edge treatment approaches that improve treatment engagement and support.

Response: The State thanks the commenter for these suggestions.

Comment: One commenter asked what plan is in place to ensure that Medicaid clients begin and end Medical Detox for opiates with a plan for care post detox

Response: Operational details like these for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: One commenter asked when medication assisted treatments are referenced, why, in addition to naloxone and methadone, is suboxone not an option.

Response: The State merely gives examples in the section to which the commenter is referring.

C.5: COMMENTS AND RESPONSES FOR SECTION 3.5: OPTIMIZATION OF THE MENTAL HEALTH SERVICE CONTINUUM

Comment: Multiple stakeholders submitted requests for additional details on the operationalization of the crisis bed benefit. These included:

- If crisis beds would require SASS authorization;
- How the family/environmental context might be relevant for eligibility;
- How the eligibility for children will work;
- What kind of staff could provide services;
- What types of providers could provide services;
- How capacity will be created;
- If "first responder" centers which have a residential room staffed by a trained peer counselor and with a psychologist and nurse available if needed (e.g., "The Living Room") will be considered; and,
- How the State defines the short-term stay for crisis beds.

Response: Operational details like these for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: Multiple stakeholders submitted suggestions and comments for the operationalization of the crisis bed benefit. These included:

- Concern that downstate areas won't be able to sustain crisis beds within separate programs so in some cases psychiatric hospitals will be a better option;
- IMDs should not be used for crisis beds because they do not provide sufficient psychiatric services for patients with mental illness and SUD;
- The setting should be correct and should not necessarily be the hospital
- There should be an emphasis on identifying and supporting EDs that handle high volumes of behavioral health related issues;
- Consistent monitoring should be applied to this service to keep short-term stays from becoming long-term stays;
- Crisis should be broadly defined and not solely focused on a serious mental illness diagnosis for youth. The definition should reflect how families define crisis;
- Maximum length of stay should be 90 days;
- There should be a strong commitment to release patients within a short period of time;
- Funding should include the 24 hour coverage cost as part of the Medicaid rate for these services;
- Piloting the Comprehensive Intervention Services Model (CISM) in conjunction with the crisis beds; and,
- Allowing APNs or establishing a regional/statewide consulting psychiatrist network to facilitate 24/7 access to psychiatric consultation.

Response: The state thanks the commenters for these comments. Operational details like these for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: One commenter suggested that crisis beds should not inhibit the State's move to community-based care.

Response: The State agrees with this comment.

Comment: Multiple commenters suggested that crisis beds be integrated into the community to the greatest extent possible.

Response: The State agrees with this comment.

Comment: One commenter noted that irrespective of improving access to a robust continuum of outpatient services, there will still be people who experience true behavioral health crises and need to utilize our ED's.

Response: The State thanks the commenter for this comment.

Comment: One commented recommended MH IMDs be carefully monitored and asked if the State will be providing such oversight.

Response: The State thanks the commenter for this comment. The State agrees with the importance of oversight and will discuss such operational details in the terms and conditions.

Comment: One commenter asked if MH IMDs can provide effective and safe short-term acute mental health crisis stabilization services in communities they are located in.

Response: The State believes that IMDs can play a role as part of an appropriate continuum of care, one that can be fully coordinated with an individual's IHH.

Comment: One commenter recommended that state resources also be used to develop acute crisis stabilization services within community based mental health centers.

Response: The State thanks the commenter for this comment.

Comment: One commenter recommended the State fully implement rules that will provide oversight to the SMHRF's.

Response: The State thanks the commenter for this comment.

Comment: One commenter recommended that the State develop mental health community provider's capacity to provide acute mental health crisis stabilization services in areas of the State where there are no IMDs.

Response: The State thanks the commenter for this comment. The State is currently proposing SPAs and state rule changes for these services.

Comment: Multiple commenters recommended that any IMD stays incorporate strict and consistent monitoring of entry and exits to ensure people who enter in crisis are not ending up in long-term stays.

Response: The State thanks the commenters for this comment and will consider it as operational details are further defined.

Comment: One commenter noted that length of stay in IMDs should be limited to only what is clinically necessary.

Response: The State agrees with this comment.

Comment: One commenter suggested state-operated mental health centers be included in the IMD request.

Response: The State notes that state operated psychiatric hospitals (SOPHs) are included in the request.

Comment: One commenter expressed opposition to the waiver's request for coverage of stays in IMDs up to 30 days, arguing that it promotes bad clinical practices and undermines Illinois' efforts to comply with the Williams Consent Decree which requires the State to develop more and better community-based crisis alternatives, such as mobile crisis teams that travel to assist individuals with mental illness where they are, and additional PSH for persons who would otherwise be admitted to IMDs.

Response: The State thanks the commenter for this comment. The State notes that it is indeed pursuing crisis stabilization services and mobile crisis response through a State Plan Amendment. It also notes that supportive housing services are a core component of the waiver. With respect to the IMD exclusion, the State notes that the request aims to enable IMDs to occupy the appropriate place in the mental health service continuum as described in the waiver.

Comment: One commenter noted that it is unclear whether IMD coverage will supplant services that are or could be offered by community providers or whether they will be considered a last resort.

Response: The State thanks the commenter for this comment and notes that the State aims to prioritize community-based services over any type of residential or inpatient care where appropriate for the member.

Comment: One commenter sought clarification around provisions proposing greater access to short-term residential treatment in facilities that are classified as Institutions for Mental Diseases (IMDs) for individuals with mental health disorders and substance use

disorders. The commenter requested that this provision be extended to inpatient hospital IMD care, arguing that this high acuity setting currently faces access barriers.

Response: The State thanks the commenter for this suggestion and believes that the waiver request does just this.

C.6: COMMENTS AND RESPONSES FOR SECTION 3. 6: ADDITIONAL BENEFITS FOR CHILDREN AND YOUTH WITH BEHAVIORAL HEALTH CONDITIONS AND/OR SERIOUS EMOTIONAL DISTURBANCE

Comment: Multiple commenters submitted comments stating intensive in-home services are currently billable under Rule 132.

Response: While Rule 132 allows services to be billed in-home, based on place of service, the intensive in-home services described in the waiver are new services that are not currently covered under the State Plan.

Comment: Multiple commenters suggested increasing the number of respite hours available with one suggesting they are not sufficient to provide support for families of children with high level mental health needs on an ongoing basis and another suggesting it align with the State's 1915(c) Home and Community Based Services (HCBS) Waiver for Persons with Disabilities which includes flexible respite services up to 240 hours annually.

Response: The State thanks the commenter for the suggestion.

Comment: Multiple commenters suggested lowering the eligibility age for respite care and intensive in-home services, with some arguing they should be provided from birth and others from 3, in order to adequately address the needs of children in Illinois.

Response: The State has expanded both pilots to 3-21, recognizing that diagnoses of serious mental illness in 3 and 4 year-olds are quite rare.

Comment: Multiple commenters requested that intensive in-home services and respite be offered to children and families in response to a mental health crisis, defined broadly (e.g., not just in response to a psychiatric hospitalization, but to enable the family to get the services they need before a hospitalization happens).

Response: Operational details like this for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: Multiple commenters questioned how the respite care services may work alongside existing programs (e.g., SASS).

Response: The State recognizes the need to have non-duplicative, complementary services and intends to design this benefit accordingly.

Comment: One commenter asked for clarification of the State’s plans to expand PRTF services as part of the N.B. settlement agreement.

Response: The State thanks the commenter for this comment and notes that this is outside of the scope of the waiver.

Comment: One commenter asked how MCO's will provide intensive in-home services, requesting that the State provide support and guidance to ensure a strong collaboration exists between community-based providers and MCO's in the implementation of these services.

Response: Operational details like this for each benefit and initiative are being discussed and would be finalized during the terms and conditions process. The State supports and aims to strengthen collaboration between MCOs and community-based providers.

Comment: One commenter stated that respite services should be monitored closely to prevent respite as the first stop to out of home placement.

Response: The State agrees with this comment.

Comment: One commenter suggested that the State should adopt the federal CMS Systems of Care values and principles for providing behavioral health services to youth and families.

Response: The State thanks the commenter for this suggestion and notes that the State has and will continue to closely consider these values and principles.

Comment: One commenter suggested that the Medicaid service array should be expanded to provide culturally competent services. Services should include care coordination with high fidelity wraparound, mobile crisis response, crisis stabilizers, and family peer support.

Response: The State thanks the commenter for this suggestion and notes that the State is pursuing a number of these services including through SPAs.

Comment: One commenter recommended that the State establish a statewide network of Care Management Entities for the most complex youth seeking publicly funded behavioral health services. The commenter stated that these entities should be responsible for the development of one single plan of care that is family driven and youth guided and provides care coordination across multiple service systems and asked if the IHHs will incorporate this model

Response: The State thanks the commenter for this suggestion and notes that operational details of the IHHs are being defined and the State will be seeking stakeholder input into the design of the model.

Comment: One commenter recommended the State implement the Medicaid CANS to serve as the uniform assessment tool to stratify youth into Medicaid service packages based on acuity.

Response: The State is pursing the Medicaid CANS as the uniform assessment tool for youth through a SPA.

Comment: One commenter recommended that the State maximize funding for these services through blending, braiding and pooling funds across child-serving systems.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested that the State focus on quality and capacity of Medicaid providers of youth behavioral health services and that CME's should be responsible for building the provider community to meet the needs of local youth.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested the State's collaboration with the University of Illinois Urbana Campaign to develop a Systems of Care Technical Assistance Center of Illinois (STACI) should be fully supported and funded. The commenter stated that STACI should be the collaboration, communication, training and technical assistance hub to ensure Systems of Care models are implemented consistently.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter recommend that respite services include in-home respite to better promote family preservation and provide services within more natural environments, and that the role of community-based mental health providers with regard to intensive in-home services be clarified.

Response: Operational details like this for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: One commenter urged the State to ensure additional efforts are made to provide these services for families on the brink of custody relinquishment. The commenter urges the State to keep this issue at the forefront of the efforts to improve the children's behavioral health system.

Response: The State agrees that custody relinquishment is a priority, thanks the commenter for this suggestion, and will consider it as it further defines operational details.

Comment: One commenter recommended the service menu for the intensive in-home service and respite care package be flexible to meet the multiple needs for children and their families. The commenter believes that for youth who have experienced trauma a broader services array is necessary to meet the needs of evidenced informed practices.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested tailoring intensive in-home services toward the family system whether the other members of the family are Medicaid eligible or not. They further recommend that it not be tied to PracticeWise.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested the State craft a specific benefit for transition-age foster youth that focuses on trauma, behavioral health services, employment, and education.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter asked what level of professional will be performing the in-home visits.

Response: Operational details like this for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

C.7: COMMENTS AND RESPONSES FOR SECTION 4.1: INTEGRATION

Comment: Multiple commenters requested additional details and submitted ideas on how to achieve the goal of integration and operationalize IHHs.

Response: The State thanks the commenters for their suggestions and looks forward to working with stakeholders to design an IHH model appropriate for the Illinois context.

Comment: Multiple commenters made recommendations regarding the uniform assessment to be established through a SPA.

Response: The design of the assessment tool is outside the scope of the waiver.

Comment: Multiple commenters requested that occupational therapy play a more prominent role across many waiver benefits and services.

Response: The State thanks the commenters for these suggestions and recognizes the important role occupational therapists play in the delivery system. It will keep these recommendations in mind as it further defines waiver benefits and initiatives.

Comment: Multiple commenters suggested the State set different reimbursement rates for the IHHs that treat those with moderate conditions and for IHHs that treat those with the most severe behavioral health conditions.

Response: The State looks forward to working with Illinois stakeholders to design the integrated health homes. It anticipates that differential coordination payments based on level of acuity will be a component of the model.

Comment: Multiple commenters urged the State to consult with providers in Illinois and entities serving as health homes in other states about the IHH SPA, waiver benefits and initiatives, rule changes, infrastructural and operational needs to adapt to value-based designs.

Response: As the State designs integrated health homes and the details of its integration pool, it intends to seek the input of stakeholders (members, families, providers, payers, etc.) across the State as co-designers of the model. It also intends to seek the counsel of the Centers for Medicare and Medicaid Services in the development of integrated health homes.

Comment: One commenter asked which health home models were the inspiration for this work.

Response: The State has looked at a number of health home models across the country and will continue to seek to leverage best practices. The State looks forward to working with Illinois stakeholders to design the integrated health homes drawing on numerous existing models.

Comment: One commenter indicated that measures of success in reaching members assigned to a health home and conducting assessments, as well as utilization measures that indicate engagement in community-based services and reduction in avoidable hospitalizations may serve as intermediary indicators of quality until more robust outcome measures are available.

Response: As the State designs the measures on which integrated health homes will be evaluated, it intends to seek the input of stakeholders (members, families, providers, payers, etc.) across the State as co-designers of the model.

Comment: One commenter noted that safety-net hospitals would like the ability to become IHHs.

Response: As the State defines the operational details for IHHs, it will consider provider eligibility criteria carefully.

Comment: One commenter noted that there needs to be adequate training and guidance for Managed Care Organizations (MCOs) to comprehend the changes and ensure a seamless transition.

Response: The State understands that training will be needed for providers and MCOs as the behavioral health system is transformed.

Comment: One commenter recommended supporting existing grant-supported work through 1115 waiver to develop the infrastructure, technology, and provider capabilities required to implement health homes.

Response: The State will work to leverage any best practices and experiences from existing models.

Comment: One commenter recommended that community behavioral health providers be able to serve as IHHs for individuals with more severe MHSU conditions.

Response: As the State defines the operational details for IHHs it will consider provider eligibility criteria carefully.

Comment: One commenter recommended that the State enable providers to have access to real-time encounter data so providers know when enrollees are hospitalized or are in emergency rooms.

Response: The State agrees with this ambition but notes that this is beyond the scope of this waiver. The IAPD the State intends to submit will be a large step in the right direction while noting that there are many steps along the way to creating real-time access to encounter data.

Comment: One commenter recommended the State address funding shortfalls and imbalances with investment into behavioral health information technology infrastructure.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter reported that while the waiver cites statistics on hospital re-admissions and over-utilization of inpatient care, it did not specifically address a major stress point for patients and providers, hospital admission and discharge.

Response: The State agrees that hospital admission and discharge can be a major pain point. When the State cites its goal of integration, it believes that well-planned and coordinated admission and discharge is a critical component of that and expects this to be a core function of integrated health homes.

Comment: One commenter requested the State promote integration of behavioral care for behavioral health members and primary care for behavioral health needs.

Response: The State agrees with this comment and believes the waiver and broader behavioral health strategy attempt to accomplish this.

Comment: One commenter stated that developing the integrated health homes will also require funding to build capacity and the reimbursement model will need to provide sufficient incentives for providers to make the necessary investments for care coordination infrastructure. They also stressed the importance of striking a balance between achieving innovation and uniformity in designing the criteria for the medical homes and requested the State to develop appropriate criteria with significant provider input to better inform future strategies.

Response: As the State designs integrated health homes, it intends to seek the input of stakeholders (members, families, providers, payers, etc.) across the State as co-designers of the model.

Comment: One commenter stated that it is vital to develop a trained physician workforce that understands how to interpret possible linkages between mental health and symptoms of other health issues.

Response: The State agrees that physician training is critical and has therefore included in the integration initiative an entire sub-initiative on preparing the workforce for integration.

Comment: One commenter stated the need to coordinate with Existing Community Impact and Performance Measure Targets.

Response: The State agrees that a broad socio-medical community and care team is essential to delivery of high-quality, integrated behavioral and physical health services. The State appreciates that knowledge and relationships are essential to deliver this vision and has crafted the waiver to help promote both of these critical functions through the workforce and integration initiatives.

Comment: One commenter suggested expanding and intensifying care coordination support for children with complex medical conditions, explicitly including behavioral health therapies.

Response: The State notes that this is a core objective of the IHHs.

Comment: One commenter suggested that eligibility for integrated health homes be based on functioning rather than diagnosis.

Response: As the State defines the operational details for IHHs, it will consider this comment.

Comment: One commenter suggested that IHHs not be viewed as delivering services only in a clinic setting but rather the "community" be viewed as the treatment setting.

Response: The State agrees with this sentiment and it is consistent with the waiver's goal to "rebalance the behavioral health ecosystem, reducing overreliance on institutional care and shifting to community-based care."

Comment: One commenter suggested that reimbursement rates for services for IHHs reflect the increased investments providers have made and/or will need to make in staffing, technology, data collection, service development and evaluation of outcomes.

Response: The State notes that funding available through Health Home SPAs does indeed attempt to go toward the enhanced level of service provided by health homes.

Comment: One commenter suggested that the definition of 'integration' in Section 1.2.3 also include that services be 'effective' and that there is a system to measure effectiveness of services.

Response: The State would like to thank the commenter for this suggestion.

Comment: One commenter suggested that the State create a plan that includes increased partnership not only between behavioral health providers and primary care, but supportive housing providers as well.

Response: The State believes collaboration across the medical and social neighborhoods is critical.

Comment: One commenter suggested that the State target as much investment as possible into expanding proven models of care (e.g., behavioral and physical health integration).

Response: The State agrees with the importance of integration and has therefore made it a high priority in the waiver.

Comment: One stakeholder recommended increased accountability to stakeholders on the waiver's impact, including a regular reporting structure and schedule.

Response: If the waiver is approved, the State will be accountable to and work with the Centers for Medicare and Medicaid Services to establish a reporting structure and schedule.

Comment: One commenter requested that family planning providers play a more prominent role across many waiver benefits and services.

Response: The State will consider this recommendation as it defines the operational details of the waiver benefits and initiatives.

Comment: Multiple commenters stated the importance of involving families and consumers in the creation of outcome measurements to ensure that their individual characteristics, needs, preferences, and circumstances are accurately represented. They also stressed the importance of being mindful of the complexities involved with defining and measuring mental health outcomes, especially among children.

Response: As the State designs outcome measures associated with integrated health homes, it will as seek the input of stakeholders (members, families, providers, payers, etc.) across the State as co-designers of the model.

Comment: Multiple commenters suggested that tele-behavioral health in an FQHC/RHC school-based clinic would be an opportunity to promote integration of behavioral health with primary care.

Response: The State agrees that tele-behavioral health is a critical component of the delivery system and has therefore included funding for telemedicine infrastructure in the workforce initiative. Operational details of these initiatives are currently being discussed and will be available at a later date.

Comment: Multiple commenters noted that the State must recognize behavioral healthcare providers may be unable to meet advanced data sharing and transparency goals due to circumstances beyond their control (e.g., federal and state confidentiality laws governing mental health and SUD treatment (42 C.F.R. Part 2)) and suggested the State work to address these.

Response: The State recognizes the challenges providers face and will work collaboratively to work through this transition.

Comment: One commenter asked if the State will include expansion of such PRTF MH and SUD services in the waiver.

Response: No, Medicaid already covers this service.

Comment: One commenter opposed a standardized assessment tool, noting that all accredited providers currently use validated and clinically appropriate assessment tools

that are integrated into electronic health records, accreditation status and operational flow.

Response: The State thanks the commenter for this suggestion but notes that there are benefits in uniformity of assessment that enable integration.

Comment: One commenter suggested the State consider a brief shared outcomes instrument to be used by all providers at specified intervals in place of a uniform assessment and suggested measuring the same National Outcomes Measures as described in Section 3.4.

Response: The State thanks the commenter for this comment.

Comment: One commenter suggested the State should finalize and implement recommendations from the SIM Technology workgroup into the waiver to enhance data sharing in an integrated delivery environment.

Response: The State notes that this falls outside the scope of the waiver.

Comment: One commenter notes that during the previous 1115 waiver process, they urged the identification of domestic violence, or intimate partner violence, as a social determinant of health prompting the need for integrated community-based services and physical health services.

Response: The State thanks the commenter for this comment and looks forward to working with stakeholders to design an IHH model that addresses this.

Comment: One commenter suggested the new uniform assessment tool must determine the whole person's needs.

Response: The State thanks the commenter for this comment. The State is pursuing a CANS and ANSA SPA that it believes assesses whole-person needs.

Comment: One commenter suggested it is important to ensure that further assessments done by managed care and providers are not duplicative, but are additive to the person's care.

Response: The State agrees with this comment.

Comment: One commenter urged the State to encourage integration of behavioral health screening and treatment in the primary care setting regardless of whether an IHH is being developed, noting that additional training is needed for primary care providers who lack experience in behavioral health services. Additionally, technical capacity and ongoing education and assistance will be needed to support integration.

Response: The State agrees with this comment and has referenced the importance of behavioral health integration into primary care in the waiver and included waiver initiatives focused on such training.

Comment: One commenter asked if the State's intention is to train law enforcement about the availability of Integrated Health Homes, whether law enforcement will be expected to connect individuals to their IHH or enrollment in an IHH, or whether law enforcement will be viewed as an outreach component of IHHs based on the State's reference to CIT.

Response: The State believes that law enforcement can be a critical outreach component for the behavioral health system and has therefore included a reference to crisis intervention training in the integration initiative.

Comment: One commenter requested the State and managed care authorization practices should be standardized, as well as billing and contracting processes, to negate the financial burden on community-based provider's infrastructures and to ensure timely service delivery.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter stated that because child mental health diagnoses may be more fluid than adult diagnosis and must be considered in the context of the child's developmental stage, identification of children who may benefit from a pediatric IHH should include a combination of standardized tools that measure clinical and functional impairment, such as the Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths (CANS) tool.

Response: The State appreciates this comment and is pursuing a SPA for the CANS.

Comment: One commenter noted that technical support that is envisioned through the 1115 waiver should include support specifically for pediatric focused providers and the development of the Systems of Care Model.

Response: The State thanks the commenters for their suggestion and looks forward to working with stakeholders to design an IHH model appropriate for the Illinois context.

Comment: One commenter suggested as the State addresses IT upgrades, consideration should be given to developing a statewide, systematic care management platform that could be utilized by all care providers and facilitate rapid data exchange and continuity of the patient care record.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter noted it is not clear whether the 1115 waiver intends to tap into the matching funds of Section 2703 of the Affordable Care Act or if it is patterned after the 2703 model.

Response: The State is indeed pursing matching funds under Section 2703.

Comment: One commenter requested additional details on the specialized managed care product for Department of Children and Family Service (DCFS) children.

Response: The State notes that this is out of scope of the waiver but that operational details are still being refined at this time.

Comment: One commenter recommended that upon a child's discharge from an inpatient psychiatric facility (IPF), general acute care hospital, or specialized acute hospital-based unit for behavioral health services, the parent or guardian have the option on the discharge papers of choosing to send any pertinent medical documents to the primary care provider (PCP).

Response: The State thanks the commenter for this suggestion.

Comment: One commenter highlighted the ability of CIT training for police as a means to prevent avoidable incarceration of persons with mental illness.

Response: The State thanks the commenter for this comment.

Comment: One commenter suggested training teachers to recognize mental illnesses and SUDs so that they can refer students for treatment.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter recommended using the AIMS Model of Collaborative Care as the model for integrated care for the proposal.

Response: The State thanks the commenter for this suggestion and will consider it as it further defines the operational details.

Comment: One commenter suggested psychiatrists should lead the integrated care teams

Response: The State thanks the commenter for this suggestion.

Comment: One commenter requested additional details on the continuing education that will be provided to behavioral health providers in managing basic physical health condition.

Response: Operational details like this for each benefit and initiative are being worked through and more information would be available in the waiver terms and conditions.

Comment: One commenter suggested expanding the Illinois DocAssist program provide consultation for adult patients as well.

Response: The State thanks the commenter for this suggestion and will consider it as it further defines the operational details.

Comment: One commenter suggested the State should implement the new care coordination codes so that providers can be reimbursed for psychiatric consultation.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter requested the chance to work with the State to establish the disease specific integration pilots.

Response: The State appreciates the commenter's willingness to collaborate and will consider this offer as it further defines the operational details for this initiative.

Comment: Multiple commenters expressed the importance of both SUD and mental health being addressed by IHHs.

Response: While the integrated health homes have yet to be fully designed and extensive stakeholder input will be sought, the intention is certainly to integrate both mental health and SUD, not only mental health. That remains the objective throughout the waiver.

Comment: Multiple commenters requested that the integrated physical and behavioral health delivery system envisioned by HFS treat mental health and SUD treatment providers as part of the continuum of care of the whole patient.

Response: The State agrees with this comment.

Comment: Multiple commenters urged the State to improve the integration of services beyond just the IHH program.

Response: The State refers the commenters to the definition of integration in Section 1.2.3, noting that it has a far-reaching vision for integration.

Comment: Multiple commenters suggested the State should expand school-based approaches to prevention, early intervention, and access to care, including expansion of school-based health centers (SBHCs).

Response: The State thanks the commenters for these suggestions and will consider them as it further defines operational details.

Comment: One commenter suggested the State invest in technology that connects community behavioral health providers, hospital, FQHCs and other providers.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter asked the State to provide examples of disease-specific pilots referenced in the waiver.

Response: The State points the commenter to Section 4.1 in which three such examples are listed.

Comment: One commenter asked what the difference is between “Integrated Health Homes” and “integrated behavioral and physical health homes,” both referenced in the waiver.

Response: The State uses these terms interchangeably.

Comment: One commenter opposed the line in the waiver that noted that there would be "greater incentives for providers that are able to move quickly towards a higher degree of integration," arguing that it will favor providers who have the least distance to travel in reforming their service approach over providers that need more help to make the transformation. The commenter believes that a more equitable incentive approach could help the system grow.

Response: The State thanks the commenter for these suggestions and will consider them as it further defines operational details.

Comment: One commenter noted that data doesn’t get shared well internally within State agencies nor are the systems efficient/non-duplicative, etc.

Response: The State recognizes data challenges both within and across State agencies and is working to address this. The State notes that this is beyond the scope of the waiver.

Comment: One commenter noted that the State should allow plans to direct high-utilizers into value-based models of care. The commenter believes that if choice is driven by the member, these models will not be sustainable and the waiver will not achieve targeted savings.

Response: The State thanks the commenter for this comment.

Comment: One commenter asked why behavioral healthcare providers are not also approved to create and run health homes.

Response: The State looks forward to working with stakeholders to design an IHH model appropriate for the Illinois context. No providers have been approved to create and run health homes at this time.

C.8: COMMENTS AND RESPONSES FOR SECTION 4.2: EARLY CHILDHOOD, CHILDREN, AND FAMILIES

Comment: Multiple commenters asked for clarity around what is included in the waiver - I/ECMHC vs. EBHV. The commenters stressed the importance of parent support and education and noted that this is primarily done through EBHV rather than through I/ECMHC which works with professionals.

Response: The State agrees that both ECMHC and EBHV are vital to improving the conditions of early childhood. The waiver includes both I/ECMHC and EBHV targeted at families of children born with withdrawal symptoms.

Comment: Multiple commenters requested the State build a full system of care for children, youth, and transition age youth. Requests include addressing the impact of violence and adverse childhood experiences on mental health, performing annual trauma assessments on youth, and ensuring youths moving to the adult system are provided transitional services to prevent the current trajectory into homelessness and justice involvement.

Response: The State thanks the commenters for this suggestion. The State recognizes the importance of addressing trauma, adverse childhood experiences, and the impact of violence as well as the importance of providing transitional services for transition-age youth. Services in the waiver as well as services rolled out through SPAs (e.g., IHHs) aim to take a person-centered, trauma-informed approach to care to address these issues.

Comment: Multiple commenters submitted suggestions on operational details of the I/ECMHC benefit. Suggestions included:

4. Ensuring there is a plan to evaluate the pilot;
5. Recommendations on provider eligibility qualifications; and,
6. Ensuring cross agency collaboration and external experts to inform and lead design

Response: Operational details for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: Multiple commenters submitted suggestions to revise the waiver to ensure target populations for pilots include children and families in addition to adults.

Response: The State thanks the commenters for these suggestions. The State has provided some additional guidance in specific waiver sections (e.g., supportive housing services) expects to further refine these operational details through the terms and conditions process.

Comment: Multiple commenters urged the State to provide Maternal Depression Screening and Treatment for the care of both mother and child despite the mother's Medicaid eligibility. Currently diagnostic and treatment services directed solely at the

mother would be coverable under the Medicaid program only if the mother is Medicaid eligible.

Response: The State thanks the commenters for this suggestion.

Comment: One commenter encouraged the State to use this opportunity to systemically address the need for a qualified workforce to provide I/ECMHC services.

Response: The State appreciates this comment and will consider it as it further defines operational details of the workforce initiative.

Comment: One commenter requested the State consider including mental health providers (including, but not limited to, child welfare workers and home visitors that are not exclusively limited to licensed medical providers) be able to submit developmental screenings for reimbursement by CMS through early intervention programs and home-visiting services.

Response: The State thanks the commenter for this suggestion.

Comment: Multiple commenters requested the chance to collaborate with the State on expanded home visiting through a SPA.

Response: The State notes that this is beyond the scope of the waiver but that the waiver does include EBHV targeted at families of children born with withdrawal symptoms.

Comment: Multiple commenters suggested that the waiver refers to children as an "add-on" rather than true integration across the age continuum.

Response: The State supports integration across the age continuum and believes that the waiver and the broader Transformation including SPAs and rule reform aims to accomplish this.

C.9: COMMENTS AND RESPONSES FOR SECTION 4. 3: WORKFORCE

Comment: Multiple commenters noted that Adler University has distinguished graduate and undergraduate programs in clinical psychology. The faculty and students participating the demonstration projects would learn the best practices in tele-behavioral health and Adler University could become an organization that advises and trains the Illinois workforce in this new modality.

Response: As operational details are finalized, guidance will be available regarding participation in the waiver initiatives.

Comment: Multiple commenters proposed areas to invest in to strengthen the workforce. These included investing in training models for pediatricians, nurses, counselors, and social workers to manage mental health needs, creating incentives for students to pursue careers in behavioral health, expanding telehealth capacity (e.g., in a FQHC/RHC school based clinic), and allowing psychologists, social workers, and school nurses to be reimbursed for consultation via telehealth.

Response: As the State further defines the operational details of the workforce initiatives, it will consider these recommendations.

Comment: Multiple commenters suggested rate reform as an important element in attracting and retaining a robust behavioral health workforce.

Response: The State notes that rate reform is beyond the scope of the waiver but encourages the commenters to view the State's comments in the rate reform section.

Comment: Multiple commenters suggested that the State should consider ways to leverage the telemedicine infrastructure to help individuals who are hard to serve due to their severe behavioral health conditions and not just focus on health professional shortage.

Response: The State agrees that telemedicine infrastructure can serve multiple purposes including reaching those who are difficult to serve.

Comment: One commenter recommended the inclusion of certified recovery support specialists (CRSSs) in strengthening the workforce (including some financial assistance as other professionals).

Response: As the State further defines the details of the workforce initiative and develops a robust evidence base on behavioral health provider needs, it will consider the need for CRSS as part of a holistic workforce strategy.

Comment: One commenter requested the application include a stronger emphasis on increasing diversity throughout the behavioral health system overall. The comment specifically recommended revising Section 4.3 to include strategies on recruiting and retaining a diverse workforce that reflects the needs, communities, and populations being

served. The comment also recommended that the waiver clearly address the need for all programs, services, and initiatives to be culturally and linguistically competent, in accordance with best practices.

Response: The State agrees that cultural and linguistic competence are critical to an effective workforce. The waiver addresses this in multiple areas: in Exhibit 21, the waiver writes that intensive in-home services "will be culturally competent and linguistically appropriate," and in Section 4.3, the waiver writes that a key focus of training will be to ensure providers are "culturally and linguistically competent and… equipped to address whole-person care for those in need."

Comment: One commenter suggested that any additional GME slots should provide reasonable compensation for residency programs.

Response: The State thanks the commenter for this comment.

Comment: One commenter suggested that with respect to tuition repayment assistance programs, community providers have a constant struggle with losing staff, especially Licensed Clinical Social Workers, to hospitals (including safety-nets) and MCOs who are able pay higher salaries. Further, the commenter notes that the National Health Service Corp Loan Forgiveness Program requires that the recipients be working at the approved site, (i.e., onsite, 32 hours/week). Staff that work for community mental health agencies that provide a majority of interventions doing home and community visits "outside of four walls" to high-needs persons with serious MHSU conditions who are unlikely to keep center-based appointments, are ineligible to participate in this benefit. The commenter urges the State to think outside of the HRSA 'box' and to include these kinds of staff (i.e., those working "out in the community" rather than solely within the four walls of a clinic) in any tuition repayment programs.

Response: The State will consider this recommendation as it defines the operational details of the workforce initiative.

Comment: One commenter urged the HFS, collaborating state agencies and participating service providers to coordinate with Illinois grantees participating in the Geriatric Workforce Enhancement Program.

Response: As the State further defines the operational details of the workforce initiatives it will consider this recommendation.

Comment: One provider recommended a multi-pronged approach to developing and building the behavioral health workforce including allowing direct Medicaid billing for mental health specialty providers that are crucial to providing services to those with the most significant conditions, including psychologists, social workers, etc.

Response: While beyond the scope of the waiver, psychologists and licensed clinical social workers will be able to bill Medicaid directly as of January 1, 2017

Comment: Multiple commenters made recommendations focused on specific types of providers including:

- Including certified alcohol and drug counselors (CADCs) in workforce initiatives;
- Allowing APNs to practice at the top of their license and consider reforms to increase their scope of practice;
- Expanding training for forensic psychiatry;
- Expanding the mental health professionals that can participate in telemedicine to allow psychologists, psychiatric APNs, social workers and other appropriate mental health professionals to take advantage of telemedicine;
- Creating fast-track training pathways for mid-levels – APNs and psychiatric social workers;
- Exploring greater use of peer mentors/recovery coaches, as well as potential paths for credentialing;
- Pursuing strategies to increase the supply of psychiatrists and other mental health professionals in the State, including loan repayment programs for a broad range of professionals working in community-based settings, including Qualified Mental Health Professionals (QMHPs), psychiatrists, psychologists, nurses, case managers, and social workers; and,
- Citing CHWs as potential care coordinators and/or brokers for better community capacity.

Response: As the State further defines the operational details of the workforce initiatives it will consider these recommendations.

Comment: Multiple commenters recommended Illinois take a multipronged approach to developing and building its behavioral health workforce by including community providers, critical access hospitals, federally qualified health centers, community mental health centers, and local health departments in the bonus payment pool for loan repayment programs.

Response: The State thanks the commenters for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter suggested a collaboration of State, Federal, and private funders to identify resources to expand access to telemedicine equipment, especially for rural providers in the region, and working with providers to provide reliable and consistent delivery.

Response: The State agrees with leveraging a wide array of resources and also points the commenter to the workforce optimization initiative on telemedicine infrastructure.

Comment: One commenter suggested identifying new skills needed by the workforce of the future and designing payment systems to fund those provider services while providing incentives for working in rural areas.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested working with universities, community colleges, and vocational schools to recruit and train new behavioral health service providers.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested addressing reimbursement issues related to LCSW, LCPC, LSW, and CADC workers.

Response: The State thanks the commenter for this suggestion. The State would like to note that as of January 1, 2017, psychologists and LCSWs will be able to directly bill Medicaid.

Comment: One commenter suggested creating a collaboration with schools and faith-based organizations.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested that incentives be provided for hospitals, community mental health clinics (CMHCs) and federally qualified health centers (FQHCs) to install appropriate technology (e.g., telehealth access to psychiatric care).

Response: The State points the commenter to the workforce optimization initiative on telemedicine infrastructure.

Comment: One commenter suggested workforce-strengthening initiatives should also focus on recruiting and retaining a racially/ethnically, and a linguistically diverse workforce that reflects the needs of communities and populations being served. Additionally, the waiver application should explicitly state that all services, interventions, assessments, and trainings will be culturally and linguistically competent.

Response: The State appreciates this comment, believes in the importance of cultural and linguistically appropriate services, and has made some updates to the waiver accordingly.

Comment: One commenter requested additional detail on the timeline for implementing incentives for mental health professionals and building out the telemedicine infrastructure.

Response: Operational details like this for each benefit and initiative are being discussed and would be finalized during the terms and conditions process.

Comment: One commenter recommended a training and technical assistance hub be created and supported by the State that is continually accessible and can provide information on best practices, intensive training and support for system improvement.

Response: The State appreciates this recommendation and will consider it as it further defines the details of the workforce and integration initiatives.

Comment: Multiple commenters stated it is not clear if the waiver includes specific attention to child-serving professionals and recommends the State include stronger language around the plans to develop a workforce capable of addressing the specific needs of children and youth.

Response: The State thanks the commenters for this suggestion and will consider it both in operational details as well as for the workforce needs assessment.

Comment: Multiple commenters suggested the loan repayment program should also include psychiatrists.

Response: The State has updated the waiver application accordingly.

Comment: One commenter suggested that loan repayment and forgiveness programs should require practitioners to help reduce both geographic and Medicaid patient population shortage areas.

Response: The State thanks the commenter for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter recommended that scholarship programs should also be a part of the 1115 waiver investment in health workforce, with a priority on diversifying the health workforce. As some students will not be able to take out the amount of loans needed to complete their schooling, scholarships will enable low-income students to gain the education needed to become health professionals.

Response: The State thanks the commenter for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter supports using Medicaid dollars for Graduate Medical Education (GME) and suggests developing residency programs training specialists in either Family Medicine, or in combined Family Medicine and Psychiatry. The commenter notes that based on the Health Resources Services Administration's (HRSA's) Teaching Health Center residency program model, these could be located within both Federally Qualified Health Centers and Integrated Health Homes (as they are developed).

Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested that Professional Learning Collaborative and pediatric consultation model pilots developed by ICMHP and others be expanded to address shortages of child psychiatrists, nurses, and other mental health specialists trained to deliver early intervention strategies in educational and community settings and hospital-based services and developing incentives to encourage the next generation to pursue careers in pediatric mental health.

Response: The State thanks the commenter for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter suggested funding GME via a State Plan Amendment (SPA) as part of the claims process or managed care program and suggested part of these funds should also be targeted towards designing and updating current curriculum.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested designing a program based upon the teaching health center (THC) model, which has been piloted and funded by the federal government.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter cautioned against viewing telemedicine as a replacement for face-to-face contact with a provider. The commenter also suggested including a plan for training those physicians using telemedicine to better understand and respond effectively to their patients' behavioral health needs.

Response: The State thanks the commenter for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter recommended that training on integrated care should be provided to residents.

Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested that emergency rooms should be included in the telemedicine needs assessment.

Response: The State thanks the commenter for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter recommended that the State offer a loan repayment differential for behavioral health professionals willing to work in rural communities as these communities already receive loan forgiveness and do not want to be further disadvantaged.

Response: The State thanks the commenters for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter suggested that other telehealth provisions should be made available and financially supported (e.g., nursing, behavioral health therapies and case management).

Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested the State help facilitate partnerships between larger providers with more experience with accessing Medicaid financing and smaller providers.

Response: The State supports this idea and believes it is captured in the workforce initiative under workforce optimization.

Comment: One commenter asked how the State plans to expand the supply of highly trained mental health professionals.

Response: The State refers the commenter to the workforce and integration sections of the waiver.

C.10: COMMENTS AND RESPONSES FOR SECTION 4. 4: FIRST EPISODE PSYCHOSIS

Comment: Multiple commenters requested the FEP program be expanded to include individuals with illnesses that cause psychosis or pre-psychosis, not just those with Schizophrenia Spectrum Disorder.

Response: The State has made this change in the waiver application.

Comment: Multiple commenters submitted suggestions on operational details to further define the FEP program. Recommendations included that the FEP team be expanded to include occupational therapists and peer support specialists who have lived with psychosis and can add unique value to the recovery-oriented program and to design the FEP payment as a bundled payment to allow for maximum flexibility.

Response: As the State further defines the operational details of the FEP initiative it will consider these suggestions.

Comment: One commenter asked how the FEP program will differ from ACT.

Response: The FEP program differs from ACT or CST on a range of elements including team composition, frequency of service, eligibility, etc. The initiative in the waiver is intended to primarily support the creation of these teams, not support the services provided in an ongoing fashion.

Comment: Multiple commenters submitted suggestions on operational details to further define the FEP program. Recommendations included:

- Expand the FEP team to include occupational therapists and peer support specialists who have lived with psychosis and can add unique value to the recovery-oriented program; and,
- Design the FEP payment as a bundled payment to allow for maximum flexibility.

Response: As the State further defines the operational details of the FEP initiative it will consider these suggestions.

Comment: One commenter suggested lowering the age range from 14 to 12 noting that studies of FEP programs, such as the Robert Wood Johnson Foundation research on Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP), demonstrate the effectiveness of FEP programs for children as young as 12. Additionally, expanding the age to 12 will align the State's efforts with existing state law providing greater behavioral health treatment autonomy and confidentiality rights for children starting at the age of 12.

Response: The State has made this change in the waiver application.

Comment: One commenter suggested that the State collaborate with a state academic or university-based partner to create and monitor the FEP program.

Response: As the State further defines the operational details of the FEP initiative it will consider this suggestion.

Comment: One commenter noted that other youth diversion, early intervention initiatives besides FEP are lacking in the waiver.

Response: The State thanks the commenter for this comment.

C.11: COMMENTS AND RESPONSES FOR SYSTEM CAPACITY

Comment: Multiple commenters raised a concern of increased relapses and an increased need for crisis level of care if the plan de-institutionalizes all patients and discharges patients from the hospital setting right to the community.
Response: The plan does not aim to de-institutionalize all patients but has a clear goal of "reducing overreliance on institutional care and shifting to community-based care." This means that it aims to de-institutionalize as appropriate but understands that it will not be appropriate for all individuals. The State agrees that step-down care is critical for some members and the behavioral health strategy aims to also ensure that these members can be stepped down as appropriate.

Comment: One commenter asked the State to ensure resources are also available in downstate regions that have fewer resources to meet behavioral health and substance abuse needs of service recipients.
Response: The State agrees with the need to ensure resources reach underserved areas.

Comment: One commenter mentioned that the behavioral health transformation plan fails to detail plans for those suffering with mental illness who either aren't ready to function independently or aren't able to in the long-term.
Response: The behavioral health transformation does not aim to disrupt care for those who cannot function independently. It aims to provide the requisite community capacity should they be able to function better in the community but does not aim to move those who require institutions from those settings.

Comment: One commenter mentioned that the waiver should create an opportunity to address the support services that behavioral health patients need once they are released into the community.
Response: The State agrees that support services are essential; that is why goals 4 and 5 of the waiver are to: 4) support development of robust and sustainable behavioral health services that provide both core and preventative care to ensure that members receive the full complement of high-quality treatment they need; and 5) invest in support services to address the larger needs of behavioral health members, such as housing and employment services, respectively.

Comment: One commenter stated that the "waiver should help prevent boarding of individuals with mental health problems in emergency rooms and local jails."
Response: The State agrees that emergency rooms and local jails are not the right setting for behavioral health services and that is why this waiver seeks to "rebalance the behavioral health ecosystem, reducing overreliance on institutional care and shifting to community-based care."

Comment: One commenter suggested using the waiver to make much needed strategic investments in workforce and infrastructure in the short and long-term.
Response: The State believes that the waiver does make strategic investments in workforce and infrastructure through its workforce initiative.

Comment: Multiple commenters stated that in order to implement many of the benefits and initiatives proposed in this waiver, there is a need to address systemic capacity, clarify roles of payers and providers (including roles of managed care organizations), as well as improve infrastructure and accountability.
Response: The State believes that the waiver addresses system capacity and infrastructure through the workforce and integration initiatives, thereby enabling implementation. Specific roles of health system actors will be more precisely defined during a detailed design phase.

Comment: Multiple commenters pointed out that continued emphasis on re-building a community mental health and substance use disorder system that has been compromised and eroded as a result of State fiscal problems and funding curtailments must be a high priority for HFS and DHS.
Response: Having a strong community mental health and substance use disorder system is a high priority of the State.

Comment: One commenter asked how the transformed Illinois system will identify families as consumers and develop capacity to serve families.
Response: The State supports member- and family-centered care and integration across the age continuum. The State believes that the waiver and the broader Transformation including SPAs and rule reform aims to accomplish this.

Comment: One commenter suggested the waiver prioritize resources to increase access to community triage, crisis stabilization, and transitional living programs.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter recommended additional mechanisms to monitor the behavioral health system capacity and offered their capacity assessment to inventory mental health, substance abuse, and violence prevention services, which we offer as a model.
Response: The State thanks the commenter for this suggestion and will consider it as it further defines operational details.

Comment: One commenter believes that some of the language in the waiver devalues the need for a continuum of care and suggests that the State remove references such as “lower cost” or “over-reliance.”

Response: The State thanks the commenter for this comment. Nowhere does the State indicate that a continuum of care is unnecessary. The State is simply indicating that the behavioral health system is heavily indexed on higher-end care and requires a greater capacity of community-based services.

Comment: One commenter recommended that the State survey the behavioral health treatment system to get an accurate account of the capacity needs of the field. The commenter also recommended that the State develop a phased-in approach to increase behavioral health service capacity.
Response: The State thanks the commenter for these suggestions.

Comment: One commenter believes the concept of increasing interventions early in treatment to avoid higher end costs should benefit individuals with behavioral health issues but that the infrastructure to provide community services would be weakened by the waiver's proposed expansion of Medicaid managed care.
Response: The State thanks the commenter for this comment.

Comment: One commenter requested a more precise definition for community capacity and asked for the methodology behind the public hearing statistic that Illinois is 53% lower than the national average in utilizing community resources. The commenter also suggested the State must ensure that this capacity is sustainable once the 5-year waiver demonstration is exhausted.
Response: The State agrees that it is essential to ensure system capacity is sustainable. The State would refer the commenter to SAMHSA's uniform reporting system for the methodology.

Comment: One commenter suggested community capacity reimbursement include MCO partnerships with food providers.
Response: The State thanks the commenter for this comment.

Comment: One commenter asked how the State will ensure that services currently provided by community mental health centers are not supplanted by the proposed IMD services, primary care physicians, FQHCs, and hospital systems.
Response: The State thanks the commenter for this comment and will consider it when defining the operational details of the waiver benefits and initiatives.

C.12: COMMENTS AND RESPONSES FOR PROVIDER INFRASTRUCTURE

Comment: One commenter asked the State to explore ways to ensure capacity funding is available in rural areas.
Response: The State agrees with the need to ensure resources reach underserved areas.

Comment: One commenter suggested that funds should be made available to non-profit providers for expansion and infrastructure development and that the State should make available additional funds for non-profit providers for this expansion of community services. The commenter believes this is particularly important given the movement to deinstitutionalize State services that will increase the demand on community-based providers.
Response: There are infrastructure and expansion funding opportunities in the waiver. In particular, the workforce and integration initiatives as well as the broader set of benefits and initiatives include funding opportunities. The State has also made clear its intention to shift toward more outcomes-based and sustainable funding sources rather than grant funding.

Comment: One commenter suggested that reimbursement be provided for establishing crisis stabilization units, incentivized participation in crisis stabilization services and enhanced rates for Rule 132 crisis assessment and stabilization.
Response: The State thanks the commenter for this suggestion.

Comment: Multiple commenters suggested that many providers, particularly community service providers, have not had the resources (time and/or money) to make investments in infrastructure (e.g., billing and documentation requirements of Medicaid), which will lead to an ongoing need for technical assistance in the provider community across many of the waiver benefits, initiatives, and beyond. Some commenters asked the State to make infrastructure investments for these providers (e.g., electronic health records, billing systems, IT platform, back-office infrastructure, etc.).
Response: The State agrees that not all providers are ready to bill Medicaid; it has included in the workforce initiative a focus on linking community services to managed care (and Medicaid more broadly) which includes training and learning collaboratives like one of the commenters mentioned. The State has not included capacity investments for billing systems, EHRs, staffing, etc.

Comment: Multiple commenters suggested the transition to integrated health homes (IHHs) will require financial and other support for providers to transition to this new integrated care model.
Response: The State thanks the commenters for this suggestion. The State recognizes that a transition will need to take place and has included in the waiver initiatives such as the integration initiative to support this transition.

Comment: One commenter noted that investing in the infrastructure for an improved system will increase the quality of the services provided and set our State up to be a national leader for children's behavioral health.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter recommended investments be made to rebuild community behavioral health infrastructures and supports to keep people healthy in their home environments and reduce avoidable urgent and inpatient care.
Response: The State believes the waiver and behavioral health strategy more broadly attempts to do just this.

Comment: One commenter suggested the State or federal support offset the costs associated with undergoing the trainings to meet the enhanced criteria the transformation calls for.
Response: The State thanks the commenter for this suggestion.

C.13: COMMENTS AND RESPONSES FOR FUNDING

Comment: Multiple commenters highlighted that taking dollars away from Medicaid programs can have adverse consequences. Commenters stressed the importance of protecting "what's currently here" while expanding and ensuring the waiver does not supplement and supplant dollars that currently exist to fund behavioral health services. One commenter wrote that the "plan is to take away $200M from Medicaid programs."
Response: The State's goal through the waiver is to build, not diminish, capacity within the Medicaid behavioral health system and to improve outcomes for all members.

Comment: Multiple commenters suggested that to further support providers with the transition to outcome-based reimbursement models, funding for behavioral health services needs to be consistent and sustainable in order to prevent service disruptions, staff turnover, and program cuts that negatively impact child and family outcomes.
Response: The State agrees that funding for behavioral health services needs to be sustainable and has designed the integration initiative to help providers transition to outcomes-based reimbursement through IHHs.

Comment: Multiple commenters urged the State to allow public safety agencies to participate in Medicaid administrative claiming. The commenters suggested that this does not necessarily need to be achieved through the waiver.
Response: The State agrees that this falls outside the scope of the waiver.

Comment: One commenter emphasized that, in addition to the Community Mental Health Boards, when making provider and funding decisions, the transformation team cannot disregard other funding resources that are contributing to the communities' behavioral health system of care.
Response: As noted during the public hearings, the State intends to pursue a diversified funding strategy, leveraging all sources of funding available that are consistent with the behavioral health strategy.

Comment: One commenter highlighted that a transformation model such as this waiver should not include granting the State the ability to diminish eligibility or services.
Response: The State notes that the waiver makes no changes to eligibility.

Comment: One commenter suggested that additional savings or matching funds generated through the waiver be re-invested in building capacity in the community system.
Response: The State notes that this is exactly what the waiver does.

Comment: One commenter requested clarification on how the uncertainty in the healthcare ecosystem will impact the proposed 1115 waiver.

Response: If approved, the State is accountable to Federal CMS for its commitments made through the terms and conditions of the waiver.

Comment: One commenter suggested that a method of direct billing needs to be created for all credentialed, certified, licensed and unlinked behavioral health professionals as well as methods to pay for non-medical services including food, housing and sober living communities as needed.
Response: The State notes that as of January 1, 2017 psychologists and licensed clinical social workers will be able to directly bill Medicaid.

Comment: Multiple commenters suggested that transitioning from state grants to Medicaid must be a gradual process and that stakeholder input should be solicited throughout.
Response: The State thanks the commenters for this suggestion and will consider it as it further defines the operational details for this benefit.

Comment: One commenter recommended exploring private, state and federal funding opportunities to pilot new alternative strategies to delivery behavioral health services in the region (crisis centers, care coordinators, etc.), optimize and leverage all federal matching dollars.
Response: As noted during the public hearings, the State intends to pursue a diversified funding strategy, leveraging all sources of funding available that are consistent with the behavioral health strategy.

Comment: One commenter stressed the importance of not letting the need to save dollars compromise the goal of customer-centered and customer-directed care.
Response: The State thanks the commenter for this suggestion.

Comment: Multiple commenters urged that the waiver should not include increased cost-sharing that would put an increased burden on the consumer.
Response: The State notes that the waiver does not increase cost-sharing.

Comment: One commenter suggested that additional savings or matching funds generated through the waiver be re-invested in other needed supports.
Response: The State notes that this is exactly what the waiver does.

Comment: One commenter asked the State if it will continue to offer SUD case management as GRF funded services during the life of the waiver.
Response: DASA intends to continue offering SUD case management to the non-Medicaid members it serves through GRF.

C.14: COMMENTS AND RESPONSES FOR RATE REFORM

Comment: Multiple commenters recommended reforming MCO rates.
Response: The State has and will continue to set rates in accordance with Medicaid rules and actuarial soundness.

Comment: Multiple commenters recommended reforming rates to expand capacity, promote workforce development and retention, and improve access to care.
Response: The State plans to increase funding but intends to do so in a way that is clearly aligned with the outcomes the State seeks. This funding will be directed toward incentivizing the right behaviors and driving the integration of physical and behavioral health. It will not be a broad, undirected rate increase across the board. Increases in funding will be strategic, targeted, and consistent with the State's focus on paying for value, quality and outcomes.

Comment: One commenter suggested that the State pay an enhanced rate (over and above rate reforms that adjust rates to cover cost) for providers and/or mental health professionals in underserved areas of the State.
Response: The State believes this recommendation is beyond the scope of the waiver.

Comment: Multiple commenters recommended establishing one equitable rate for each category of service, with the possibility of an enhancement to be added for certain identified criteria such as population served, professional shortage areas, enhanced evidence based practices, incentives for quality care, tracking of quality outcomes or implementing modern billing practices.
Response: The State thanks the commenters for this suggestion.

Comment: One commenter requested additional details on the proposed fee structure and billing expectation for various services pertaining to children and families.
Response: Operational details like this are still being worked out.

Comment: One commenter asked if pre-enrollment medications will be provided outside of the scope of the MCO contract as state-operated initiatives or, if they are included, how the capitation rates will be adjusted to reflect actuarial soundness.
Response: The State is still working out the operational details but has and will continue to set rates in accordance with Medicaid rules and actuarial soundness.

Comment: One commenter sought clarification as to which portions of the benefit service package would become a part of the MCO capitation rates and how the new services and benefits/costs will be calculation.
Response: The State is still working out the operational details but has and will continue to set rates in accordance with Medicaid rules and actuarial soundness.

Comment: One commenter recommended that the State take a portion of the savings from the waiver to phase-in rate increases for the community behavioral health providers over the five year life of the waiver.
Response: The State plans to increase funding but intends to do so in a way that is clearly aligned with the outcomes the State seeks. This funding will be directed toward incentivizing the right behaviors and driving the integration of physical and behavioral health. It will not be a broad, undirected rate increase across the board. Increases in funding will be strategic, targeted, and consistent with the State's focus on paying for value, quality and outcomes.

Comment: One commenter requested further clarification as to what extent reimbursement rates will be re-negotiated, who will be responsible for doing so, what the rates will be based upon, and where and when they will be made available.
Response: The State notes that this falls outside the scope of the waiver.

Comment: One commenter asked for the opportunity to share concrete examples of rate negotiations for managed care.
Response: The State thanks the commenter for this suggestion.

C.15: COMMENTS AND RESPONSES FOR BUDGET NEUTRALITY

Comment: Multiple commenters requested greater detail on the budget neutrality calculations.
Response: The State has complied with the CMS budget neutrality requirements.

Comment: One commenter requested additional detail regarding the anticipated up-front costs, money disbursement timelines and requested the State to outline a mechanism by which to ensure that the State does not go above budget.
Response: The State has complied with the CMS budget neutrality requirements.

C.16: COMMENTS AND RESPONSES FOR PAYMENT REFORM

Comment: One commenter recommended that the State allow providers to access encounter data to drive down unnecessary hospitalizations and help individuals with a successful transition back to the community.
Response: The State agrees with this ambition but notes that this is beyond the scope of this waiver. The IAPD the State intends to submit will be a large step in the right direction while noting that there are many steps along the way to creating real-time access to encounter data.

Comment: One commenter requested that the rules that govern and set the parameters for value-based contracting must be written in partnership with providers and MCOs to ensure implementation is possible and encouraged.
Response: As the State designs the value-based reimbursement model for integrated health homes it intends to seek the input of stakeholders (members, families, providers, payers, etc.) across the State as co-designers of the model.

Comment: One commenter inquired as to what steps will be taken to ensure providers receive payment for services in a timely manner, especially as the current system has payments that are six to nine months behind schedule.
Response: This is a Medicaid waiver and HFS believes it is a priority to pay Medicaid providers in a timely fashion.

C.17: COMMENTS AND RESPONSES FOR OPERATIONAL DETAILS

Comment: Multiple commenters provided feedback on operational details, including:

- Need for cross-agency collaboration to occur, including detailed discussions of sustainability for the initiative;
- Beneficiary eligibility services should be determined by level of functioning, existing needs, and available supports rather than specific diagnostic or definitional requirements;
- Assessment scores necessary to authorize services must allow early interventions for those who may need services and prevent further deterioration in their level of functioning;
- Implement an easily accessible, standardized, streamlined and consistent assessment and authorization process;
- Ensure that DSHPs that receive Federal Financial Participation will not require all grantees to become Medicaid certified providers, nor all program participants be enrolled in Medicaid;
- Include language addressing how to access crisis beds, respite care, and intensive in-home services, allowing for families to participate in determining when services could be helpful for youth;
- Thoughtfully consider how current patient referral patterns flow as you define boundaries when creating Regional Health Partnerships (Similar model to Texas);
- Telemedicine should be used to alleviate shortages and leverage expertise where needed;
- Ensure that outcome menu options are flexible enough to allow innovation as projects evolve over the five year timeframe;
- Outcome measures from the DSM5 should be used in addition to the PHQ-9;
- Ensure measures are in place to capture potential population that may be deflected from inpatient yet not successfully connected to community mental health utilization; and,
- Ensure that supported services can bridge across inpatient and residential treatment settings.

Response: The State thanks the commenters for these suggestions. Operational details are being worked through and will be discussed in detail with Federal CMS. More detail will be available in the special terms and conditions of the waiver. The State notes that DSHPs do not require all grantees to become Medicaid certified providers and has updated the waiver accordingly. For a number of waiver benefits, initiatives, and for integrated health homes, the State will be seeking stakeholder input.

Comment: Multiple commenters requested additional operational details. Details requested included more information on:

- How developing training and learning collaboratives for smaller community providers to support their capacity to work effectively with Managed Care Organizations will be achieved;
- What the timeframe is for the development of a specialized managed care product;
- Outcome based payments and how they will be implemented ;
- How eligibility will be determined for new benefits;
- How pilot programs will be targeted;
- The size and scope of pilot programs;
- The amount of funding allocated for provider and workforce capacity initiatives ;
- Approach to implementing assessment and authorization processes;
- Model for crisis stabilization (e.g., the Living Room model);
- Process to provide education regarding rates, billing codes, service limitations, etc.;
- The evaluation plan (e.g., what does an 'enabling environment' mean, how will the State measure whether members remain in their communities?);
- How data will be collected and used, what the plan is for Value Options, and what can be done about system integration now;
- When more details are going to be known, if there are other documents that stakeholders can be reviewing, if there are foundational material that was used from other states;
- How the pilot regions will be chosen, if there is going to be an RFP process and if so, how it going to happen;
- What the implementation timeline is;
- What type of provider will qualify to provide Medicaid services;
- How rates and service codes will apply to the essential work in family homes and communities;
- How the workforce development components can apply to child welfare and family service providers;
- If the CCBHC model will be used;
- If collaboration between providers will be allowed;
- If IHHs will use a new or different payment model;
- If children and adolescents will be part of the health home concept;
- Definition of community behavioral health providers;
- If the waver factors in a DCFS system MCO carve-in;
- If DMH is not included in the plan for SDHPs;

- Feasibility of DSHP goals without knowing which programs would qualify for federal DSHP; and,
- If supportive housing providers and supportive employment providers need to be Medicaid certified.

Response: Operational details are being worked through and will be discussed in detail with Federal CMS. More detail will be available in the special terms and conditions of the waiver. For a number of waiver benefits, initiatives, and for integrated health homes, the State will be seeking stakeholder input.

Comment: One commenter requested additional details of HHS Transformation, the State plan amendments and the updated rules and other documents in the demonstration waiver to evaluate the comprehensiveness and appropriateness of the provisions of the waiver.
Response: The State thanks the commenter for this question and notes that this is the public comment period for the 1115 waiver; both SPAs and administrative rule changes each follow their own process.

C.18: COMMENTS AND RESPONSES FOR PREVENTION

Comment: One commenter recommended the State continue to initiate prevention and early intervention programs that promote early identification of mental, emotional, social and behavioral disorders in children and adolescents.
Response: The State is committed to prevention and early treatment as evidenced by its early childhood initiatives, first episode psychosis initiative, and, perhaps most importantly, its integration funding and commitment to IHHs.

Comment: Multiple commenters called for additional resources to be appropriated for universal (primary) prevention programming.
Response: Primary prevention is a priority and is already funded today through SAMHSA block grant to the Division of Alcoholism and Substance Abuse (DASA); 20% of this $67 million grant is earmarked for prevention.

Comment: Multiple commenters urged the State to take a targeted strategy to increase prevention and early treatment.
Response: The State is committed to prevention and early treatment as evidenced by its early childhood initiatives, first episode psychosis initiative, and, perhaps most importantly, its integration funding and commitment to IHHs.

C.19: COMMENTS AND RESPONSES FOR DUAL DIAGNOSIS

Comment: Multiple commenters asked how the waiver address how to treat children and adults with dual diagnoses with behavioral health (e.g., developmental disabilities, intellectual disabilities).
Response: The waiver is focused on behavioral health and the integration of physical and behavioral health. To the extent that members have dual diagnoses, this waiver will enhance support provided to them through more robust behavioral health services and ensuring that all services they receive are integrated within the context of an integrated health home.

Comment: One commenter stated that the waiver needs to consider the DD population through several sections, in particular those with ASD, who are not currently considered under "behavioral health" within Medicaid.
Response: The waiver is focused on behavioral health and the integration of physical and behavioral health. To the extent that members have dual diagnoses, this waiver will enhance support provided to them through more robust behavioral health services and ensuring that all services they receive are integrated within the context of an integrated health home.

C.20: COMMENTS AND RESPONSES FOR POLICY REFORM

Comment: Multiple commenters have recommended the State waive the parental income requirement for at-risk youth on Medicaid applications.
Response: The State is not pursuing this approach to Medicaid coverage at this time.

Comment: One commenter noted the difficulty in dealing with multiple agencies and departments and how that leads to redundancies and inconsistencies (e.g., DHS for early intervention (0-3); mental health and eligibility; DCFS for children within our child welfare system; HFS as the lead Medicaid agency and others).
Response: The State also views coordination across providers and agencies as critical to seamless provision of care.

Comment: One commenter requested the creation of policies and practices that enforce state and federal mental health and substance abuse parity provisions.
Response: The State fully supports mental health and substance abuse parity and believes that the waiver and accompanying SPAs go a long way toward promoting these provisions.

Comment: One commenter stated that to the extent that the State avails itself of IMD use despite the historic IMD exclusion, it must create policies and procedures to prevent the loss of housing and benefits and promote use of community options in lieu of IMDs.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested State agency leaders and providers meet to discuss reductions in duplication related to assessments, patient forms, and provider reporting requirements through technology programs and software.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested the State enhance transportation funding for voluntary admits, mid-level providers, and for return trips from hospitals and providers.
Response: The State notes that such transportation (emergency and non-emergency) is a State service.

Comment: One commenter urged the state to pursue a state plan amendment to enable Medicaid re-imbursement for community health workers.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter urged the state to be cautious not to "create a new poverty-wage workforce category" when adding re-imbursement for CHWs.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested that community health workers be permitted to perform coordination services for low risk Medicaid enrollees.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter recommended that the waiver allows for the inclusion of expanded Outreach and Engagement as a Medicaid-reimbursable service for persons with serious mental illnesses and substance use disorders.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested that the waiver increase the flexibility and the choice of long-term services and supports for children and adults based on need and consistent with implementing true person-centered services and supports.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter recommended that the waiver incorporates similar provisions that guarantee the availability of legal resources to those in need, similar to the way the Health Resources and Services Administration recently modified its funding eligibility rules.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter encouraged the State to review the recommendations from the CMS letter and the Office of the National Coordinator and the State's 2012 Behavioral

Health Integration Project as this includes a legal and operational framework necessary to protect confidentiality while helping to facilitate data exchange.
Response: The State thanks the commenters for this suggestion.

Comment: One commenter requested that the State consider, and modify as necessary, any unnecessary regulations that limit the impact of potential 1115 Waiver projects and other innovative ways to reach out to patients through technology enabled care.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter requested that alcohol and drug laboratory testing services through Medicaid be covered.
Response: The State believes this falls outside of the scope of the waiver.

Comment: One commenter recommended that non-violent offenders suffering from addiction and/or mental health disorders be identified for placement in less restrictive settings and for those not able to be placed in less restrictive settings, medication-assisted treatment should be made available to those individuals.
Response: The State believes MAT is a priority and has submitted a SPA. It also agrees with the need to identify less restrictive settings for these individuals and believes that many of the waiver benefits and initiatives support this.

C.21: COMMENTS AND RESPONSES FOR RULE REFORM

Comment: Multiple commenters submitted rule change recommendations to improve the provision of behavioral health in Illinois. Suggestions included:

- Remove barriers for prescribing psychiatric medications such as: (a) pediatricians that are willing to manage lower acuity children; (b) providers who struggle to get their kids the clinically appropriate drugs because of "step therapy";
- Ensure reimbursement for nonphysician mental health providers is not governed by specific types of locations where services are delivered;
- Bring rules in line with an outcomes-driven delivery system and maximize all services allowed under the rehab option rather than using existing State rules;
- Allow and foster integration of mental health, substance use, and medical treatment;
- Remove regulatory barriers that limit the existing workforce from transitioning to the new system of behavioral health services;
- Modernize and streamline rules for community mental health and substance use treatment to allow providers to deliver high quality services that deliver the best outcome;
- Reform Rule 132, Rule 2060 and Rule 2090 regulating mental health and substance use to reflect the changing landscape derived from Medicaid expansion and Medicaid managed care to expand eligibility and reform an increased array of services;
- Activities billable as case management services should be the same for MH clients as well as SUD clients; and,
- Develop rules to carry out the intent of the law such as statue PA97-1061.

Response: In parallel with this waiver, the State is examining Rule Reform and will take these suggestions into consideration;

Comment: Multiple commenters recommended specific changes to Rule 132, including:

- Integrating children, in-home family work and young adult services into the Medicaid rules;
- Provide for flexibility, growth, and innovation of mental health services, incentives for quality care, and collaboration in providing services and supports, and alignment with the requirements of managed care;
- Ensure that all licensed mental health providers including but not limited to social workers, psychologists, and psychiatrists be able to bill for mental health services provided in all settings; and,
- Allow billing for short-term brief interventions and screenings for children and families such as those provided without a full assessment.

Response: In parallel with this waiver, the State is examining Rule Reform and will take these suggestions into consideration.

Comment: One commenter expressed confusion over the waiver sentence "for example, proposed changes to Illinois' administrative rules aim to ease the burden on providers and break down barriers to the integration of behavioral and physical health, such as requiring that all services provided by CMHCs be tied back to a mental health need."
Response: The waiver describes the need to change this requirement which serves as a barrier to the integration of behavioral and physical healthcare.

Comment: One commenter requested the state to identify ways in which FQHCs, RHCs and MH providers can bill medical and behavioral health services to Medicaid for timely, patient-centered services.
Response: The State thanks the commenter for the suggestion.

Comment: One commenter encouraged the state to work with the provider community to identify other potential regulations that impede the provision of care and are in conflict with the objectives of behavioral and physical health integration.
Response: The State thanks the commenter for this suggestion

Comment: One commenter recommended that the proposed re-organization or modification to the system be completed through a transparent and public process.
Response: The State thanks the commenter for this suggestion. The waiver, administrative rules, and SPAs each have a specified process the State itnends to follow.

Comment: One commenter requested the State to allow for same day billing for primary care and behavioral health services.
Response: The State thanks the commenter for this suggestion.

Comment: Multiple commenters urged the State to seek input from stakeholders, including the public, before and during the administrative rule change process.
Response: Rule changes will follow the JCAR process.

Comment: One commenter suggested that DHS approved certification programs could be made much broader.
Response: The State thanks the commenter for this suggestion.

Comment: Multiple commenters requested clarification on changes under Rule 132 and Rule 2060 and asked the timeline for these changes.
Response: The State is currently working through these but no timeline is available.

Comment: One commenter asked if the Mobile Crisis Response and Crisis stabilization will be updated in Rule 132.

Response: In parallel with this waiver, the State is examining Rule Reform and will take these suggestions into consideration.

Comment: One commenter suggested some guiding principles for rule reform including:

- Provide flexibility to providers in terms of staffing composition, treatment setting, and service provision. This will allow providers to craft services based on their clients' needs rather than the requirements of Illinois administrative rules;Simplify and streamline documentation, assessment, and prior authorization requirements;
- Limit the frequency of reassessments and treatment plan reviews;
- Promote the integration of mental health and substance use disorder treatment, as well as the integration of behavioral health and primary care;
- Reflect the new managed care environment and allow value-based payment models;
- Incentivize treatment for the hardest to serve such as those diagnosed with severe and persistent mental illnesses, who are experiencing homelessness or who have criminal justice backgrounds;
- Consider all opportunities under the Medicaid Rehabilitation Option to design and deliver services needed by the diverse population served under this benefit;
- Allow all licensed mental health providers including but not limited to social workers, licensed counselors, psychologists, and psychiatrists to bill for behavioral health services and make this billing process as straightforward and timely as possible; and,
- Allow for same day billing and for certain populations such as those receiving ACT team services to engage in other helpful treatment options, such as psychosocial rehabilitation.

Response: The State thanks the commenter for these suggestions. In parallel with this waiver, the State is examining Rule Reform and will take these suggestions into consideration.

Comment: One commenter urged the State to continue promulgating rules that allow licensed clinical social workers to bill Medicaid for services provided as well as fee schedules associated with care coordination and screening provided within reproductive health care settings

Response: As of January 1, 2017, licensed clinical social workers will be able to directly bill Medicaid.

C.22: COMMENTS AND RESPONSES FOR STATE PLAN AMENDMENTS

Comment: Multiple commenters requested the opportunity to provide input on State Plan Amendments, alluding to the Health Home SPA in particular.
Response: The State thanks the commenter for this comment. The public comment period is exclusively for the 1115 waiver. However, as the State designs integrated health homes, it intends to seek the input of stakeholders across (members, families, providers, payers, etc.) the State as co-designers of the model.

Comment: Multiple commenters noted that 99-480 expressly extends protections to the Public Aid Code. "Notwithstanding any other provision of this Code to the contrary, on or after July 1, 2015, all FDA approved forms of medication assisted treatment prescribed for the treatment of alcohol dependence or treatment of opioid dependence shall be covered under both fee-for-service and managed care medical assistance programs for persons who are otherwise eligible for medical assistance under this Article and shall not be subject to any (1) utilization control, other than those established under ASAM patient placement criteria, (2) prior authorization mandate, or (3) lifetime restriction limit mandate." Thus, the waiver and state plan amendments should not be limited to expansion of methadone or injectable naltrexone – all FDA approved forms of MAT should be included.
Response: Details on the MAT State Plan Amendment are beyond the scope of this waiver. The injectable naltrexone is a pilot for justice-involved individuals before release from facilities.

Comment: One commenter had questions regarding the data and information used to justify the SPAs:

- How many potential children/families would benefit?
- How do the new services in the SPAs link with existing services provided for DCFS children and families—both children in care and intact families at risk of child placement?
- How does the State project that the services will reduce the number of children who are left beyond medical necessity in psychiatric hospitals?
- How does the State project that the services will reduce the number of children whose parents seek custody relinquishment in order that their child can receive necessary services?
- Is there recognition in any of the SPAs of the need to broaden the focus of clinical care to acknowledge the role of trauma and the need to address the impact of trauma to stabilize families?

Response: The State thanks the commenter for these questions and notes that this the public comment process for the 1115 waiver.

Comment: One commenter asked which benefits will not be pursued through the SPA in the Coverage of Behavioral Health Services for Children, Youth and Youth Adults with Significant Mental Health conditions and what the rationale for not pursuing this is.
Response: The State has submitted SPAs for the CANS, ANSA, crisis stabilization, mobile crisis response, health homes (though it intends to update this with the support of llinois stakeholders), and MAT.

Comment: One commenter asked clarification on Section 1.2.4.1, in particular:

- What uniform screening and assessment tools are going to be used?
- Will these tools and gathered data mesh with the electronic records providers currently utilize or will they require a new system?
- Will funds be provided to assist providers in transitioning to these systems?

Response: The State has SPAs for the CANS and ANSA assessments. The State understands that training will be needed for providers and MCOs as the behavioral health system is transformed. EHR interoperability is being explored.

Comment: One commenter urged the Sate to dramatically increase access to other MAT products, including Probuphine, in order to meet the needs of beneficiaries as envisioned in Public Act 99-480.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter requested that the waiver include "the need to assess with providers the true costs of new components of the children's system" and asked if the state will provide the necessary training and development for the use of the Medicaid CANS tool.
Response: The State understands that training will be needed for providers and MCOs as the behavioral health system is transformed.

Comment: One commenter noted that member assessments should also be evidence-based and validated with similar populations, as well as applied across all providers and MCOs. The commenter encouraged the State to leverage existing assessments, such as the CANS and ANSA assessment tools developed by the University of Chicago and the Metropolitan Healthcare Council or the federal CMS' Continuity Assessment Record and Evaluation (CARE).
Response: The State has SPAs for the CANS and ANSA assessments.

C.23: COMMENTS AND RESPONSES FOR ROLE OF MCOS

Comment: One commenter requested clarification regarding the current role of MCOs in addressing the behavioral health needs of the people in their care.
Response: Illinois has carved behavioral health into managed care. MCOs are responsible for whole-person care and outcomes.

Comment: One commenter stated that since Illinois is a carve-in state with behavioral health carved into managed care, all policies need to be operationalized through MCOs.
Response: The State agrees that MCOs are essential partners in achieving the behavioral health vision. Many operational details will be worked through as this process progresses.

Comment: One commenter stated that there is no assurance that any Information Technology system changes will be compatible with MCO systems.
Response: The State appreciates this comment.

Comment: Multiple commenters stated that the role of MCOs needs to be clarified so that it is clear how they are accountable under the waiver. One commenter highlighted a belief that a disconnect exists in that an inherent goal of managed care is to reduce spending through the denial or restriction of services while this waiver proposal seeks to enhance service availability, access, and offerings in order to improve client outcomes and to promote successful recovery.
Response: The State believes that MCOs are essential partners in achieving the behavioral health vision and will be collaborating closely with them to optimize outcomes and value while ensuring accountability.

Comment: One commenter suggested that there will need to be continued oversight of MCOs to gain provider participation and to inspire confidence in the process.
Response: The State believes that MCOs are essential partners in achieving the behavioral health vision and will be collaborating closely with them to optimize outcomes and value while ensuring accountability.

Comment: Multiple commenters urged the State to involve both providers and MCOs in the development and implementation of IHHs.
Response: The State intends to involve both providers and MCOs in the development and implementation of IHHs.

Comment: One commenter requested the role of MCO's in the new system and when details of expansions to other areas of the State will be available.
Response: The State believes that MCOs are essential partners in achieving the behavioral health vision and will be collaborating closely with them to optimize outcomes and value while ensuring accountability.

Comment: One commenter recommended that MCOs be required to demonstrate competency, tying performance benchmarks to bonus payments from the State into the algorithm that is used to auto-assign members to plans.
Response: The details of the auto-assignment algorithm are beyond the scope of this waiver.

Comment: One commenter cautioned the State that IHHs could have unintended consequences, leaving community mental health agencies without contracts or Medicaid revenue and could result in reimbursement rate cuts.
Response: The State thanks the commenter for this comment.

Comment: Multiple commenters noted that the waiver's reference to ensuring best practices is vague and requests clarity on the role of MCOs in ensuring best practices.
Response: It is the State's intention that HFS maintain a proactive role throughout the implementation of the waiver and the plan for transformation.

C.24: COMMENTS AND RESPONSES FOR RISK SELECTION

Comment: One commenter suggested to be careful when considering creating a behavioral health system that promotes the selection of clients for services which are most likely to attain a successful program of recovery. Providers should not be pressured or given incentives to "cherry pick" clients who are most likely to succeed with treatment expectations.
Response: The State agrees that providers should not be incentivized to select clients who are most likely to succeed over those with the greatest needs. Many operational details for waiver benefits and initiatives are still being defined and the State intends to take great care to avoid the wrong incentives for providers.

C.25: COMMENTS AND RESPONSES FOR UNINTENDED CONSEQUENCES

Comment: One commenter recommends that the transformation team should consider the preservation of community assets and investments, where significant resources, time, and efforts have been devoted to building and developing behavioral health services. Another warned not to harm community partnership efforts as unintended consequences could occur resulting in overburdening community entities, such as police departments, hospitals, clinics, shelters and crisis response programs.
Response: The State has sought to factor this into the behavioral health strategy but would welcome any specific examples of risks the commenter foresees.

C.26: COMMENTS AND RESPONSES FOR POPULATION FOCUS

Comment: One commenter requested the State expand the focus of the waiver to those at high-risk (e.g., those born prematurely or those born drug exposed).
Response: The State thanks the commenter for this suggestion and has included home visiting for children born with withdrawal symptoms.

Comment: One commenter stressed the importance of addressing the mental and behavioral health needs of children and youth, stating a belief that this will provide a high societal return.
Response: The State agrees that focusing on children in addition to adults is essential. The State believes that many of the benefits and initiatives in the waiver apply equally to children and adults. Further, there are some benefits that are exclusive to children (e.g., intensive in-home services, respite care).

C.27: COMMENTS AND RESPONSES FOR OTHER POPULATIONS

Comment: Multiple commenters requested the waiver cover services for all children, not only those in the Medicaid program.
Response: This is a Medicaid waiver and this comment falls outside of the scope of the waiver.

Comment: One commenter asked what happens to those with spend down or dual eligibility with Medicaid/Medicare.
Response: The waiver benefits and initiatives are focused on all Medicaid enrollees to the extent that the members fall within the eligibility criteria.

Comment: One commenter requested that the State allow opportunities for qualified providers to manage care or take risk for non-mandatory Medicaid populations of children such as those enrolled in DCFS, DSCC, and SSL.
Response: The State is actively considering similar measures at present. This would be done outside the context of this waiver.

Comment: One commenter urged HFS, collaborating State agencies, and participating service providers to integrate health care, behavioral health and long-term services and supports for older adults with multiple chronic health conditions and functional impairments who reside in community-based settings and in long-term care facilities.
Response: This waiver is focused on behavioral health and the integration of physical and behavioral health. To the extent that members with behavioral health conditions overlap with the LTSS population, this waiver will enhance support provided to them through more robust behavioral health services and ensuring that all services they receive are integrated within the context of a health home.

Comment: One commenter encouraged the state to support those trying to overcome the psychological trauma of violence through the proposal targeted interventions.
Response: The State thanks the commenter for this comment and recognizes the importance of addressing trauma and the impact of violence. Services in the waiver as well as services rolled out through SPAs (e.g., IHHs) aim to take a person centered, trauma informed approach to care to address these issues.

Comment: One commenter suggested that the waiver include social benefit indicators such as habilitation, preventative health services, skill development, employment, transportation, and housing supports.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested that the community-based supports and services that are available to seniors and those with a physical disability should be just as available to those with a behavioral health diagnosis.

Response: The State thanks the commenter for this suggestion.

Comment: Multiple commenters highlighted the need for continued State-funded behavioral health grants as many Illinoisans will continue to be uninsured and underinsured.
Response: The State thanks the commenters for this suggestion and understands that there will still be uninsured and underinsured Illinoisans. The waiver does not impact resources for programs targeted at these populations.

C.28: COMMENTS AND RESPONSES FOR OTHER INITIATIVES

Comment: One commenter requested the status of an application for the 1915k Medicaid plan.
Response: The State does not plan to pursue a 1915k. It is focused on this waiver.

Comment: One commenter suggested the State include an intention to join a national Medicaid initiative focused on children with medical complexity.
Response: The State does not believe the waiver is the appropriate venue for such a commitment.

Comment: Multiple commenters requested a separate pilot program for fetal alcohol spectrum disorder.
Response: The State thanks the commenter for this suggestion.

C.29: COMMENTS AND RESPONSES FOR OTHER COMMENTS

Comment: One commenter recommended the State consider all chronic conditions when discussing the concept of whole-health care (e.g., exhibit 24).
Response: The State notes that whole-person care is a priority and that exhibit 24 only shows select illustrative examples.

Comment: One commenter requested clarity on how 10 percent of the population can receive behavioral health services without a diagnosis.
Response: The State thanks the commenter for this question; rather than going into great methodological detail the State has removed this exhibit from the waiver.

Comment: One commenter said that the State should be able to display cost-savings associated with the program and not place financial burdens on Illinoisans through increased cost-sharing.
Response: The waiver does not increase cost-sharing.

Comment: One commenter submitted many specific line-edit and word suggested revisions to the waiver, documented by page number.
Response: Many of the suggested revisions were incorporated in the updated version.

Comment: One commenter suggested the State create or leverage existing Behavioral Health Collaboratives/Networks around common needs such as transportation, alternative service models, etc. to pool resources and implement new models for patient services.
Response: The State thanks the commenter for this suggestion

Comment: One commenter suggested the State review ways in which groups can collaborate to reduce the duplication and overhead.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter requested clarification on the overlap and conflict of what is in the N.B. lawsuit settlement and the planned children's services in the waiver or state plan amendments.
Response: The State is currently developing an implementation plan for the N.B. settlement.

Comment: One commenter suggested that the waiver should allow for smaller demonstration projects around the state for those projects that the Federal CMS is not willing to allow statewide initially.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested that the state should pursue a designated mental health assisted living/supportive living facility as a pilot waiver program.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter proposed the development of assertive community based aftercare services for post discharge inpatient children/adolescents.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested changing the program description in Section 1.1 of the waiver to be clearer by changing the line on page 2 to state "reduce the risk that individuals with behavioral disorders will be violent crimes victims, perpetrate violent crimes, or face encounters with police that may become violent."
Response: The State thanks the commenter for this suggestion.

Comment: One commenter highlighted that the waiver proposal does not specify fund Designated State Health Programs that include health services provided through the Illinois Sate Board of Education. The commenter urges youth over 14 to have their educational needs explored with academic assessments with the goal of returning to school or obtaining a GED.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter recommended that the waiver services be a "person-driven long-term support system in which people with disabilities and chronic conditions have choice, control and access to a full array of quality services that assure optimal outcomes, such as independence, health and quality of life."
Response: The State thanks the commenter for this suggestion.

Comment: One commenter urged caution about over-regulating and excessive monitoring as this can result in higher rates both at the State and provider level.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested that needs to be careful oversight of pilot projects that already in place or in the future that fully evaluate cost analysis and long-term sustainability.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter requests that the State clearly distinguishes residential settings from PRTFs as residential care settings are lumped into psychiatric hospital numbers in many states.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter urged caution about using "conflict free' case management as it often eliminated providers who know the systems and community needs.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested that contract and regulatory requirements between systems at all levels need to be more flexible for clients to move across systems and programs to work with the needs of clients.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter highlighted that the state should focus on true impact and long-term sustainability rather than only focusing on the demonstration period.
Response: The State believes the waiver demonstration is part of the critical path to long-term sustainability but is certainly focused on sustainability and not only the demonstration period.

Comment: One commenter sought clarification of the status of the Health Information Exchange and what role this may, if any, play in the Demonstration waiver.
Response: The State notes that this is beyond the scope of the waiver.

Comment: One commenter asked what a "social service neighborhood" is (Section 1.2.3).
Response: The State uses this to refer to the full spectrum of services with which members interact.

Comment: One commenter asked how oversight for higher-acuity services would be different from the way it has been in the past under CCEs which the commenter described as "problematic."
Response: The State believes that MCOs are essential partners in achieving the behavioral health vision and will be collaborating closely. As the State is primarily concerned with

outcomes for its members, MCOs will be held accountable for outcome measures to be defined through the detailed design process.

Comment: One commenter cautioned against using self help group participation as a measure for social connectedness.
Response: The State notes that this is a reference to what is currently being done. Various other measures will be considered as the waiver benefits are operationalized.

Comment: One commenter asked for the State's overall assessment of the implementation of Medicaid services detailed in the N.B. settlement and the references services that will be detailed in the State plan amendments.
Response: The State is currently developing an implementation plan for the N.B. settlement.

Comment: One commenter requested that the demonstration eligibility for medical necessity, in particular related to trauma, be clarified to include the difference between implications for children versus adults.
Response: The State thanks the commenter for this suggestion.

C.30: COMMENTS AND RESPONSES FOR REQUEST FOR INVOLVEMENT

Comment: Multiple commenters applauded the State on the cross-agency collaboration of this work and noted it has created an unprecedented opportunity in the State to create cohesion and unify efforts to promote effectiveness and efficiencies across systems.
Response: The State intends to continue its cross-agency approach.

Comment: One commenter offered assistance to work with the State in looking at how it is using Medicaid managed care to ensure that it can capitalize on the expertise of community providers.
Response: Many of the benefits, initiatives, and other core components of the behavioral health strategy (e.g., integrated health homes) will require detailed design. The State intends to fully leverage the experience and knowledge of the Illinois stakeholder community for this design and has and will continue to convene focused working groups for this purpose. It appreciates the stakeholder community's willingness to participate in this process.

Comment: One commenter recommended the State bring housing, employment, and Medicaid providers together to ensure any new rules do not create duplication of case management services provided through Medicaid, but rather that the services are all integrated and work together (rather than operating as separate siloed services).
Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested that the transformation team has properly included a wide range of State public serving Departments, but for the transformation to have the greatest impact and chance of success, it is critical to recognize that local communities have similar entities that must be taken into account when building a local system of care.
Response: The State is grateful for and mindful of the essential role played by local agencies. The behavioral health strategy has already benefited from input of similar organizations to date, and the State hopes to continue to obtain insights from such actors throughout the detailed design process and certainly as critical stakeholders in implementation.

Comment: Multiple commenters offered their assistance and support to the State as the waiver is finalized and implementation plans are developed.
Response: Many of the benefits, initiatives, and other core components of the behavioral health strategy (e.g., integrated health homes) will require detailed design. The State intends to fully leverage the experience and knowledge of the Illinois stakeholder community for this design and has and will continue to convene focused working groups for this purpose. It appreciates the stakeholder community's willingness to participate in this process.

Comment: Multiple commenters highlighted the importance of continued feedback and involvement with all key stakeholders going forward and requested the following:

- Transparency and input from the provider community on any potential SPAs and rule changes;
- Establishing a working committee of State officials, behavioral and general health providers, as well as all other stakeholders;
- Provide public reports on evaluation metrics on a regular basis;
- Seek more in-depth and qualitative responses from impacted Medicaid beneficiaries beyond the CAHPS survey; and,
- Specific stakeholder involvement in the development of a comprehensive behavioral health system for children and youth;

Response: Many of the benefits, initiatives, and other core components of the behavioral health strategy (e.g., integrated health homes) will require detailed design. The State intends to fully leverage the experience and knowledge of the Illinois stakeholder community for this design and has and will continue to convene focused working groups for this purpose. It appreciates the stakeholder community's willingness to participate in this process.

Comment: One commenter requested to work together with the Department and other statewide organizations to:

- Provide an effective use of hospitals' emergency departments by developing a continuum of crisis intervention services, such as crisis stabilization centers and home-based counseling services;
- Improve assessments of Emergency Department patients to get them to the right care and effectively facilitate transition of car;
- Expand access to inpatient Psychiatric service in southern Illinois to meet current and future projected demand through partnerships;
- Coordinate care for patients and their families who navigate through the service delivery system;
- Expand access to integrated behavioral health services;
- Identify a centralized patient access system to ensure patients receive the right level of care at the right time and in the right setting (in-patient, out-patient, treatment, tele-psychiatry, counseling, prevention);
- Utilize community-based mental health centers, substance abuse providers, home health agencies and others to track and monitor patients with chronic conditions to keep them out of crisis;
- Facilitate intake process and case management through use of electronics and technology; and,

- Strengthen mental health infrastructure and bring together mental health, behavioral health, and substance abuse services.

Response: The State thanks the commenter for their interest.

Comment: One commenter recommended to involve a group of providers in planning a re-design of the funding streams within the region and to following a patient through the behavioral health system.
Response: The State thanks the commenter for this suggestion.

Comment: One commenter suggested their organization is ready to provide educational tools to help physicians understand and implement health homes through their extensive experience in medical education.
Response: The State thanks the commenter for this offer and intends to involve stakeholders in the design and development of IHH during which this expertise will be greatly appreciated.

Comment: One commenter requested more information on the savings anticipated through value-based reimbursements and the estimated savings attributed to value-based reimbursements.
Response: The State would refer the commenter to Section 6 of the waiver application.

Comment: One commenter offered to share their current system of data collection with the State to support it in determining the true value of services provided.
Response: The State thanks the commenter for this offer.

Comment: One commenter asked if the workgroups will continue following federal government approval.
Response: Yes, the State intends to continue the workgroups through the detailed design phase.

Comment: One commenter asked if the State will make decisions on how concepts are moved forward or if workgroups will inform the decision-making process as well.
Response: The State is accountable but intends to leverage the collective knowledge and experience of Illinois stakeholders in the highest value way possible.

Comment: One commenter urged the state to include MCOs in the development of new programs and payment methodologies they will be responsible for covering as the current type of providers will have to be registered to the IMPACT system and billing codes and fee schedules will have to be developed in advance of these programs being implemented.
Response: The State has and will continue to collaborate with its MCOs to maximize outcomes for Medicaid members.

Comment: One commenter requested involvement in the determination of what providers are qualified to do children's behavioral health assessments.
Response: The State thanks the commenter for their interest.

Comment: One commenter requested clarification on how stakeholder involvement will occur and asked if the State should not already be working with the stakeholder community on Rule 132 together now.
Response: Rule 132 is beyond the scope of this waiver. The will follow the JCAR process as all administrative rule changes require.

Comment: One commenter expressed interest in providing comments on the detailed financial assumptions and requested that details on the savings assumptions and how the federal funding will be allocated to various HHS transformation initiatives will be shared publicly.
Response: The State thanks the commenter for their interest.

Comment: One commenter urged the State to work with other states that can offer "lessons learned" and provide input into how Illinois can leverage evidence-based designs and models of care in our own redesign efforts.
Response: The State has and will continue to learn lessons from other States.

We welcome any comments, data, views or arguments concerning these proposed changes. All comments not provided at the hearing must be in writing and received by September 26, 2016, and addressed to:

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