State of Illinois Response to Mid-Point Assessment Feedback

Questions	
1. The report notes that two of the milestones which have incomplete action items have been delayed partly due to delays in passing updates to Rule 2060. Does the state have any further information on this delay? For example, has Rule 2060 been passed, or is there an updated estimate for when it may be passed?	The state (SUPR) does not contract for Medicaid funds. When these milestones were originally developed, SUPR planned to merge the State Medicaid Rule (Part 2090) into Administrative Rule Part 2060. It was subsequently decided to focus only on the licensure components of Part 2060 and leave Part 2090 as the singular Medicaid Rule for SUD services. Therefore, SUPR will amend Part 2090 upon adoption of Part 2060. It is anticipated that the revision process for Part 2090 will begin in late 2023. Furthermore, case management, clinically managed withdrawal, providers offering MAT on-site or facilitating off-site, and the implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays are all required in the contracts between SUPR and providers throughout the state. Therefore, these services should already be in place despite the delay in passing/updating Rules 2060 and 2090.
2. No stakeholder feedback was included in this assessment, nor has the state completed a provider availability assessment. The report notes that "due to the timeline of this report, provider availability, and the closure of several provider agencies, the state did not pursue stakeholder interviews or provider availability assessments. We hope to be able to conduct these for inclusion into future reports". Could the state further expand on why neither of these were possible to conduct, and outline its plans and estimated timeline to complete these?	During the COVID-19 pandemic, several agencies were closed and did not provide services for several months to a year. Therefore, the state was unable to conduct stakeholder interviews with these providers who were slated to implement the pilot programs for the demonstration. Due to the passage of time and high rates of staff turnover, many staff who were present when the demonstration pilots began are no longer with the agencies. Therefore, we believe that it will not be possible to conduct stakeholder interviews with staff who could speak about the benefits and challenges of the pilot programs at this time. Regarding the provider availability assessment, similar barriers were encountered. The high rate of staff turnover due to the COVID-19 pandemic and subsequent shutdown have impacted provider availability in unanticipated ways.

Suggested Revisions	
1. We noticed that the introduction to the report incorrectly lists the approval date as August 13, 2021 (page 3). The demonstration was issued approval on May 7, 2018, with an effective date of July 1, 2018.	The date listed was the approval date of the evaluation plan. This has been updated to the approval date for the demonstration.
2. Many of the directionality goals for metrics listed in the report appear to be different from those outlined in the approved Monitoring Protocol. • Specifically, the targets for Metrics #8, 22, 12, and S2 are listed as "consistent," but the state's approved Monitoring Protocol has the target listed as "increase".	Metrics 8, 22, and S2 were updated to "increase" as listed in the state's approved Monitoring Protocol. Metric 12 was already listed as "increase."
3. Many of the metrics with "consistent" as a goal or observed directionality are incorrectly noted. If there is less than a 2% change in a metric, the directionality observed is "consistent"; otherwise, the directionality is noted as either "increase" or "decrease". These should be revised to accurately reflect progress made towards the respective metric goals. • Metrics #9, 10, and 23 have a goal of "consistent" but the observed directionality was "decrease." • Metrics #2 and 4 have a goal of "increase" but the observed directionality was "consistent." • Metrics # 29 and 31 have a goal of "consistent" but the observed directionality was "increase."	All of the bullets provided in the feedback are what was listed in the report. We assume CMS is requesting we revise the "Yes" or "No" listed under the Progress column; and if so, we have changed Metrics 2, 4, 29, and 31 from Progress "Yes" to "No." For metrics 29 and 31, please see the highlighted rationale on page 25 that describes why an increase was seen rather than maintaining consistency. We did not update metrics 9, 10, and 23 because we believe progress was made for the following reasons: • A decrease in the number of beneficiaries who used Intensive Outpatient and Partial Hospitalization Services (metric 9), and Residential and Inpatient Services (metric 10) was listed as Progress: "Yes" because of the sharp increase in less costly services, such as Outpatient Services (increased by 71.1%) and Medication-Assisted Treatment (increased by 52.7%). Please see our description and rationale highlighted in section C1f on page 22. • Metric 23 was listed as Progress: "Yes" because a decrease in Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries is a positive

	development since we would rather have those diagnosed with SUD utilizing outpatient services rather than a more costly service such as the emergency department.
4. On page 23 of the report, the assessor listed nine action items for Milestone #1, eight of which were complete (89 percent). However, based on pages 13–15 of the report, CMS believes the milestone is associated with 11 action items, eight of which were complete (73 percent). This would also change the risk of not meeting the milestone from "low" to "medium" risk.	Milestone #1 has been updated to reflect this change.
5. Finally, we would encourage the state to make note of any actions that are being taken to implement incomplete action items, and/or which might positively affect the trends of metrics which are not yet trending in the hypothesized directions. This could come in the form of state responses added in the "next steps" section and could include updates or estimated timelines.	Milestone 1 was changed from low risk to medium risk due to the change in the number of action items suggested in #4 above. However, all of these items are related to the delay in the passage of rule 2060. Milestone 2 was changed from low risk to high risk due to the decrease in one metric (50% of metrics achieved and 0% of action items. We believe the decrease in metric 5 (treated in an IMD for SUD) likely decreased due to the closure of several IMDs during the COVID-19 pandemic. The action item was again related to Rule 2060. Therefore, the independent assessor does not have any recommended actions beyond passing Rule 2060. Milestone 3 and 6 remained at medium risk and Milestones 4 and 5 remained at low risk. The independent assessor feels that all the milestones that are not in the "low risk" category are at risk due to the delay in the passage of Rule 2060/2090 and these will all move into the "low risk" category when changes. Therefore, the recommendations and next steps are still valid and were not updated.

Illinois Behavioral Health Transformation Section 1115(a) Demonstration
Mid-Point Assessment Report

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Contents

A. General Background Information

1. Demonstration Information

The Illinois Behavioral Health Transformation Section 1115(a) Demonstration was approved on May 7, 2018 by the Centers for Medicare and Medicaid (CMS). This demonstration addresses Substance Use Disorder (SUD) in Illinois. Specifically, the goal of the Residential and Inpatient Treatment for Individuals with SUD Pilot is for the state to maintain critical access to opioid use disorder (OUD) and SUD services and continue delivery system improvements for these services to provide more coordinated and comprehensive OUD/SUD treatment for Medicaid beneficiaries. The demonstration began on July 1, 2018 and this mid-point assessment reviews progress between the start of the demonstration and the most recent quarterly reporting period (Q2 of 2021).

2. Description of the Demonstration's Policy Goals

The State of Illinois listed 10 milestones in the Special Terms and Conditions. These include:

A. Access to Critical Levels of Care for OUD and other SUDs: Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval.
B. Use of Evidence-based SUD-specific Patient Placement Criteria: Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval.
C. Patient Placement: Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval.
D. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities: Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in the Illinois administrative code and the Division of Substance Use Prevention and Recovery (SUPR) contractual provider manual. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval.
E. Standards of Care: Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval.

F. Standards of Care: Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval.
G. Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for OUD: An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT, within 12 months of SUD program demonstration approval.
H. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD: Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.
I. SUD Health IT Plan: Implementation of the milestones and metrics as detailed in STC 27.
J. Improved Care Coordination and Transitions between Levels of Care: Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

Updates on metrics are provided in section C.1.c. of this report and updates on implementation plan action items are provided in section C.1.d. Under this demonstration, there is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan. All affected groups derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable.

Pilot demonstration start dates are listed in the table below. Pilots 1-4 began in 2018 and 2019 and are currently ongoing. The Crisis Intervention Services pilot has been under development and delayed due to provider participation and availability (pilot 5). The Evidence-Based Home Visiting Services pilot (pilot 6) was dropped as a waiver pilot with plans to incorporate into state plan service. Pilots 7 and 8 will be moved to the new 1115 Healthcare Transformation Application (HTA) waiver, and pilots 9 and 10 were moved to the 1915(i) State Plan Amendment – Pathways to Success.

Service Name	**Start Date**	**Status in 1115**
1. SUD Implementation Protocol featuring up to 30 Day IMD Funding	7/1/2018	Ongoing
2. Clinically Managed Withdrawal Management Services Pilot	2/1/2019	Ongoing
3. SUD Case Management Pilot	2/1/2019	Ongoing
4. Peer Recovery Support Services Pilot	2/1/2019	Ongoing
5. Crisis Intervention Services Pilot	N/A	Implementation delayed
6. Evidence-Based Home Visiting Services	N/A	Planned to move to State Plan Service

7. Assistance in Community Integration Services	N/A	Transitioned to 1115 HTA waiver
8. Supported Employment Services	N/A	Transitioned to 1115 HTA waiver
9. Intensive In-Home Services	N/A	Transitioned to 1915(i)
10. Respite Services	N/A	Transitioned to 1915(i)

B. Methodology

1. Data Sources Used

The majority of the metrics use Medicaid claims data accessible from the Enterprise Data Warehouse housed at the Illinois Department of Healthcare and Family Services (HFS). For metrics Q1-Q3 the data were gathered from the Illinois Prescription Monitoring Program (PMP). In addition to these data, emergency department visits were provided by using a combination of Medicaid claims data and overdose data provided by the Illinois Department of Public Health.

2. Analytic Methods

Different timelines and calculations were used for the metrics, depending on what has been reported to CMS previously in quarterly reports. The same calculations were used to maintain consistency and are described below. Progress was assessed by subtracting the mid-point average/rate from the baseline rate and comparing the increase, decrease, or consistency with the state's demonstration target. Consistency was considered a change of less than +/-2%. Both the count change and percent change are provided in section C.1.

Quarterly metrics for the baseline are reported from quarter 1 demonstration year 1, which began July 1, 2018 and ended September 30, 2018. Note that the PMP quarterly metrics (Q1, Q2, and Q3) are reported for quarter 3 of state fiscal year/demonstration year 1 because the PMP had not yet started reporting data until this time. PMP data is from January 1, 2019 through March 31, 2019. The mid-point for all quarterly metrics is April 1, 2021 through June 30, 2021 (Q4 of demonstration year 3). All quarterly metrics are reported by the average across the quarter with a few exceptions. The total number of beneficiaries was used for Early Intervention since this program had not begun during the baseline reporting quarter. The total number of people was also used for Q2 and Q3, PMP Queries within EHRs and MAT Users Connected to Recovery Services, through the Prescription Monitoring Program (PMP), but the average was reported for the number of users.

For Annual Established metrics, all metrics are reported by calendar year. Baseline is January 1, 2018 through December 31, 2018 and mid-point is January 1, 2021 through December 31, 2021. For all of the Annual Established metrics, the rate of beneficiaries was used. There were changes that impacted metrics 18-20 during this time period. These are explained in section C.1.h. "Changes in Technical Specifications and Metrics."

For Other Annual Metrics, all metrics are reported by state fiscal year. Baseline was July 1, 2018 through June 30, 2019 and mid-point was July 1, 2020 through June 30, 2021. Metrics 28-31 used the total spending across quarters. Metrics 4, 5, 13, and 14 included the total number of beneficiaries or providers and metric 26 was the count of people who died from an overdose. Average rate and length of stay was used for metrics 25, 27, and 36.

3. Assessment of Overall Risk of Not Meeting Milestones

Milestones were assessed using the metric data and implementation plan action items. The metric data was gathered from the Enterprise Data Warehouse that houses Medicaid claims data in Illinois, and progress was assessed from baseline to the mid-point. The number of yes/no responses for each metric were summed and entered into the table in section C.2.

The implementation plan action items were examined for progress from the beginning of the waiver to the most current information available. They were assigned either completed, open, or suspended in section C.1.d. The total number of action items that were completed divided by the total number was entered into the table in section C.2. Using both the percentage of metrics that showed progress and the completed implementation plan action items, milestones were given a risk of low, medium, or high.

4. Limitations

Stakeholder interviews and provider availability assessments were not conducted for this report. HFS and the independent evaluator worked closely with the Department of Substance Use Prevention and Recovery (SUPR) at the Illinois Department of Human Services to update the implementation plan action items. However, due to the timeline of this report, provider availability, and the closure of several provider agencies, the state did not pursue stakeholder interviews or provider availability assessments.

C. Findings

1. Progress Towards Demonstration Milestones

The following tables contain 3 types of metrics: quarterly, annual established metrics, and other annual metrics. Annual metrics are color-coded for identification purposes since the timeline of data reported is unique.

- Quarterly metrics
- Annual established metrics
- Other Annual metrics

a. Critical Metrics by Milestone

Milestone 1: Access to critical care levels of care for OUD and other SUDs

Metric #	Metric Name	Monitoring metric rate or count				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		At baseline	At mid-point	Absolute change	Percent change			
7	Early Intervention (total)	0	73	73	100%	Consistent	Increase	Yes
8	Outpatient services	22,093	25,875	3,782	71.1%	Increase	Increase	Yes
9	Intensive Outpatient and Partial Hospitalization Services	2,340	2,171	-169	-7.2%	Consistent	Decrease	Yes
10	Residential and Inpatient Services	3,995	3,855	-140	-3.5%	Consistent	Decrease	Yes
11	Withdrawal Management	989	811	-178	-18%	Increase	Decrease	No
12	Medication-Assisted Treatment	11,988	18,309	6,321	52.7%	Increase	Increase	Yes
22	Continuity of Pharmacotherapy for Opioid Use Disorder	0.259	0.356	0.097	37.6%	Increase	Increase	Yes

Milestone 2: Use of evidence-based, SUD-specific patient placement criteria

Metric #	Metric Name	Monitoring metric rate or count				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		At baseline	At mid-point	Absolute change	Percent change			
5	Medicaid Beneficiaries Treated in an IMD for SUD	10,037	9,516	-521	-5.19%	Consistent	Decrease	No
36	Average Length of Stay in IMDs	11.01	12.58	1.57	14.26%	Stabilize to no more than 30 days	Increased, but does not exceed 30 days	Yes

Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities does not have any critical metrics.

Milestone 4: Sufficient provider capacity at each level of care

Metric #	Metric Name	Monitoring metric rate or count				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		At baseline	At mid-point	Absolute change	Percent change			
13	SUD Provider Availability	87,802	117,680	29,878	34.03%	Consistent	Increase	Yes
14	SUD Provider Availability – MAT	2,967	3,963	996	33.57%	Increase	Increase	Yes

Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

Metric #	Metric Name	Monitoring metric rate or count				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		At baseline	At mid-point	Absolute change	Percent change			
18	Use of Opioids at High Dosage in Persons Without Cancer	15.098	1.602	-13.496	-89.39%	Decrease	Decrease	Yes
19	Use of Opioids from Multiple Providers in Persons without Cancer	50.418	1.800	-48.618	-96.43%	Decrease	Decrease	Yes
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer	1.866	0.067	-1.799	-96.41%	Decrease	Decrease	Yes
21	Concurrent Use of Opioids and Benzodiazepines	21.420	16.380	-5.040	-23.53%	Decrease	Decrease	Yes
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries (average rate across quarter)	4.27	3.31	-0.96	-22.5%	Consistent	Decrease	Yes
27	Overdose Deaths (rate)	0.74	0.93	0.19	25.03%	Consistent	Increase	No

Milestone 6: Improved care coordination and transitions between levels of care

Metric #	Metric Name	Monitoring metric rate or count				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		At baseline	At mid-point	Absolute change	Percent change			
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Refer to S1-S8						

17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence	Refer to S9-S10						
25	Readmissions Among Beneficiaries with SUD	0.26	0.26	0.00	0.00%	Consistent	Consistent	Yes

b. Other Monitoring Metrics

#	Metric Name	Monitoring metric rate or count				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		At baseline	At mid-point	Absolute change	Percent change			
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	10,515	10,465	-50	-0.48%	Increase	Consistent	No
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	121,225	130,816	9,591	7.9%	Increase	Increase	Yes
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	197,092	197,269	177	0.09%	Increase	Consistent	No
6	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	41,945	49,082	7,137	17.0%	Increase	Increase	Yes
24	Inpatient stays for SUD per 1,000 Medicaid beneficiaries	7.15	6.01	-1.14	-15.95%	Consistent	Decrease	Yes
26	Overdose Deaths (count)	2,663	3,725	1,062	39.9%	Consistent	Increase	No
28	SUD Spending	$1,040,281,744	$1,122,198,609	$81,916,865	7.87%	Increase	Increase	Yes
29	SUD Spending within IMDs	$40,033,205	$51,160,444	$11,127,239	27.80%	Consistent	Increase	No

30	Per Capita SUD Spending	$5,278.15	$5,689	$410.52	7.78%	Increase	Increase	Yes
31	Per Capita SUD Spending within IMDs	$3,988.56	5,376	$1,387.70	34.79%	Consistent	Increase	No
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD [Adjusted HEDIS measure]	0.843	0.837	-0.006	-0.68%	Consistent	Consistent	Yes

c. State-Specific Metrics

Metric #	Metric Name	Monitoring metric rate or count				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		At baseline	At mid-point	Absolute change	Percent change			
Q1	PMP Registered Users	48,980	55,083	6,102	12.46%	Increase	Increase	Yes
Q2	PMP Queries within EHRs	13,286,044	23,229,756	9,943,712	74.84%	Increase	Increase	Yes
Q3	MAT Users Connected to Recovery Services	9,748	14,194	4,446	45.61%	Increase	Increase	Yes
S1	Adjusted Initiation of AOD Treatment - Alcohol abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	58.52%	55.96%	N/A	-2.56%	Consistent	Decrease	No
S2	Adjusted Initiation of AOD Treatment - Opioid abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	63.94%	60.75%	N/A	-3.19%	Increase	Decrease	No
S3	Adjusted Initiation of AOD Treatment - Other drug abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	55.69%	54.9%	N/A	-0.79%	Consistent	Consistent	Yes

S4	Adjusted Initiation of AOD Treatment - Total AOD abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	57.58%	55.61%	N/A	-1.97%	Consistent	Consistent	Yes
S5	Adjusted Engagement of AOD Treatment - Alcohol abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	13.11%	12.26%	N/A	-0.85%	Consistent	Consistent	Yes
S6	Adjusted Engagement of AOD Treatment - Opioid abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	25.56%	24.93%	N/A	-0.63%	Consistent	Consistent	Yes
S7	Adjusted Engagement of AOD Treatment - Other drug abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	12.58%	11.24%	N/A	-1.34%	Consistent	Consistent	Yes
S8	Adjusted Engagement of AOD Treatment - Total AOD abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	15.66%	13.8%	N/A	-1.86%	Consistent	Consistent	Yes
S9	Adjusted - 8-day Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)	11.83%	14.45%	N/A	2.62%	Consistent	Increase	Yes
S10	Adjusted – 31-day Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #3488; Medicaid Adult Core Set; Adjusted HEDIS measure]	17.56%	20.97%	N/A	3.41%	Consistent	Increase	Yes

d. Implementation Plan Action Items

Action Item Number	Implementation Plan Milestone Description	Action Item Description	Date to be completed	Current status (completed, open, suspended)
1.6	Ensure access to OUD and SUD treatment services for Medicaid beneficiaries across a continuum of care.	1) Illinois SUPR staff will issue Medicaid certification and establish all billing procedures.	September 2018	**Completed**
		2) Illinois SUPR staff will amend administrative rules to reflect these changes to services delivered in an IMD.	February 2019	**Open:** Rule 2060 is currently being revised but not completed yet. Update on timeline is needed. In the last stage of final review. Will begin formal process of rule adoption by end of December 2022
		3) Illinois SUPR staff, with input from HFS staff, will evaluate the possibility of increasing the number of providers and /or bed size by July 2020.	July 2020	**Completed:** IMD Pilot started with 13 providers operating 25 Residential IMD programs; today there are currently 10 providers operating 19 IMD programs. Between 2019 and 2020, 6 participating SUD Residential IMD programs ceased operation. In addition, 6 non-IMD Residential facilities closed as well as 6 Adolescent Residential 3.5 programs closed. Through State Opioid Response Funds, Expansion of Recovery Homes services for persons with OUD and are active in some form of Medication Assisted Recovery (MAR), has occurred. Between July 1, 2018 and June 30, 2022 the state added 8 recovery homes with expanded services for persons with OUD. As of March 31, 2022, 945 clients have been admitted to a Recovery Home.

1.7	Peer Recovery Support is not a covered service in the Medicaid State plan, but some funding is provided with Illinois GRF.	4) Illinois SUPR staff will select the provider and have the service fully operational by September 2018. Illinois SUPR staff will amend administrative rules to include a section that includes recovery support requirements for all licensed providers. 5) Illinois SUPR staff, in coordination with IHFS staff, will explore the possibility of expanding providers to continue piloting peer recovery support during treatment.	July 2019 July 2020	**Completed** **Completed:** Peer Recovery Support Services are currently part of the pilot program but will be moving to a Medicaid eligible service. During the 102nd Legislative Session, legislation was passed requiring Healthcare and Family Services to establish SUD Peer Recovery Support Services as a Medicaid Eligible service effective January 1, 2023.
1.8	Case Management for SUD is not a covered service in the Medicaid State plan. This service is funded with Illinois GRF.	6) Illinois SUPR staff will work with designated program licensed providers to identify billing procedure and have the service fully operational. 7) Illinois SUPR staff will amend administrative rules to include a section that includes specification of case management requirements for all licensed providers.	September 2018 July 2019	**Completed** **Open:** Rule 2060 revisions are still in process.

		8) Illinois SUPR staff, in coordination with IHFS staff, will explore the possibility of expanding providers to continue piloting case management for the individuals' diverted into SUD treatment.	July 2020	**Completed:** There are currently two providers (TASC and Family Guidance Center) that deliver Case Management to criminal justice populations under this pilot. These two providers operated 13 site locations across the state of Illinois. No additional providers will be added to this pilot.
1.9	Clinically Managed Withdrawal Management (Level 3.2) is not covered service in the Medicaid State plan. This service is funded with Illinois GRF.	9) Illinois SUPR staff will issue Medicaid certification to all Level 3.2 programs and have providers enrolled and billing. 10) Illinois SUPR staff will start the formal amendment process for administrative rules to reflect these changes by February 2019. Projected effective date of December 2019. 11) Illinois SUPR staff, with input from IHFS staff, will evaluate the possibility of increasing the number of providers.	July 2019 December 2019 July 2021	**Completed:** There are two providers participating in the Clinical Withdrawal Management pilot: South Suburban Council and Greater River Recovery Center. **Open:** Rule 2060 revisions are still in process. **Completed:** A third provider was scheduled to begin Level 3.2 Clinical Withdrawal Management services under the pilot, but to date no additional programs have been added. Due to the COVID-19 pandemic, existing participating providers ceased providing this service level of care.
2.2.1	Utilization management approaches are implemented to ensure that beneficiaries have access to SUD services at the appropriate level of	1) Illinois SUPR staff will start the formal amendment process for administrative rules to reflect these changes by February 2019.	December 2019	**Open:** Rule 2060 revisions are still in process. Language specific to the need to perform retrospective reviews of client records is an anticipated revision. Currently, this is required to be performed quarterly by either Internal Quality Management staff, or an independent Quality

	care and that interventions are appropriate for the diagnosis and level of care and there is an independent process for reviewing placement in residential treatment settings.	Projected effective date of December 2019.		Management contractor. The majority of the Utilization Management activities are performed as part of the Medicaid Managed Care plan responsibilities.
3.3.1	Require all residential treatment providers to offer MAT on-site or facilitate MAT off- site	1) SUPR will enact a policy change within 6 months that require all residential providers to have MAT on-site or a linkage agreement for MAT off-site. 2) Illinois SUPR staff will start the formal amendment process for administrative rules to reflect these changes by February 2019. Projected effective date of December 2019.	December 2019	**Completed:** Effective January 1, 2017, Public Act 99-0553 requires that all SUPR licensed substance use disorder (SUD) treatment organizations provide educational information to patients identified as having or seeking treatment for an opioid use disorder (OUD) that includes the use of medication for an OUD, recognition of and response to an opioid overdose, and use and administration of Naloxone. (Source: SUPR Contractual Policy Manual). **Open:** The revisions to SUPR Rule 2060 are still in the rules review process. The draft Rule 2060 will contain language that specifically requires a provider to directly offer MAT or link with a provider that can deliver MAT.
4.1	Identify and expand, as needed, access to critical levels of care, including MAT for OUD.	1) Based upon the results of all SOAP activities in this area, Illinois will propose methods to address capacity insufficiency and include recommendations for	July 2021	**Completed:** Revisions to the State Opioid Action Plan (SOAP) began in the fall of 2020 and were finalized and approved by the governor on March 21, 2022. 2022 State of Illinois Opioid Action Plan

		redistribution of services no later than July 2021.		
5.1.1	Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse.	1) Continue implementation of the Electronic Health Records into the PMP. DHS will implement technical infrastructure to enroll and give access to licensed delegates within 12 months. 2) The Department of Financial and Professional Regulation (DFPR) will adopt rules for the new continuing education requirement within 12 months. 3) DFPR is currently in the process of implementing rules that will adopt the Federation of State Medical Boards' Guidelines for the Chronic Use of Opioid Analgesics into the Medical Practice Act's rules which govern al Illinois licensed physicians. This should be	Ongoing	**Completed:** **Improved Medical Provider Electronic Health Record (EHR)** IDHS/SUPR is supporting a portion of the PMP's PMPnow campaign, an effort to support improved opioid prescriber reporting in commonly used EHR systems among Illinois medical provider systems. Public Act 100-0564 Effective January 1, 2018, all prescribers possessing an Illinois Controlled Substance license must register with the PMP. On or before January 1, 2021 all EHR systems shall interface with the PMP ensuring all providers have access to specific patient records. **Completed:** Effective 1/1/2019, Public Act 100-1106 requires that prescribers complete 3 hours of continuing education on safe opioid prescribing practices in order to renew a license to prescribe controlled substances. **Completed:** Effective July 6, 2018, IDFPR adopted the Federation of State Medical Board's Guidelines on the Use of Opioids in the Treatment of Chronic Pain.

		completed within 12 months.		
5.1.2	Facilitate Naloxone access statewide and expand Naloxone purchase, training, and distribution services throughout Illinois. Expand coverage of, and access to, Naloxone for overdose reversal.	4) Continue to maintain and expand training on the use of Naloxone and access to overdose prevention treatment and services.	Ongoing	**Completed: 1)** Access Narcan IDHS/SUPR manages the Drug Overdose Prevention Program (DOPP), the state's overdose prevention program, as authorized by the Substance Use Disorder Act (20 ILCS 301). Organizations that are currently enrolled and new DOPP enrollees will be provided with access to directly order Narcan (Naloxone nasal spray) at no cost to the organizations. 2) SUPR Funded Providers: Access Narcan can assist with meeting the following contractual requirement: All funded treatment organizations must certify that all professional and support staff have received opioid overdose education and training that includes how to recognize an overdose and instructions on how to administer Naloxone. Organizations must also certify that Naloxone is readily accessible to all staff members at each treatment facility and that such training is a part of any new employee orientation.
5.2.1	Infrastructure for SUPR provider and federal reporting.	5) Ensure accuracy of shared data within 12 months	Ongoing	**Completed**
6.1	Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community- based services and supports following stays in these facilities.	1) Illinois SUPR staff will start the formal amendment process for administrative rules to reflect these changes by February 2019. Projected effective date of December 2019.	December 2019	**Open:** SUPR is actively engaged in drafting changes to the Rule 2060 which will include language specific to Referral Agreements. Part of existing state monitoring is reviewing providers documentation and follow-up with referrals.

e. Surveys or Qualitative Interviews with Key Stakeholders

Formal surveys or interviews with key stakeholders were not conducted. However, the HFS and the independent evaluator consulted with SUPR for updates to implementation plan action items discussed in the above table in section C.1.d. During the COVID-19 pandemic, several agencies were closed and did not provide services for several months to a year. Therefore, the state was unable to conduct stakeholder interviews with these providers who were slated to implement the pilot programs for the demonstration. Due to the passage of time and high rates of staff turnover, many staff who were present when the demonstration pilots began are no longer with the agencies. Therefore, we believe that it will not be possible to conduct stakeholder interviews with staff who could speak to the benefits and challenges of the pilot programs at this time, and we do not intend on conducting these interviews in the future.

f. Narrative Monitoring or Evaluation Report Data

Milestone 1: Access to critical levels of care for OUD and other SUDs: The majority of metrics presented in C.1.a have shown progress. Illinois has experienced significant increases in MAT from baseline to mid-point (52.7%) and outpatient services (71.1%). Early Intervention, a new program, started and is now serving, on average, 73 beneficiaries per quarter. While decreases were seen in Intensive Outpatient and Partial Hospitalization Services (-7.2%), Residential and Inpatient Services (-3.5%), and Withdrawal Management (-18%), we believe this is due to the substantial increases in MAT and outpatient treatment. In addition, there has been a downward trend in hospitalizations due to the COVID-19 pandemic. In Illinois, telehealth was used more frequently than prior to the pandemic, which may also account for some of the decreases in service use for hospitalizations and withdrawal management. This is consistent with stakeholder interviews done in other states showing that residential services experienced significant financial strain and workforce turnover during the pandemic (Pagano et al., 2021). Furthermore, the decreases in Residential and Inpatient Services and Intensive Outpatient and Partial Hospitalization Services are quite small and could be attributed to fluctuations in the data. The implementation plan action items for this metric have mostly been completed as well. The 3 outstanding items that have yet to be completed are the adoption of administrative rule changes, referred to as Rule 2060. The committee has made significant progress and is in the final stages of review. Passage is expected soon.

Milestone 2: Use of evidence-based, SUD-specific patient placement criteria: One of the two metrics has shown progress. Metric 36, Average Length of Stay in IMDs maintained consistency and was less than 30 days. However, Metric 5, Medicaid Beneficiaries treated in an IMD for SUD, decreased. While the goal was to maintain consistency, this metric was also likely impacted by the COVID-19 pandemic. As shown in Milestone 1, there has been a decrease in inpatient services and a corresponding increase in outpatient treatment. To verify, we looked at the data for the year between baseline and mid-point (July 1, 2019 through June 30, 2020, state fiscal year 2020) and found that it was actually lower at 8,088. Therefore, we believe that Metric 5 was impacted by the pandemic and will continue to increase over time. The only outstanding implementation action item for this milestone is the passage of Rule 2060, which will include language requiring retrospective reviews of client records.

Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities: There were no metrics for this milestone, but two implementation plan action items are listed above. One of the two has been completed, and the outstanding item is again the passage of Rule 2060. Providers are currently required to provide information about Medication Assisted Treatment and potential places to receive this service, but Rule 2060 will require all providers to provide MAT directly.

Milestone 4: Sufficient provider capacity at each level of care: Both Metrics 13 and 14 increased over time. SUD provider availability was expected to remain consistent, but 34% more were available at mid-point than baseline. SUD providers who offered MAT services also increased by 33.57%. The corresponding implementation action plan item for this milestone was recently completed. The state of Illinois has made significant progress in the availability of MAT as buprenorphine is now available in every county; but has made several recommendations to further enhance MAT availability and sufficient provider capacity moving forward as well. This information can be found in the "State of Illinois Overdose Action Plan" (State of Illinois, 2022).

Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD: Five of 6 (83%) of metrics have shown progress for this milestone and all implementation plan action items have been completed. The state has been working on policies with providers to ensure access to Naloxone and adequate training for staff. However, despite these efforts and the successful decreases seen in high use of opioids and emergency department visits, Metric 27 (overdose death rate) still increased by 25%. It is worth noting that this is consistent with national trends. A recent report by Mattson and colleagues (2022) reported that overdose death rates increased by 30% from 2019 to 2020, despite "two-thirds of decedents having at least one opportunity for linkage to care or implementation of a life-saving action." However, Illinois' overdose rate of .91 per 100,000 is low relative to the national figure of 27.9 per 100,000, so the increase is percentage change is not alarming (Centers for Disease Control, 2021). Furthermore, Illinois is a Medicaid expansion state, which is known to reduce the number of opioid overdose deaths substantially (Kravitz-Wirtz et al., 2020). Thus, our State's efforts may have offset an even greater increase in opioid-related mortality, even though our overdose deaths increased during this period commensurate with the national trend. Given that all other metrics in this area showed progress, we feel that the overall progress for this milestone in Illinois is moving in the right direction.

Milestone 6: Improved care coordination and transitions between levels of care: Nine of 11 (82%) of the metrics for this milestone were completed, but the implementation plan action item was not. Readmissions for beneficiaries with SUD remained consistent along with treatment engagement and follow-up visits. The two metrics that were not achieved were initiation of treatment for Alcohol Use Disorder and Opioid Use Disorder. However, the total initiation of treatment did maintain consistency. It is worth noting that the majority of the state specific metrics (S1-S10) had very small changes (0.63% to 3.41%) and are possibly due to variations in the data. Therefore, these changes are not considered significant over time. The implementation action item for this milestone that remains open will be part of the administrative Rule 2060 that is likely to be passed in the near future. While this is in process, the state has been monitoring provider referrals until the more formal monitoring process is implemented via Rule 2060.

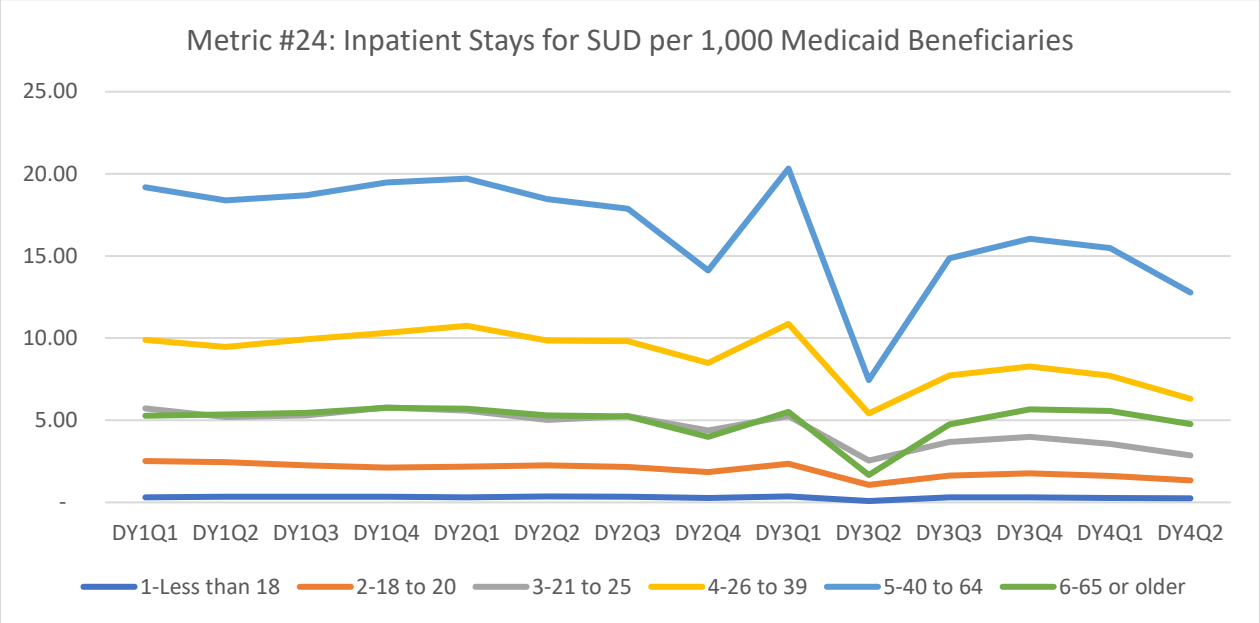
Other Monitoring Metrics and PMP Metrics: In addition to the 6 milestones presented above, Illinois has 11 other metrics that are continually monitored for the 1115 waiver evaluation. These include beneficiaries with an SUD diagnosis (metrics 3 and 4), those who newly initiate treatment (metric 2), the total number receiving services (metric 6), inpatient stays (metric 24), the count of overdose deaths (metric 26), SUD spending (total, per capita, and within IMDs – metrics 28-31), and access to preventative/ambulatory services (metric 32). These are listed in section C.1.b. Progress was shown across all of these metrics except for the count of overdose deaths. As explained previously, despite numerous efforts and progress on addressing OUD in Illinois, overdose deaths continue to increase as they have nationwide.

A few other metrics changed, but progress was shown. Metric 24, inpatient stays for SUD per 1,000 Medicaid beneficiaries, decreased. However, this was rated as "yes" in the progress column, because the overall goal is to have fewer beneficiaries in inpatient settings. The IMD waiver during the COVID-19 pandemic didn't increase inpatient stays because less people were going to the hospital, and more were using telehealth and other services. For metric 29, SUD spending within IMDs, it is worth noting that effective September 2020 there was a SUPR residential rate restructuring that raised the majority of rates and created a single rate for all residential treatments. Adult level 3.5 went from an average of $225 to an average of $271, adolescent level 3.5 went from an average of $284 to $377; and level 3.7 went from an average of $316 to $410. Therefore, while the goal was to maintain consistency with spending in this category and it increased, this was still marked as "yes" under progress since this increase can be explained by the rate increase and is not likely to be related to increased patient volume.

In addition to the 11 other metrics, there are also 3 metrics related to the Prescription Monitoring Program (PMP). These are listed in section C.1.c. as Q1, Q2, and Q3 and monitor the usage and progress of the PMP. All 3 of these metrics showed considerable progress from baseline to mid-point.

Impact of the COVID-19 Pandemic: As described throughout the milestones above, the COVID-19 pandemic had a substantial impact on Medicaid in the state of Illinois. First, many providers shut down during the pandemic temporarily or permanently. A continuous struggle remains for existing providers to get back on track with providing services at full capacity. Workforce shortages have been a major issue in addressing the capacity issues throughout the state. As shown in the metric data, the types of services provided experienced a shift away from residential and inpatient treatment to increased outpatient and telehealth services. There was a definitive decrease in services provided during late March through May of 2020 (DY2Q4) and in January through March of 2021 (DY3Q2). While these decreases were seen across several metrics, we have provided metric 24 in figure 1 (presented below) to illustrate the decrease in the rate of inpatient services for all age groups during these two time periods. Fortunately, this impact was short-lived during the shutdown period, but other long-lasting changes impacted the system as a whole.

Figure 1: Metric #24, Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries



g. Provider Availability Assessment Data

At this time, Illinois has not conducted a formal assessment of provider availability but has tracked the number of providers and MAT providers as reported in metrics 13 and 14. Regarding the provider availability assessment, similar barriers as collecting stakeholder interview were encountered. A high rate of staff turnover due to the COVID-19 pandemic and subsequent shutdown have impacted the provider availability in unanticipated ways.

h. Changes in Technical Specifications and Metrics

There were a few changes in the Illinois metrics from baseline to mid-point. First, there were two changes in the technical specifications that impacted metrics 18 and 20. Metrics 18, 19, and 20 were the rate per 1,000 during baseline, but during the mid-point are now the rate per 100. The definition of what constitutes a "high" dosage of opioids was also changed and affects metrics 18 and 20. During baseline reporting, the metrics included beneficiaries who had more than 120 MMEs per day on average as having a high dose, and current reporting for the mid-point includes a threshold of 90 or more MMEs a day on average. Thus, while the data is provided for metrics 18 and 20, they really aren't comparable over time.

CMS metrics 15 and 17(1) were changed to 10 sub-metrics for Illinois reporting. Metric 15, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, is represented by Illinois metrics S1-S8. S1 through S4 report on initiation of treatment separately for alcohol, opioids, other drugs, and the total for initiation of treatment, while S5-S8 report engagement of treatment separately for the same substances. CMS metric 17(1), Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence, is represented by Illinois metrics S9-10. S9 shows the 8-day follow-up and S10 the 30-day follow-up after an emergency department visit for SUD.

There were no changes in the implementation plan action items at the time of this report.

2. Assessment of Overall Risk of Not Meeting Milestones

Milestone	Percentage of monitoring metric goals met (# metrics/total)	Percentage of fully completed action items (# completed/total)*	Risk level	For milestones at medium or high risk, independent assessor's recommended modifications	State's responses and planned modifications
1	6/7 (86%)	8/11 (73%)	Medium	At this time, the independent assessor does not have any recommended modifications. This milestone is delayed because Rule 2060 has not been implemented at this time but will contain language requiring providers to offer MAT. This is likely to occur in the very near future and will be sufficient for the state of Illinois to reach this milestone.	The State agrees with the assessor's recommendations. SUPR rule 2060 has been going through a complete rule revision beyond the addition revisions related to the 1115 waiver.
2	1/2 (50%)	0/1 (0%)	High	At this time, the independent assessor does not have any recommended modifications. It is highly likely that metric 5 decreased due to the COVID-19 pandemic, since less IMDs were open and accepting patients during this time. In addition, the action items were not met because of the delays with Rule 2060 as mentioned above.	The State agrees with the assessor's recommendations. SUPR rule 2060 has been going through a complete rule revision beyond the addition revisions related to the 1115 waiver.
3	Not Applicable	1/2 (50%)	Medium	At this time, the independent assessor does not have any recommended	The State agrees with the assessor's recommendations. SUPR rule 2060 has

				modifications. This milestone is delayed because Rule 2060 has not been implemented as mentioned above.	been going through a complete rule revision beyond the addition revisions related to the 1115 waiver.
4	2/2 (100%)	1/1 (100%)	Low	Low risk, not applicable	N/A
5	5/6 (83%)	5/5 (100%)	Low	Low risk, not applicable	N/A
6	9/11 (82%)	0/1 (0%)	Medium	At this time, the independent assessor does not have any recommended modifications. The metric changes for this milestone that did not show progress had very small changes over time that could be due to the COVID-19 pandemic or fluctuations in the data and are not significant enough to draw conclusions. In addition, this milestone is also delayed because Rule 2060 has not been implemented as mentioned above.	The State agrees with the assessor's recommendations. SUPR rule 2060 has been going through a complete rule revision beyond the addition revisions related to the 1115 waiver.

3. Assessment of State's Capacity to Provide SUD

a. Adequacy of the State's Capacity

Looking across the milestones presented above, the state of Illinois is at a low risk for meeting 2/6 (33%), medium risk for 3/6 (50%) and high risk for 1/6 (17%). The state's capacity to provide SUD and OUD services remains good despite challenges faced during the COVID-19 pandemic. Spending increases, the rolling out of PRSS, and increases in MAT services are encouraging. Additionally, the state has a SUPPORT grant from SAMHSA where they are thoroughly studying capacity and have been addressing workforce needs. Provider, consumer, and other stakeholder surveys were conducted, and results are forthcoming from many of these efforts. Additionally, studies on alternative payment models to incentivize bundled services are underway.

b. Changes in State's Capacity

There has been a shift in capacity that has moved providers in the direction of providing more MAT services and utilization of services such as IMDs and withdrawal management has decreased as a result.

c. Need for Additional Capacity

The following suggestions are made for monitoring the need for additional capacity, including:

- Building out SBIRT and PRSS services in emergency departments. There have been slight increases in ED visits among enrollees and only 1 in 5 enrollees receive follow up services within 31 days (see state specific metric S10). SBIRT services to date have not shown radical increases in linkage to future SUD services (Glass et al., 2015), but research was conducted before intensive PRSS models were implemented.
- Base capacity building efforts on studies conducted under the SUPPORT grant project, including: 1) integrating family preferences for treatment, 2) understanding the ease of access (i.e., study of MAT deserts and transportation needs to obtain services), and 3) considering alternative payment models.
- Continue studying the need for recovery homes and the outcomes of individuals receiving such services.
- The number of providers and expenditure data is useful in describing the quantity of services at the systems level; however, time to service entry may be inflated due to reliance on billing data and provider self-interest in documenting outcomes. A key theme emerging in the SUPPORT grant from consumers is that wait times present challenges for people with SUD, whose motivation waxes and wanes. Developing better accountability standards for tracking waiting times and implementing triage services (i.e., pre-treatment PRSS, groups or telemedicine options) before treatment slots open would provide better insight.

4. Next Steps

At this time, the next steps for Illinois are to complete and implement Rule 2060 to outline specific policies for SUD and OUD providers statewide. The passage of these administrative rules was the largest barrier to meeting the goals and requirements outlined above by the mid-point assessment point of the 1115 SUD demonstration. Additional recommendations were made above under 3C regarding system-level capacity.

D. Attachments

1. Independent Assessor Description

The independent assessors for this report were Crystal Reinhart, PhD and Doug Smith, PhD. Dr. Reinhart works as a Research Scientist for the Center for Prevention Research and Development (CPRD) at the University of Illinois at Urbana-Champaign. Dr. Reinhart works closely with the director of CPRD, Dr. Doug Smith, and the agency has agreed to conduct the evaluation of the 1115 Demonstration Waiver under contract with the Office of Medicaid Innovation and the Illinois Department of Healthcare and Family Services. The experience of Dr. Smith, Dr. Reinhart, and the staff at CPRD are well suited to conduct a fair and impartial evaluation and ensure that there are no conflicts of interest.

2. Data Collection Tools

There were no data collection tools used for this report beyond the Medicaid claims data from the Enterprise Data Warehouse, the Prescription Monitoring Program, and the overdose data from the Illinois Department of Public Health.

3. Citations

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