N.B., et al.

v.

Theresa Eagleson, et al.

Report of the Expert

April 2022

Respectfully Submitted:
John O'Brien
Expert
jobrien@tacinc.org

N.B., et al. v. Theresa Eagleson, et al.

Report of the Expert

April 2022

Table of Contents

Second Annual Subject Matter Expert Report
April 2022

Introduction

The N.B. lawsuit was filed in 2011 on behalf of Medicaid-eligible children under the age of 21 in the State of Illinois seeking certain mental and behavioral health services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement of the Medicaid Act. Federal EPSDT statute and policies require the states to provide comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

On February 13, 2014, the United States District Court for the Northern District of Illinois certified the case as a class action for the following individuals: "All Medicaid-eligible children under the age of 21 in the State of Illinois: (1) who have been diagnosed with a mental health or behavioral disorder; and (2) for whom a licensed practitioner of the healing arts has recommended intensive home- and community-based services to correct or ameliorate their disorders." While the Department is working to develop a specific projection for the number of children in the N.B. Class, based on updated data, it is estimated that 6,000 children in the N.B. Class will receive services in the first full year of implementation of new care coordination and services, projected to start in 2022.

The Department and Plaintiffs agreed to resolve the N.B. class action through a Consent Decree approved by the Court on January 16, 2018. The N.B. Consent Decree requires the Department to develop, through an Implementation Plan, a behavioral health delivery "Model" to provide Class Members with a continuum of Medicaid-authorized and required mental and behavioral health services, including home- and community-based services. The Implementation Plan was developed by the Department with input from the Expert, Class Counsel, and stakeholders and was finalized by agreement of the parties on December 2, 2019.

The N.B. Consent Decree also requires an Expert to evaluate, provide input, and report to the parties and the Court during implementation of its requirements. The Consent Decree requires the Expert to file a written report to the Court and parties within sixty (60) days after the first anniversary of the approval of the Implementation Plan and annually thereafter. The report is to provide information regarding the Defendant's progress on implementing the requirements of this Consent Decree and the Implementation Plan as necessary to meet the Benchmarks in the Consent Decree. This is the second report of the Expert, encompassing the timeframe of January 1, 2021, through December 31, 2021.

Overview of Report

The report provides an assessment by the Expert regarding the progress the Department has made regarding key tasks and activities in the Implementation Plan that were to be completed in Calendar Year (CY) 2021 and the extent to which the Department is complying with the substantive paragraphs of the Consent Decree. The initial section of the report summarizes

progress on the initial Implementation Plan that was filed in December 2019. It should be noted the Department has developed an update to the Initial Implementation Plan that will reflect updated information on implementation activities and timelines. This update has not been released due to unforeseen delays in federal Medicaid authority approval. However, the Department has stated that the updated plan will be released soon after approval from the Centers for Medicare and Medicaid Services (CMS) regarding the Medicaid authority, the1915(i) Home and Community Based Services (HCBS) State Plan Amendment (SPA). The Department has titled this new initiative as the Pathways Program.

The review in this first section focuses on the initial and not revisions to the implementation plan. The next section provides information regarding the Department's efforts to address the relevant paragraphs of the Consent Decree. This section also provides recommendations from the Expert to the Department regarding policy and additional implementation activities that the Expert believes will ensure the Department meets its goals and objectives set forth in the Implementation Plan and overall Consent Decree. The report concludes with a summary of critical areas the Department should focus on over the next reporting period.

Progress on Implementation Plan

The Department, in conjunction with the N.B. Consent Decree Expert and input from Class Counsel and additional stakeholders, developed an initial Implementation Plan during CY 2019, filed on December 2, 2019. The Consent Decree requires the Department to implement several provisions to ensure the availability of services, supports, and other resources of sufficient quality, scope, and variety to meet the obligations of the Consent Decree through the development of a Medicaid behavioral health delivery model ("Model") for Class Members. The Implementation Plan consisted of several sections that provide additional details of the Model components, the action steps required to implement this plan, and the federal and state authorities under which the Model components are authorized and funded. This section of the report is structured to describe the activities the Department proposed for CY 2021, the progress made on those activities over the past year, and the Expert's recommendation for subsequent activities for CY 2022.

A major challenge for the Department to implement many of the activities set forth in the Implementation Plan has been obtaining approval from CMS regarding the 1915(i) HCBS State Plan Amendment for the Pathways Program. The Department submitted the 1915(i) application in December of 2020 and continues to pursue the application but has not yet received approval from CMS to implement this Medicaid authority. When the application was submitted in December of 2020, it was anticipated that CMS would approve the Department's 1915(i) SPA in mid to late summer 2021. The Expert reviewed the comment that was posted for public comment and provided substantive and technical comments on the Department's 1915(i) SPA prior to submission in December of 2020. Per the Expert's review, the SPA language was clear and consistent with other states that have requested and received approval of similar Medicaid authorities focusing on youth and families with significant behavioral health needs. The

Department did meet with CMS leadership in late CY 2021. CMS leadership was supportive of the Department's request (e.g., there were no significant issues) and seemed committed to approve the 1915(i) SPA in a timely manner. They also suggested the Department work with their 1915(i) technical assistance vendor to address CMS final concerns. The Department engaged and received assistance from this vendor and has responded to CMS concerns and made the changes requested by CMS. They are planning on resubmitting the 1915(i) SPA in Spring 2022. The Expert is frustrated by the lack of progress by CMS to respond to the State and process the 1915(i) application in a timely manner. CMS has indicated they have no issues with the design of the model in the 1915(i); however, they are perseverating on some technical issues that, in the Expert's opinion, should be easily addressed and approved by CMS with information already provided. In some instances, CMS has requested the same information provided by the Department in early CY 2021 or later raised new or previous issues that appeared to be resolved. Without the approval from CMS, much needed services for N.B Consent Decree youth and families have languished.

In the previous report, the COVID-19 pandemic was identified as a major barrier to implementation. Two years after the start of the pandemic, Illinois, similar to other states, continues to be plagued by the effects of this pandemic. Department leadership has been able to refocus their efforts on overseeing the day-to-day functions and responsibilities of the agency. However, the impact of the pandemic has affected the behavioral health provider network significantly. Staff shortages, especially of licensed clinicians, will be an important factor in service delays and disruptions. The Department has developed the service requirements for 1915(i) services to align staffing requirements to ensure the most qualified but appropriate staff persons deliver these services. In many instances, service delivery does not require a licensed professional. For other services, the intensity and the service intervention will require a licensed practitioner to oversee or provide the service. The Department will continuously need to assess the workforce issue during implementation to identify and address gaps in services due to work force shortages and determine alternative staffing strategies (including the use of telehealth) to ensure consistent access to quality services offered to N.B. youth and their caregivers.

Despite the ongoing discussion with CMS regarding the approval of the 1915(i), there were many tasks for the Department to complete during this reporting period. Progress was made on most activities set forth in the initial implementation plan, despite the lack of approval from CMS and the challenges presented by the ongoing COVID-19 pandemic. Below is a summary of activities the Department was to complete during the reporting period, the activities the Department undertook, and activities the Expert recommends for the next reporting period:

Model Component #1--Ongoing Class Member and Family Input

- Proposed activities for CY 2021:
    i. Continue to convene the N.B. Subcommittee and provide additional opportunities to provide feedback on the Department's implementation

efforts regarding the Pathways Program and other components of the N.B. Consent Decree and Implementation Plan.

ii. Align the Managed Care Organizations' (MCOs') ongoing Family Driven Care Plan efforts with the implementation activities for the N.B. Consent Decree in late spring of 2021 and provide that information to the N.B. Subcommittee and the Children's Behavioral Health Family Leadership Workgroup.

iii. Finalize process flows and review with the N.B. Subcommittee, the Children's Behavioral Health Family Leadership Workgroup, Department of Children and Family Services (DCFS), and other state child serving agencies.

- Accomplished activities:
  i. Reconfigured the N.B. Subcommittee to obtain feedback for the Pathways Program. Provided detailed information to the N.B. Subcommittee regarding the Pathways Program and solicited information from Subcommittee members regarding recruitment strategies for new services offered under Pathways.
  ii. Met with managed care organizations to review their implementation of their Plans for Family Driven Care, including their implementation of Family Leadership Councils.
  iii. Finalized the process flow for children who are not in DCFS custody and provided this information to the N.B. Subcommittee, DCFS, and other state-child-serving agencies. Included the flow in the general information regarding the Pathways Program presented during town halls in the summer of 2021.
- Activities recommended for next 12-month period:
  i. Provide the N.B. Subcommittee with updates during the implementation of the Pathways Program. This should include information gleaned from implementation meetings with the Care Coordination Services Organizations (CCSOs) and providers of new Pathways services (described in Model Components 2 and 7).
  ii. Solicit feedback from the N.B. Subcommittee on the Department's overall quality assurance process for the N.B. Consent Decree. This includes feedback on structural measures, reporting timeframes, and reports recommended for CCSOs and new Pathway services.
  iii. Consider merging the Children's Behavioral Health Family Leadership Workgroup with the existing N.B. Subcommittee. The Department has not made significant progress to develop the Workgroup. The membership and charter of the N.B. Subcommittee could be amended to include youth, family, providers, and other stakeholders. This would allow the Department to receive much needed input from a wide variety of stakeholders and would not silo responses or reactions from various stakeholder groups.

Model Component #2-- Managed Care Organizations

- Proposed activities for CY 2021:
    i. Develop state administrative rules and additional guidance for providers regarding care coordination and services set forth in the HCBS initiative.
    ii. Finalize and execute the MCO contract amendment by late spring to reflect the new benefit design and other processes included in the State's HCBS State Plan.
    iii. Develop Medical Necessity Criteria (MNC) for services included in the HCBS initiative.
    iv. Develop an overall quality assurance plan that will include initial outcome measures, reporting frequency, data sources, and technical specifications by late summer.
    v. Finalize and implement the approach to connect children and youth in the N.B. Class who are not enrolled in managed care with care coordination and new services through the Model.
- Accomplished activities:
    i. Developed and submitted state administrative rules for the Pathways Program in late spring of CY 2021. The State has received and incorporated comments pursuant to the rulemaking process and will submit final rules based on final approval from CMS for the Pathways Program.
    ii. The Department has developed a draft of the MCO contract amendment. The Expert has reviewed the contract amendment and provided Health and Family Services (HFS) comments. HFS incorporated those comments as well as comments from the MCOs and has finalized the MCO contract amendment for execution.
    iii. The State has developed a quality assurance approach for the Pathways Program as required by CMS.
    iv. HFS has developed an approach for N.B. class members who are not enrolled in managed care. There are projected to be a relatively small group of youth that will remain fee-for-service (FFS). These youth will have access to all services in the Pathways program as well as other behavioral services offered under the Medicaid State Plan. Rather than create another managed care strategy for a small volume of youth, HFS, in cooperation with its university partner, will oversee the care coordination efforts by the CCSOs for youth and families that remain in FFS and are not enrolled in a Medicaid managed care plan.
- Activities recommended for the next 12 months:
    i. Finalize and submit rules for the Pathways Program.
    ii. Execute the contract amendment for MCOs for the Pathways Program.
    iii. Develop the prior authorization criteria guidelines for N.B. Services. HFS has determined that the only services that will require prior authorization are

Respite, Therapeutic Support Services, Individual Support Services, and Psychiatric Residential Treatment Facility services. Specific prior authorization processes will be developed for each of these services. No other service in the Pathways Program will require prior authorization. HFS also will need to develop medical necessity criteria for admissions to Psychiatric Residential Treatment Facilities (discussed in Model Component 5) prior to implementing their Psychiatric Treatment Residential Facility (PRTF) strategy.

iv. Develop a comprehensive quality assurance plan that sets forth the following:
    1. The purpose of the quality assurance plan
    2. The use of data to inform HFS quality assurance activities
    3. The following data measures:
        a. Structural
        b. Process Measures
        c. Outcome Measures
    4. Table Shells for the measures sets forth in #3 above
    5. Process that HFS will deploy to review and act on the data
    6. Process that HFS will use to provide the data to stakeholder committees and the public-at large

v. Provide Class Counsel and Expert with initial information on Key Structural Measures (by month or quarter) including:
    1. The number of Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) performed for individuals under the age of 21 in CY 2022
    2. The number of class members in Intensive Care Coordination and High-Fidelity Wrap
    3. The number of CCSO providers
    4. The number of care coordinators (providing each level of care coordination) by CCSO
    5. The number of providers for each other service in the Pathways Program by DSA
    6. The number of class members and their families that used each Pathways Service
    7. The average number of units per month of service per class member for each of Pathway's Services (except CCSO)
    8. Total Pathways expenditures to date and expenditures per service, per class member

vi. Finalize and implement the approach to connect children and youth in the N.B. Class who are not enrolled in managed care with care coordination and new services through the Model.

Model Component #3—Care Coordination

- Proposed activities for CY 2021:
    i. The Department should continue to finalize efforts in the summer of 2021 to test and refine the decision support criteria to stratify Class Members.
    ii. The Department should engage N.B. Subcommittee, Children's Behavioral Health Family Leadership Workgroup, DCFS staff, and other state agencies serving children to review and provide input to the decision support criteria.
    iii. The Department should finalize the process and necessary documents (e.g., application materials and contracts) to select CCSOs. These processes and materials should be finalized by late spring. In early summer, the Department should meet with the MCOs to initiate the application and selection process.
    iv. The Department should finalize the appeal process for the HCBS initiative and service eligibility determinations.
    v. The Department should implement care coordination training for CCSOs in early fall.
- Accomplished activities:
    i. The Department has continued testing, adjusting, and reanalyzing data related to the decision support criteria. The Department provided updates to the Expert and Class Counsel and incorporated their feedback in the overall process of finalizing the criteria. The Department continues to work to refine the criteria and is moving closer to finalization.
    ii. The Department developed a Clinical Working Group comprised of clinicians who represented agencies that were deploying the IM+CANS, state sister-agency staff (i.e., DCFS and DHS-DMH) and MCO staff to obtain recommendations regarding potential changes to the decision support criteria to appropriately identify N.B. Class Members. The Workgroup commenced in summer and completed its efforts in late CY 2021.
    iii. The Department developed a robust process for providing information regarding the Pathways program for stakeholders and potential providers, including information (written and webinars) regarding the proposed Care Coordination and Support Organizations (CCSOs).
    iv. The Department developed a Request for Application (RFA) for potential CCSOs. The Expert reviewed and provided input into the RFA.
    v. The Department developed Designated Service Areas (DSAs) for each CCSO service area. Specifically, the Department identified 32 DSAs for the Pathways Program. The Department developed these DSAs using a formula regarding children and youth with significant mental health conditions (including use of crisis, emergency departments, and inpatient behavioral health hospitalization).

vi. The Department released the RFA for the CCSOs in early fall and worked with the MCOs to implement a process to review and select CCSOs. Announcement of qualified CCSOs will occur after CMS approval of the 1915(i) SPA application.
vii. The Department has developed and finalized the care coordination training for CCSOs; however, they have not begun training CCSOs using this curriculum. Training will begin once the 1915(i) SPA application has been approved and qualified CCSOs have been notified.
viii. HFS has developed an appeal process for individuals to seek review of Department determinations regarding Pathways services. The proposed appeals process provides for an informal review to allow the Department to review and resolve appealable issues when possible. The process then provides for a formal appeal for matters that are not able to be resolved at the informal review stage, should the appellant wish to pursue formal appeal. The formal appeal process will follow the Department's existing Medical Assistance Recipient appeal process. This appeal process is expected to be finalized once the administrative rules are fully promulgated.

- Activities recommended for next 12-month period:
  i. Identify the CCSOs for any DSAs that do not have a qualified CCSO before program launch.
  ii. Roll out developed trainings to the CCSOs prior to program launch.
  iii. Develop a technical assistance plan by September 2022, for CCSOs to address their training and technical assistance needs in real time. The plan should identify the responsibilities of the Department, the university partner, and the MCOs to identify and respond to CCSO training and technical assistance needs. This should include weekly or more frequent meetings with the CCSOs to identify implementation issues and develop solutions to those issues with real-time emphasis. This information will be critical to ensure the CCSOs are supported during the initial months of implementation.
  iv. The Department and MCOs should develop a process for CCSOs to report the information referenced on page 8 of this report to track the program roll-out and to identify initial and ongoing access issues.
  v. After program launch, the Department should discuss the decision support criteria process with the N.B. Subcommittee, DCFS staff, and other state agencies serving children to receive their feedback regarding implementation of the process.
  vi. The Department should implement the appeal process for the HCBS initiative and service eligibility determinations once administrative rules are finalized. Specifically, the Department should develop and publish information regarding the process that individuals may pursue when seeking to appeal an action or determination by the Department. The Expert recommends that

HFS consider offering this information using multiple platforms (e.g., clearly represented on the HFS and Pathways website, providing guidance to providers on the process).

Model Component #4--New Services, Providers, and Policies to Enhance Access to Behavioral Health Services

- Proposed activities for CY 2021:
    i. The Department should convene the Primary Care Physician (PCP) and provider workgroup and ensure the PCP behavioral health screening tool(s) has been identified by the State.
    ii. The Department should develop Crisis Triage and Stabilization services during this reporting period. This should include reviewing and making any modifications to the definition, meeting with MCOs to develop and implement a network development plan for these services, developing the necessary medical necessity criteria to be applied for these admissions, and developing and implementing a process to track referrals and lengths of stays to ensure they are consistent with the State's intent for these services, post discharge referrals, and engagement in HCBS services.
    iii. The Department should work with the MCOs to develop and implement a network development strategy for the new services in the HCBS initiative.
- Accomplished activities:
    i. The Department, in cooperation with the State Chapter of the American Academy of Pediatrics (AAP), has identified a lead for the PCP and Provider Workgroup. The Department has not identified other Workgroup members and has yet to convene this workgroup.
    ii. HFS has determined the Department will be responsible for recruiting, identifying, and enrolling providers of Pathways Services. Once enrolled, HFS will provide information regarding the Pathway's provider network to each MCO. The Department will require that MCOs will initially contract with each enrolled provider of Pathways services rather than selecting a network from enrolled providers.
- Activities recommended for next 12-month period:
    i. Identify the PCP working group members and meet with the work group to develop recommendations for the screening tool and process that primary care providers should use to screen, report the results of the screening, and make a timely referral to a follow-up CANS to identify need and connect to ongoing behavioral health services when appropriate.
    ii. Other strategies will be dependent on accomplishments for ii and iii referenced in the preceding section.
    iii. Develop protocols and provide training regarding the interface between CCSOs, Mobile Crisis Response, and Intensive Home-Based Services. This will

ensure that CCSO and these providers have clear roles and responsibilities, especially when youth are in crisis and de-escalation and implementation of their crisis safety plan will be necessary.

Model Component #5--PRTFs

- Proposed activities for CY 2021:
    i. The Department should conduct an analysis to determine the initial volume and location of PRTF beds.
    ii. The Department, in cooperation with DCFS, should continue efforts to research the Building Bridges Initiative and the quality requirements from the Family First Preservation Services Act to determine how to best apply these to Illinois in-state PRTF development efforts.
- Accomplished activities:
    i. The Department has initiated efforts to conduct the analysis by identifying children and youth with two or more hospitalizations and three or more mobile crisis response events over the past year to determine what areas of the State have the highest needs for these beds. The Department will also use this data to determine the capacity (e.g., number of beds) that will need to be developed.
    ii. HFS has begun to develop some in-state short-term stabilization beds for youth needing a transition from inpatient or as a diversion from inpatient behavioral health services. They have developed medical necessity criteria consistent with the Interim Relief Program that are applied to all admissions to this in-state short-term stabilization program.
- Activities recommended for next 12-month period:
    i. Finalize the needs assessment and determine the potential number of PRTF beds needed and locations of these facilities.
    ii. Develop a model for PRTFs based on other states' successful efforts to offer these services, consistent with the Building Bridges approach that ensured that these services have been provided consistent with the amount and duration needed by youth in the exemplary states. This will include working with the Expert team to identify these models and determine their applicability to the Department's efforts to develop these facilities in-state.
    iii. Develop a selection process for PRTFs that is consistent with the exemplary models identified in ii above.

Model Component #6: Implementation Training and Technical Assistance

- Proposed activities for CY 2021:
    i. The Department should develop an overall training plan for new and existing services included in the N.B. Consent Decree Implementation Plan.

ii. The Department, in cooperation with the Expert and the University of Illinois, should develop and implement the necessary training modules for new services with particular attention to Intensive In-Home, Family Peer Support, and Therapeutic Mentoring.

- Accomplished activities:
  i. The Department has developed a training plan for new services, including Mobile Crisis Response and Crisis Stabilization.
  ii. The Department has developed the training modules and materials for the services in the Pathways Program, including Intensive Home-Based, Family Peer Support, and Therapeutic Mentoring. They have not started the training due to the delay in approval of the 1915i SPA.
- Activities recommended for the next 12-month period:
  i. Implement the training plan and modules developed for these services.
  ii. Solicit feedback from individuals and agencies that participated in the training and, using this feedback, develop the necessary changes to the curriculum.
  iii. Develop a process to meet with providers of Pathways Services during the initial months of implementation (similar to the recommendations regarding CCSO start up) to identify and address initial implementation issues on a timely basis. This process should identify the roles of the Department, the university partner, and the MCOs.

Model Component #7: Cross-Agency Collaboration on Model Development and Implementation

- Proposed activities for CY 2021:
  i. The Department should finalize the process flow specific to DCFS children, youth, and caregivers who will participate in the HCBS initiative.
  ii. The Department should develop education and training for care coordinators/caseworkers/case managers from other child service agencies on how children can access services in the 1915(I) initiatives.
  iii. The Department, in cooperation with other state child-serving agencies, should develop a cross agency training plan for their respective staff regarding the N.B. Consent Decree, the HCBS initiative, and the referral process for the HCBS Initiative.
  iv. The Department should solicit feedback from state child service agencies regarding the proposed outcome measures for the N.B. Consent Decree to ensure alignment with the State's overall approach for children's behavioral health services.
- Accomplished activities:

i. The Department has developed the process flow for DCFS involved N.B. Class Members and is meeting with new leadership at DCFS for final review and approval.

- Activities recommended for next 12-month period:
  i. The Department should develop education and training for care coordinators/caseworkers/case managers from other child service agencies on how children can access services in the 1915(I) initiatives.
  ii. The Department should initiate this training prior to the launch of the Pathways program.
  iii. The Department should develop referral and participation protocols for other state and local child-serving agencies to use for referring children to the Pathways program. The protocols should also specify the expectations of participation by the other state child-serving staff (e.g., participation in Child and Family Team meetings, conflict resolution process, etc.). A sample of these protocols can be found at: https://www.mass.gov/lists/cbhi-state-agency-protocols.
  iv. The Department, in cooperation with other state child-serving agencies, should develop a cross agency training plan for their respective staff regarding the N.B. Consent Decree, the Pathways Program, and the referral process for the Pathways Program prior to the launch of the initiative.
  v. The Department should solicit feedback from state child service agencies regarding the measures recommended in Model Component #2 for the N.B. Consent Decree to ensure alignment with the State's overall approach for children's behavioral health services.
  vi. The Department should also develop a process for developing critical reports for other state agencies that includes information referenced on page 8 of this report. The Department should meet with leadership from the other child-serving agencies to identify the information, format, and frequency of these reports.

Progress on Key Provisions of the Consent Decree

As indicated earlier in this report, the Consent Decree was approved by the Court in January 2018. The N.B. Consent Decree requires the Department to develop, through an Implementation Plan, a behavioral health delivery "Model" to provide Class Members with a continuum of Medicaid-authorized and required mental and behavioral health services, including home- and community-based services. The Consent Decree sets forth various provisions that frame the purpose of the Consent Decree, implementation requirements, benchmarks for success, and other areas. Listed below are the key paragraphs from the consent decree, the Department's progress towards meeting the requirements in the paragraph, and recommendations set forth by the Expert.

V. The System for Providing Mental and Behavioral Health Services to Children under the EPSDT Requirements

7. The purpose of this Consent Decree is to design and implement a systemic approach through which Class Members will be provided with reasonable promptness the Medicaid-authorized, medically necessary intensive home- and community-based services, including residential services, that are needed to correct or ameliorate their mental health or behavior disorders.

As indicated in the first report, the Department has developed a Model, laying the foundation for a systemic approach meeting the expectation of this paragraph, setting forth the services that will be developed and available for N.B. Class Members. The Department has submitted the necessary state plan requests or changes to the Centers for Medicare and Medicaid Services (CMS) which will allow them to implement the design of the Pathways Program. The Department did not receive approval of its 1915(i) SPA application as anticipated in late spring or early summer of CY 2021, delaying their implementation efforts. Despite this delay, the Department developed the necessary foundational documents that will guide their implementation effort. This includes:

- Service definitions that describe the approach, activities, and qualified provider and staff that will render these services
- Training materials and approach for each of the major services, including care coordination, intensive home-based, therapeutic mentoring, and family peer support
- Detailed information materials regarding the Pathways Program for stakeholders
- The Request for Application for the CCSOs
- Final draft of the MCO contract that sets forth expectations regarding the Pathways Program for the MCOs and the State
- Proposed administrative rules to govern operation of the Pathways Program.

In addition, the Department is finalizing its provider manual for the Pathways Program that will be ready prior to program launch.

9. Defendant shall ensure the availability of services, supports and other resources of sufficient quality, scope and variety to meet their obligations under the Consent Decree and the Implementation Plan as necessary to achieve the Benchmarks required in Paragraph 35. Defendant shall implement sufficient measures, consistent with the preferences, strengths and needs of the Class Members, to provide the services required by the terms of this Consent Decree.

As set forth below in Paragraph 11, the Department has identified the array of services and supports that will be available to Class Members. There are several services the Department has implemented, including Integrated Assessment and Treatment Planning and Mobile Crisis Response. There was some limited implementation of Intensive In-Home as discussed in this report. Due to delays in obtaining CMS approval, the remaining services will be implemented later in CY 2022.

The first Expert report provided significant background regarding the services and processes the State will deploy to implement the Pathways Program. This includes the process for assessing the needs and strengths of all Illinois Medicaid-eligible children seeking behavioral health services, including N.B. Class Members, using the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS). As described in the first report, the IM+CANS is a standardized framework for assessing the needs and strengths of Class Members who require mental health treatment. All Medicaid enrolled providers who want to offer behavioral health services to Medicaid eligible children and families are required to be trained and certified annually to render the IM+CANS. Since 2018, the Department, through an external vendor, has provided training and certification for 15,672 individuals to render the IM+CANS. More information regarding the IM+CANS is provided in paragraph 17.d. From July 2018 through December 2021, there were 85, 043 children and youth under the age of 21 who had an IM+CANS.

In the previous report, the Expert recommended the Department increase the number of Integrated Assessment and Treatment Planning (IATP) significantly in CY 2021 and set a target of 30-45,000 IM+CANS to be performed for children and youth by October 2022.

In 2019, the Department transitioned the Screening, Assessment, and Support Services (SASS) program to develop a mobile crisis response benefit. The new service, Mobile Crisis Response (MCR), includes face-to-face crisis screening, short-term intervention, crisis safety planning, brief counseling, consultation with other qualified providers to assist with the client's specific crisis, referral and linkage to community services, and, in the event that the client cannot be stabilized in the community, facilitation of a safe transition to a higher level of care. In addition, the Department has developed and implemented a training curriculum for MCR providers. From January 2021 through December 2021, there were 14,569 unduplicated children and youth under the age of 21 who received MCR.

Over this reporting period, the Department revised the training for MCR providers to ensure that other providers (CCSO care coordinators and behavioral health providers) received

information regarding the crisis events in a timely manner. In addition, the Department has revised protocol for developing and sharing crisis/safety plans for care coordinators and DCFS permanency workers in "real time."

In addition to MCR, Crisis Stabilization was introduced as a new component of the Department's crisis services array available to individuals following a Mobile Crisis Response event. Crisis Stabilization includes observing, modeling, coaching, supporting the implementation of the client's Crisis Safety Plan, performing crisis de-escalation, and responding to the behavioral health crisis, when necessary. Crisis Stabilization is to be provided in the Class Member's home or other community setting where the crisis has occurred. From January 2021 through December 2021, there were 249 unduplicated children and youth under the age of 21 who received Crisis Stabilization.

As discussed above, the Expert recommended the Department undertake the various activities during the previous reporting period. The Department did revise and implement new training for MCR providers. The Department should agree to carry out the following activities that were recommended for CY 2021 in the next reporting year to improve access to and the quality of MCR Services:

- Develop key reporting indicators and an MCR dashboard to ensure MCR services are provided on a timely basis.
- Develop a monitoring approach to review a sample of youth who have received MCR to ensure youth have a crisis/safety plan and the plan has sufficient information to provide direction to the youth, caregiver, crisis providers, and case managers when a crisis occurs.
- Based on the findings of this review, develop a technical assistance approach to assist providers across the state to ensure the quality of MCR Services.

The Expert is requesting the Department conduct these reviews early in the reporting period (within 180 days) and report to the Expert the findings of their monitoring efforts.

As indicated in the first report, the Department piloted Intensive In-Home Services, under an 1115 waiver authority, which provided face-to-face, time-limited, focused interventions to stabilize behaviors that may lead to crisis or may result in inpatient hospitalizations or out-of-home care. Intensive In-Home Services contained two components: Clinical and Support. As indicated in the previous report, very few children participated in the 1115 waiver pilot project due to the lack of incentives for providers to offer this service, lack of clarity and training regarding the intensive in-home benefit, and a complicated and poorly understood reimbursement methodology. The Department determined that this service would be better suited under the 1915(i) benefit in order to align it with other services targeted toward the N.B. Class under a single authority instead of as a stand-alone service. Therefore, the Department transitioned Intensive In-Home Services under the 1115 waiver to Intensive Home-Based services under the 1915(i) benefit. By doing this, the Department was able to clarify the service specifications and provider requirements. The Expert recommended and the Department completed the following activities in CY 2021:

- Developed clearer guidance that included a service definition of Intensive Home-Based services consistent with national and other state models.
- Worked closely with Case Western University and the University of Illinois to develop a training curriculum for Intensive Home-Based services.
- Developed a reimbursement methodology that incentivizes providers to offer this service. The Expert reviewed this methodology and the rate and believes this rate should be sufficient to begin the service based on other jurisdictions' reimbursement strategies, taking into account higher wages to address workforce shortages for staff that would likely deliver this service.
- Met with providers and the N.B. Subcommittee to identify recruitment and retainment strategies to ensure access to Intensive Home-Based services when the Pathways Program goes live.

The Department has yet to develop projections regarding the number of children, youth, and caregivers that will likely need Intensive Home-Based services in the first and subsequent years of the Pathways Program. The Expert recommends the Department project the need for this service early this reporting period and closely monitor the number of Intensive Home-Based providers to ensure a preliminary network of these providers is available to N.B. Class Members. The Department will monitor the development of the Intensive Home-Based provider network to ensure that CCSOs will have an initial referral source for youth and families when the CFT identifies the need for this service. Later in this reporting period the Department should develop a network development strategy, in cooperation with the MCOs, to adequately meet the needs of these children, youth, and caregivers on an ongoing basis.

To ensure the array (existing and new services) is available to meet the obligations of this paragraph, the Expert recommended the Department develop information regarding the Pathways Program to raise the awareness of the N.B. Consent Decree and the Pathways Program, including information on how to make referrals to the program, the eligibility criteria for participating in the program, information regarding the services available under Pathways, the Care Coordination, and the Child and Family Team process. The Department developed these informational materials and developed a fairly robust dissemination strategy for stakeholders, including youth and families, advocacy organizations, state child-serving agencies, providers, and MCOs. During the Summer of 2021, the Department hosted several weeks of town hall meetings that provided an overview of the Pathways Program and detailed information regarding critical services offered under the Pathways Program. This information can be found at:
https://www2.illinois.gov/hfs/MedicalProviders/behavioral/pathways/Pages/default.aspx

The Expert recommended the Department develop consistent access standards for each service and support identified in paragraph 11. Federal managed care regulations require the State ensure MCOs maintain a provider network that is sufficient to provide timely access to all medically necessary covered services (including services offered through the Pathways

Program, once federally approved) to eligible members. The Expert recommended the Department develop access standards to be used by all MCOs. The Department included these standards in the MCO Contracts.

The Expert recommended the Department develop a strategy for monitoring access to services in paragraph 11. The various discovery and remediation strategies identified in the HCBS 1915(i) SPA for the Pathways Program, when implemented, will provide valuable information on whether a child/youth is receiving services in their plan. Once the Pathways Program goes live, the Department should focus the N.B. Subcommittee efforts to solicit information on access issues or service gaps.

In the first reporting period, the Expert recommended the Department develop measure sets for various measure categories (structural, process, and outcomes). The Department has yet to finalize measures or develop a quality assurance process for the N.B. Consent decree. As indicated in the previous report, it will be important for the Department to develop these measures to inform the standards necessary to meet paragraph 35 of the Consent Decree. The Expert continues to recommend the Department develop measure sets for the following categories:

- Structural Measures that will ensure that the Model infrastructure is being established in an efficient manner. At a minimum, this should include information regarding:
    - The number of children projected to need select services (care coordination and intensive in-home) set forth in the Pathways Program.
    - The projected number of providers that will be necessary to ensure adequate access to these services.
    - Information quarterly on the number of individuals enrolled and participating in the HCBS initiative and the number of children receiving each service.

  The Department should also develop measures that are critical to determining if children and youth are using more intensive services, including emergency department, psychiatric inpatient, and other out of home (and out of state) services.
- Process Measures that assess whether specific activities are implemented consistent with standards set forth by the Department. Process measures can also include an assessment of whether a particular service is being delivered consistent with a fidelity tool. The Department has developed process measures in the Pathways Program, including:
    - Service plans address assessed needs of Pathways participants.
    - Providers meet the qualifications for specific services.
    - Processes and instruments for determining Pathways eligibility are applied appropriately.

  While these measures are important, additional process measures should be developed to ensure that children, youth, and their caregivers receive services consistent with their needs. Some of these measures specific to access and timeliness

were recommended above. Additional process measures the Department should consider are:

  - Whether services identified in the assessment are reflected in service plans
  - Whether services are delivered consistent with the scope, amount, and duration as identified in the plan
  - Whether services are being delivered consistent with their evidence base including High Fidelity Wraparound Care Coordination and Support
  - Rate of out of home placement
  - Lengths of stay in these out of home placements
  - Follow up after a hospitalization or an ED visit for mental health purposes.

- Outcomes Measures that assess whether the Model is achieving its intended results. These measures are more challenging to develop since there is not a national set of outcome measures for some of these services. However, several states with similar approaches have developed outcome measures that include:
  - Increased school attendance
  - Decreased involvement with the juvenile justice system
  - Increases in a child or youth's functioning in key areas
  - Satisfaction with services (child, family, and caregiver).

  These states have often used a combination of assessment data (e.g., IM+CANS), and utilization, and other information to be able to create these measures.

The Expert recommends the Department develop these measures during the next reporting period in cooperation with various stakeholder groups, state agency representatives, and MCOs who will likely be the conduit for data and other information to support these measures. At a minimum, the structural measures should be created prior to the start of the Pathways Program. The Department will want to collect and track utilization and access issues early in the implementation process.

The Expert recommended, but the Department did not develop, a quality assurance plan in the previous reporting period that is specific to the Consent Decree. The Expert is recommending this plan be completed within the next 90 days and submitted to the Expert for review and comment.

10. Annual budgets submitted by Defendant on behalf of her agency shall request sufficient funds necessary to develop and maintain the services, supports and structures described in the Consent Decree for which Defendant's agency has statutory and regulatory authority. Nothing contained in this Paragraph shall be deemed to create or operate as (a) a condition or contingency upon which any term of the Consent Decree depends; or (b) a circumstance entitling Defendant to alter, amend or modify the implementation or timing of Defendant's obligation under the Consent Decree.

The Governor's FY 2022 budget did not have an explicit line item in the HFS budget for the Pathways Program; however, the funding was included in HFS's overall operating budget. HFS did release a notice for public comment regarding the Pathways Program and stated the

first-year budget for the program is $100 million. HFS has indicated there is no change for the FY 2023 budget since the Pathways Program has yet to be approved by CMS.

11. Subject to the provisions of this Consent Decree, Defendant will make available to Class Members a continuum of medically necessary mental and behavioral health services authorized and required by the EPSDT requirement of the Medicaid Act (see 42 U.S.C. §§ 1396a(a)(43); 1396d(a)(4)(B); 1396d(a)(13)(C), 1396d(a)(16), and 1396d(r)(5)).

12. The continuum of care will be provided through the development of a Medicaid behavioral health delivery model ("Model"). The process and principles of the Model shall be set forth in the Implementation Plan. Among other matters, Defendant shall be allowed to incorporate SOC, care coordination, case management, and community integration into the Model and Implementation Plan.

13. The Model shall be developed and implemented in phases and the Medicaid services included in the continuum of care under the Model shall be set forth and defined in this Consent Decree and the Implementation Plan. The continuum of care available to Class Members shall include all medically necessary home- and community-based services and supports, as well as inpatient psychiatric services in a Psychiatric Residential Treatment Facility ("PRTF"), that are authorized, approved, and required under 42 U.S.C. § 1396d(a)(16), 1396d(h) and implementing federal regulations and that are eligible for Federal Financial Participation. The Implementation Plan shall describe a method to triage or otherwise phase in the utilization of PRTF services during the development of home- and community-based services in the Model so as to serve Class Members in the least restrictive appropriate setting and avoid the unnecessary institutionalization of Class Members. Nothing in this Consent Decree shall require or authorize any particular service to be covered or made available to any Class Member if such service is beyond the federal Medicaid provisions that authorize services. This Consent Decree shall not override or supersede applicable Medicaid law, and nothing in this Consent Decree shall require the provision of any type of service prior to approval from CMS.

Paragraphs 11 through 13 are addressed together. As indicated in the previous report, the Department has developed a Model that sets forth the specific services and supports that will be provided to the N.B. Class. This Model was described in the Department's Initial Implementation Plan (12/2019). The Model was developed using information from other states that have developed a System of Care approach for children with significant mental health or behavioral disorders. The Department also uses an informational bulletin from the Centers for Medicare and Medicaid Services (CMS) that sets forth the services and supports that could be included in a State's Medicaid Plan to meet their EPSDT obligations[1]. This model includes:

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf

- Care Coordination—including two levels of care coordination intensity to meet the behavioral health needs of Class Members: High Fidelity Wraparound (high intensity level) and Intensive Care Coordination (moderate intensity level). The Department had proposed a Care Coordination program for Transition Age Class Members. At the encouragement of the Expert, the Department included these youth into the two care coordination levels that will maintain continuity but also address the needs of Class Members around transition to adult mental health services as appropriate.
- Mobile Crisis Response—a mobile, focused, and time-limited service designed to achieve crisis symptom reduction, stabilization, and restoration of the client to the previous level of functioning.
- Intensive Home-Based—services provided directly to children and their caregivers in home and community settings to 1) improve child and family functioning; 2) improve the family's ability to provide effective support for the youth; and 3) promote healthy family functioning. Interventions are designed to enhance and improve the family's capacity to maintain the child within the home and community, and to prevent the child's admission to an inpatient hospital or other out-of-home treatment settings.
- Respite—including activities to relieve stress and ultimately maintain individuals in the home and community, as respite services provide safe and supportive environments on a short-term basis for children with mental health conditions when their families need relief.
- Family Peer Support—including activities that assist the family to engage in services and supports, assisting the family in self-advocacy, assisting in systems navigation, providing information about the child's behavioral health needs and strengths, identifying and building natural supports, and promoting effective family-driven practice.
- Therapeutic Mentoring—assists the child or youth with improving their ability to navigate various social contexts, observing and practicing appropriate behaviors and key interpersonal skills that build confidence, improving emotional stability, demonstrating empathy, and enhancing positive communication of personal needs without escalating into crisis.
- Therapeutic Support Services—help children and youth find a form of expression beyond words or traditional therapies in an effort to reduce anxiety, aggression, and other clinical issues while enhancing service engagement through direct activity and stimulation.
- Individual Support Services—non-traditional activities, services, and goods that provide therapeutic supports to children with significant behavioral health needs in support of the child's person-centered service plan and serve as an adjunct to traditional therapeutic services the child receives.

As indicated in the first report, in the opinion of the Expert, the Department has set forth the necessary possible services for the members of the N.B. Class. Once services are initiated and service planning commences, there will likely be additional services the Department may want to consider based on children, youth, and caregiver information and preferences. The

Department has made a commitment to research and explore developing practices and services that may better inform or improve the Model for Class Members and has stated that future Implementation Plan reviews may include different or modified practices or services as necessary to improve the Model and better address the needs of Class Members.

During the previous reporting period, the Department has taken steps to implement services offered in Psychiatric Residential Treatment Facilities (PRTFs). A PRTF is an alternative to psychiatric hospitalization and provides intensive inpatient care designed to help stabilize the youth, provide for immediate treatment needs, and quickly return the youth to their prior care setting (often a lower level of residential care), in order to continue their course of treatment. PRTFs are unique to the Medicaid program, offering this benefit only to Medicaid-eligible individuals under the age of 21 who meet medical necessity criteria. Currently, the Medicaid program in Illinois does not include systemic coverage of behavioral health PRTFs, thus there is no behavioral health PRTF Medicaid provider network. The Department does reimburse children placed in PRTFs in other states. Currently, there are 15 children and youth from Illinois in these out-of-state facilities. The Department is continuing to plan for the development of in-state PRTFs while the home and community-based service delivery system is being built to sufficient capacity to effectively serve Class Members.

While the Expert still contends a PRTF benefit should not be implemented prior to the home and community-based services offered through the Pathways Program, it does make sense for the Department to begin planning activities for the PRTF benefit. In the previous report, the Expert recommended the Department initiate efforts to identify the in-state PRTF capacity needed and continue efforts to explore other state's efforts to implement the Building Bridges Initiative as part of the design and specifications for this service. As indicated previously in this report, the State has developed a methodology to initially identify the need for PRTF beds on a regional basis. The Expert is requesting the Department provide the methodology and findings from this analysis this reporting period.

During this next reporting period, the Department should develop necessary PRTF policies, procedures, and administrative rules. The initial Implementation Plan indicates that the Department will utilize clinical and treatment concepts from the Building Bridges Initiative and quality requirements from the Family First Preservation Act to develop the treatment expectations for time limited PRTFs and will work in close collaboration with the Department of Children and Family Services in this process[2]. The Expert will make recommendations to the Department and stakeholders regarding the PRTF Model. Several states, including New Hampshire and New Jersey, have specifically designed their PRTF programs to align with the Building Bridges Initiative[3]. The Expert will assist in the initial design of the PRTF benefit and implementation strategy.

[2] https://www.buildingbridges4youth.org,

[3] rfp-2021-dbh-11-psych.pdf (nh.gov)

15. Services provided through the continuum of care shall be based on clinical decisions and medical necessity criteria as determined by Defendant, consistent with applicable law. Defendant may make medical necessity determinations and establish utilization control procedures through the use of such entities as Quality Improvement Organizations or other entities chosen by Defendant. Defendant shall retain the authority to establish medical necessity criteria and cost sharing as permitted under Title XIX and, where applicable, approval by CMS. Defendant may require Class Members to enroll with a managed care entity for any or all care coordination, case management and services. Nothing in this Consent Decree shall prohibit Defendant from using managed care entities as determined by Defendant and authorized or required under applicable law. Any services provided pursuant to this Consent Decree shall remain subject to all applicable requirements herein, even if arranged through managed care entities or other third parties.

As indicated in the first report, federal Medicaid policies require states to develop policies for ensuring a Medicaid service is medically necessary. Federal policies do not set forth a definition of medical necessity and therefore, each state develops its own definition and application. During the previous reporting period, the Department developed criteria and processes for determining eligibility for the Pathways Program. Rather than assessing eligibility for each service, the Department has developed eligibility criteria and processes for the overall Pathways Program. As discussed previously in this report, data from the IM+CANS is used to determine if a Medicaid enrolled youth meets the decision support criteria for the program. The IM+CANS assesses the strengths and needs of the youth and includes a review of the environment including the capabilities of the caregiver to support the youth at home. Therefore, the IM+CANS and decision support system are the primary methods the Department will use to determine eligibility for services in the Pathways Program.

Once the individual is determined eligible for the Pathways program, the available services are reviewed and recommended by the child and family teams (CFT) included in the Pathways Program Model. The CFT, with the aid of the care coordinator (employed by the CCSO), will assist with the plan of care process. These teams will develop the initial plan of care and review the plans at each meeting. The Department is requiring the care coordinator to update the plan at least every 30 or 60 days, depending on the child's intensity of care coordination, and as needs and strengths change.

A significant number of youth participating in the Pathways Program are also receiving care coordination through the Medicaid MCOs. The Department is developing a process for these MCO care coordinators to interface with the CFT. Specifically, these care coordinators serve as the liaison from the MCO to the youth's CFT and will provide education and navigation, as needed, of the MCOs processes and requirements regarding covered benefits. In addition, the MCO care coordinator will assist the CFTs in their efforts to identify providers in their networks and to identify other resources to ensure access to services set forth in the youth's plan of care and assist the CFT to identify and reduce barriers to accessing care. The care coordinator will be invited to attend the CFT as requested by the youth and family.

While this process has been developed, detailed policies and procedures need to be developed within the next 90 days prior to the Pathways Program going live.

The Department, during this reporting period, identified that Respite, Therapeutic Support Services, Individual Support Services, and Psychiatric Treatment Facility Services will require a formal prior authorization. For services other than PRTF, these prior authorization criteria should be developed within the next 90 days. For PRTF services, medical necessity criteria will be applied as part of prior authorization and should be developed during the Department's efforts in Paragraph 13 regarding PRTFs. The Department should also provide MCOs with sufficient guidance to implement the criteria.

16. After the Approval Date and before final approval of the Implementation Plan, the parties agree to work collaboratively to address the needs of Class Members who require PRTF services on an emergent basis.

While the Department focuses initial implementation efforts on the development of home- and community-based services as required by Paragraph 13, it has and will continue to address the needs of Class Members demonstrating medical necessity for a PRTF level of care through the current Interim Relief process. The Implementation Plan sets forth the specification of the Interim Relief Process. The Expert has reviewed this process and concurs with the Department's Interim Relief approach. During this reporting period there were 39 children and youth referred for PRTF using this process. Fifteen of the 39 received PRTF services in out-of-state facilities. The 20 youth who were referred but did not receive placement through the Interim Relief Process were either placed under other programs/state agencies, did not respond to requests for information, or are on waitlists for programs. In addition, the Department has established a program with a provider in Northern Illinois area to provide short-term intensive residential treatment services to Interim Relief Class Members as an initial step to address youth with significant behavioral needs who are at-risk of out-of-state placement.

17. Defendant shall timely develop and implement a Model in the Implementation Plan that shall, at a minimum:

a) Include a structure to link Class Members to medically necessary services on the continuum of care.

The Department, in consultation with the Expert, has developed the processes for engaging children, youth, and caregivers to receive the continuum of behavioral health services offered though the Pathways Program. Specifically, the Department has developed a process flow that establishes how children and youth (who are not in DCFS care) are identified as a Class Member and are enrolled in the Pathways Program and identifies how youth will be offered either level of care coordination from the CCSO, the CFT process, and the service delivery options. This flow can be found on page 9 of the following link:

https://www2.illinois.gov/hfs/SiteCollectionDocuments/Pathways%20to%20Success%20Program%20Overview.pdf. The Department met with the N.B. Subcommittee to discuss these flows and make any necessary changes based on those conversations. These flows were included in the information regarding the Pathways Program that was disseminated during the summer 2021 town halls and other informational sessions.

The flow for Class Members in DCFS care is almost finalized between the HFS and DCFS. Final approval of these client flows will be discussed with the new leadership at DCFS. Similar to the process for children and youth not in DCFS care, children and youth in DCFS care will be referred for an IM+CANS, to determine if they meet the criteria for the Pathways Program, identify the care coordination tier, and set forth the activities CCSOs will undertake to provide outreach and engage the child, youth, and caregiver. The Expert recommends the Department finalize and operationalize this flow in the next 90 days and develop the operations protocols discussed earlier in this report that will provide information to DCFS caseworkers on how to access and participate in the Pathways Program.

b) *Provide statewide medically necessary mental and behavioral health services and supports required and authorized under the EPSDT requirement of the Medicaid Act that are sufficient in intensity and scope and appropriate to each Class Member's needs consistent with applicable law;*

c) *Provide notice to HFS-enrolled Primary Care Physicians ("**PCP**s") who perform periodic and medically necessary inter-periodic screenings to offer Class Members and families the opportunity to receive a mental and behavioral health screening during all periodic and inter-periodic screenings;*

EPSDT requires states to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT requires physicians and other practitioners to screen for certain conditions, including developmental and behavioral screening. These screenings are essential to identify possible delays in growth and development, as well as behavioral health challenges. The N.B. Consent Decree recognizes the need to improve behavioral health screening for children and youth who may have mental health or behavioral issues and to create the necessary referral pathways for primary care practitioners to additional assessments or treatment and supports.

The initial Implementation Plan sets forth a strategy for improving screening and referral for children and youth in Illinois with possible mental health and behavioral conditions. Specifically, the plan requires the Department to work with physician associations, psychiatric associations, and stakeholders to determine which nationally recognized screening tools should be utilized by PCPs as behavioral health screening tools. In addition, the Department, as part of the plan, will work with MCOs, physician associations, and other partners to conduct education and training for PCPs who serve Medicaid-eligible youth and families. The training will:

- Reinforce the EPSDT requirements to offer screening at all routine and periodic medical appointments
- Provide information on how PCPs can use these screening tools
- Determine how the PCPs are to notify MCOs of the screening results
- Support PCPs to make referrals to community mental health providers if a screening indicates further assessment may be appropriate
- Provide information for PCPs regarding the role of the CCSOs.

In 2020, the Department began developing a workgroup to make recommendations regarding which nationally recognized behavioral health screening tools should be utilized by PCPs. However, the Department has yet to launch the workgroup, adopt this tool, and provide training to PCPs on the tool, citing the delay in these activities was largely due to the pandemic. In the first report, the Expert recommended the Department convene the workgroup and finalize a decision regarding the tool and implement the necessary training for PCPs during this previous reporting period. The Department has neither finalized the tool nor conducted the training. The Expert is recommending the Department convene the workgroup within 90 days and finalize the recommended tools and begin training on this tool within 180 days.

d) Implement a standardized assessment process, including an assessment tool that shall be utilized statewide, for the purpose of determining Class Members' strengths and needs and informing treatment planning, medical necessity, intensity of service, and, as applicable, appropriate services for Class Members;

The Department developed and implemented a standardized assessment process to meet the intent of this paragraph. The standardized assessment tool created for this process is the Illinois Medicaid–Comprehensive Assessment of Needs and Strengths (IM+CANS). The IM+CANS integrates assessment and treatment planning into a single process. It contains a complete set of core items that assess function across multiple life domains such as risk behaviors, trauma exposure, behavioral/emotional needs, substance use, and cultural factors, as well as a physical health risk assessment. The Expert and the team have reviewed the IM+CANS and believe the instrument and process the Department has developed for its use regarding the N.B. Consent Decree should support its intended goal. In addition, the Department, through its partnership with the University of Illinois, has developed and implemented the necessary training and certification process for providers to deploy the IM+CANS. Currently, there are 15,672individuals that are IM+CANS certified.

Building upon the application of the IM+CANS to assess Class Members' needs, the Department has developed decision support criteria that will use IM+CANS data to operationally identify Class Members who are eligible to receive Pathways services. The Experts and Class Counsel have reviewed the decision support criteria and provided recommended changes to the criteria. The Department has made the changes to the decision support criteria requested by

the Expert and Class Counsel. During the last reporting period, the Department, in collaboration with the developer of the IM+CANS, also conducted a workgroup comprised of providers and others who are end-users of the IM+CANS for further refinements to the criteria. This multi-month process has been completed and the criteria is close to being finalized. Once finalized, the Expert and Class Counsel will review the criteria and either recommend additional changes or approve the criteria for implementation. The Expert recommends this be completed in the next 60 days prior to the launch of the Pathways Program.

The Department has also created the necessary infrastructure for providers to collect and submit information from the IM+CANS. As of July 1. 2020 certified providers began direct data entry into a portal created specifically for IM+CANS. As of December 31, 2021, 73,871 IM+CANS have been entered into this portal for children and youth under 21 who have behavioral health issues. Given that an IM+CANS is to be completed for every Medicaid enrolled child in need of behavioral health services, the Expert finds this number to be very low. The Department should undertake several steps to increase the number of children and youth who will receive an IM+CANS, since this will no doubt increase the number of children and youth that will be identified for the Pathways Program.

e) Establish a stratification methodology of identifying which Class Members qualify for particular services (including sub-acute care), the intensity of service delivery, and the intensity of care coordination, based upon the standardized assessment process and consistent with the requirements of the Consent Decree;

The Department has developed a decision support system using the IM+CANS to meet the intent of this paragraph. Information collected from the IM+CANS serves as the foundation of the stratification approach. Since November 2020, the Expert, N.B. Class Counsel, the Department, and the developer of the IM+CANS instrument have met to review the IM+CANS instrument and the stratification process to ensure that it is identifying cohorts of children with similar needs, strengths, and service utilization appropriate for each level of care coordination and service intensity. As indicated in 17.e, the Department is finalizing the IM+CANS-based decision support process that will stratify children and youth into two levels of care coordination based on the intensity needed and requested by the youth and their caregiver.

f) Establish tiers of care coordination consistent with the requirements of the Consent Decree, with caseloads and service intensity consistent with the stratification and assessment process. The Implementation Plan may provide that Class Members demonstrating the greatest needs and qualifying for intensive community services and sub-acute inpatient services shall qualify for intensive care coordination, such as High Fidelity Wraparound services, as defined by the National Wraparound Initiative (http://nwi.pdx.edu/). To the extent Class Members qualify for the services set forth in this Paragraph, such services will be provided in a timely manner;

As indicated previously in this report, the Department has developed two tiers of care coordination. These two tiers include:

- Care Coordination Services—High Fidelity Wraparound (CCSW) delivered in accordance with national standards for these services and delivered with a caseload of no more than one care coordinator to every 10 children (1:10). Children receiving CCSW will receive child and family team (CFT) meetings a minimum of every 30 days as well as frequent in-person and phone contacts.
- Care Coordination Services Intensive (CCSI) delivered in accordance with wraparound principles but with less frequent contact requirements with the child and family, as appropriate to stabilize the child's moderate behavioral health needs. CCSI care coordinators will have a caseload of no more than one care coordinator to every 25 children (1:25). Children receiving CCSI will receive CFT meetings a minimum of every 60 days as well as frequent in-person and phone contacts.

As discussed above, the Department had proposed a third tier of Care Coordination for transition age youth 19 years old and older. The Expert did not recommend a separate tier for these individuals and the Department chose to include these transition age youth in the two levels of care coordination.

> g) *Prepare and implement with reasonable promptness individual plans of care for each Class Member to serve the Class Member in the least restrictive setting appropriate to meet the Class Member's treatment goals. Individual plans of care shall describe the Class Member's treatment goals, objectives, and timetables for achieving these goals and objectives, including moving to less intensive levels of service, and that set forth the specific services that will be provided to the Class Member and family, including the frequency, intensity and providers of such services. The individual plans of care shall be reviewed at least annually and updated as needed to reflect the changing needs of the Class Member and family, using, as necessary, re-assessment and other clinical instruments to identify the changing needs of the Class Member and family. Individual plans of care may be prepared by or in conjunction with one or more MCEs;*

The Department has developed standards that set forth timeframes for development and review of a plan of care for Class Members who participate in the Pathways Program. The timeframes are consistent with the Implementation Plan and require the CFT (discussed in the paragraph below) to meet on a regular basis (every 30 days for children and youth receiving CCSW and every 60 days for children and youth receiving CCSI). The Department has also developed policies that require a plan of care to be revisited and potentially revised if the child or youth's condition changes between these established timeframes.

in CY 2020 the Department, in cooperation with the Expert and the University of Illinois Office of Medicaid Innovation and the School of Social Work, developed a training package for care coordinators in CCSOs to ensure services that set forth the process for convening the child and

family team and developing the plan of care. The training is consistent with both System of Care principles and national standards for Wraparound. The training and technical assistance for the CCSOs has been finalized and the Department has stated they will train the CCSO within 60 days of the Pathways Program going live.

As recommended by the Expert, the Department did not develop a standardized format for the individual plan of care but requires CCSOs to develop a plan of care format that includes the following items:

- Timeframe covered by the service plan
- Goals
- Objectives
- Recommended services
- Rendering provider for each service
- Amount and duration recommended for services.

In the previous report, the Expert recommended that the Department should develop reporting requirements and a tracking system to determine if the standards for the development and review of individual plans of care are being met. The Department has not developed these requirements. Therefore, the Expert recommends the Department develop these requirements and develop the necessary reporting requirements and mechanisms within the next 90 days.

h) Establish child and family teams including the group of people chosen by the Class Member and family with the aid of the care coordinator to assist with the treatment planning process;

The Department has included child and family teams (CFT) in their model. Both tiers of care coordination, the High-Fidelity Wraparound Level and the Intensive Care Coordination Level, require the use of CFTs in the development of the Plan of Care. The Department has developed preliminary requirements for CFTs. In the first report, the Expert recommended additional policies and protocols need to be developed or adopted by the Department to ensure that CFTs meet the provisions of this paragraph. This includes specific guidance to care coordinators regarding the protocols. The Department has stated they will include these policies in a provider handbook for CCSOs. The Expert is requesting the Department provide the Expert with the provider handbook prior to finalization for his review.

i) Establish a Mobile Crisis Response ("MCR") model, including the development of crisis stabilizers, to provide behavioral health crisis response on a twenty-four hour a day, seven day a week basis; the MCR shall be established consistent with, or as the successor to, the Screening, Assessment and Support Services ("SASS") program;

The Department has developed and implemented a Mobile Crisis Response Model as described in the review of paragraph 9. However, given a recent review of the MCR service system, the

Expert is recommending the Department take the appropriate actions recommended in paragraph 9 to improve the timeliness and quality of MCR teams.

j) Include a plan to coordinate among providers the delivery of services and supports to Class Members in order to improve the effectiveness of services and improve outcomes;

There are several activities the Department has undertaken (but has not yet implemented) to address this paragraph. In the first report, the Expert recommended each MCO develop a network development plan for services set forth in the Pathways Program. The Department has revised the process for network development for many of the services included in the Pathways Program. Specifically, the Department has taken on the role of recruiting and identifying the network for providers delivering Pathways Program services. Once identified, the Department will undertake a readiness review of certain providers (CCSOs and Intensive Home-Based) to ensure they can perform their duties prior to going live. All providers identified by the Department that enroll to provide services under the Pathways Program will initially be required to be in the MCOs' networks. The Department has included a requirement in the MCO contract to initially contract with all providers identified by the Department who are eligible to deliver Pathways Program's service array. This will remove the "guess work" for the MCOs to determine provider readiness for the Pathways Program and will also provide some assurance to providers that they will be included in the MCO networks. While this is no guarantee of referral or volume of referrals (which is dependent on the CFTs versus the MCOs), it does provide an incentive to recruit and train staff for potential referrals.

The Department's current MCO contract includes provisions for network adequacy and provider education. The draft contract is being amended to require the MCOs to meet the provisions for access to new services included in the N.B. Implementation Plan.

Given the Department's efforts to work with the MCOs in the initial development of the provider network for the Pathways Program, the Department should consider subsequent requirements for the MCOs in the second year of the Pathways Program to produce an updated network development plan specific to N.B. Class Members, including a process for the MCOs to collaborate on their network development efforts. Since children and youth in the N.B. Class will be enrolled across all managed care plans, it is in the Department's best interest to ensure efficiency and standardization in identifying, recruiting, and developing providers to offer these services. In addition, the Department should develop a process to specifically monitor these network development efforts, including a quarterly review of network adequacy for the Pathways Program's services.

k) Establish a process to communicate with Class Members, families, and stakeholders about the service delivery, service eligibility, and how to gain access to the Model, regardless of the point of entry or referral source; and

During this past year, the Department developed materials and processes for communication regarding the Pathways Program. This included information that was discussed in paragraph 9. However, the Expert continues to recommend the Department have a formal Communication Plan that takes into account the first year of implementation of the Pathways Program. The Expert recommends this plan be developed and presented to the N.B. Subcommittee within the next 90 days.

l) Contain procedures to minimize unnecessary hospitalizations and out-of-home placements.

The Department has developed messaging regarding a goal of the Pathways Program, to implement more effective home and community-based services to reduce inpatient behavioral health hospitalizations and out-of-home placements. If implemented correctly, the proposed care coordination approach, using a System of Care framework with fidelity to wraparound, emphasizes that children and youth receive services in the least restrictive setting. The Department has yet to develop provider guidance for CCSOs that will reinforce the minimal use of inpatient settings and other out-of-home placement. In addition, the Department will work with MCOs to develop policies and processes for the review and approval of admissions to PRTFs. As indicated in paragraph 15, the Department will need to develop the necessary medical necessity criteria and authorization processes for MCOs to use in order to ensure the criteria and processes for youth in acute crisis that need this level of care are applied consistently.

The Expert recommends the Department develop an initial data analytic strategy for determining how effective the work of the CCSOs, MCR Teams, other Pathways Program service providers, and the MCOs are in diverting children and youth from inpatient behavioral health and PRTFs. Initially, the Department should collect an aggregate baseline of emergency department (ED) visits and inpatient behavioral health admissions for children and youth. The Department should consider a "look back" period of two years to look at utilization for these children and youth. This can serve as a reasonable baseline proxy that can be compared to similar aggregate data regarding visits and admissions after the Pathways Program is implemented. The Expert is recommending this baseline be developed within the next 180 days.

As indicated in the first report, other out-of-home placements are outside the purview of the Department or their contracted MCOs. Admissions to Qualified Residential Treatment Programs (QRTPs), foster care, and other residential facilities are overseen by other state agencies. For N.B. Class Members who are in out-of-home placements and funded by Medicaid, the Department should, in close collaboration with DCFS, develop a longer-term strategy for preventing admissions to these placements. This approach should align with this paragraph of the N.B. Consent Decree and Family First Prevention Services Act (FFPSA)[4].

[4] https://www.childrensdefense.org/wp-content/uploads/2020/07/FFPSA-Guide.pdf

VI. IMPLEMENTATION

21. *Within nine (9) months after the Approval Date, Defendant shall provide Class Counsel and the Expert with a draft Implementation Plan. Class Counsel and the Expert will provide input regarding the draft Implementation Plan, which shall be finalized within twelve (12) months following the Approval Date. If, after negotiation, the Expert or Class Counsel disagrees with Defendant's proposed Implementation Plan, the Court shall resolve all disputes and approve a final Implementation Plan. The Implementation Plan, and all amendments or updates thereto, shall be filed with the Court and shall be incorporated into and become enforceable as part of this Consent Decree. Defendant shall make the Implementation Plan available to Class Members and the public by posting it to Defendant's website within five (5) business days after it is filed with the Court and within five business days after any changes to the Implementation Plan are filed with the Court. The Implementation Plan, must, at a minimum:*

a. *Establish specific tasks, timetables, goals, programs, plans, strategies and protocols describing Defendant's approach to fulfilling all of the requirements of this Consent Decree;*
b. *Describe the hiring, training and supervision of the personnel necessary to implement this Consent Decree;*
c. *Describe the activities required to support the development and availability of services, including inter-agency agreements, and other actions necessary to implement this Consent Decree;*
d. *Identify, based on information known at the time the Implementation Plan is finalized and updated on a regular basis, any Medicaid-authorized services or supports anticipated or required in Service Plans developed pursuant to this Consent Decree that are not currently available in the appropriate quantity, quality or geographic location;*
e. *Describe the methods by which information will be disseminated, the process by which Class Members may request services, and the manner in which Defendant will maintain current records of Class Member service requests;*
f. *Describe the requirements of an interim plan of care for individuals receiving services in accordance with Paragraphs 24-25 that is consistent with Paragraph 17(g); and*
g. *Describe the methods by which Defendant intends to meet the obligations of this Consent Decree.*

22. The Implementation Plan shall be reviewed by the Defendant at least annually and updated or amended as necessary. Class Counsel and the Expert shall have the opportunity to review and comment upon any proposed updates or amendments at least 60 days before the effective date of any updates or amendments. In the event Class Counsel or the Expert disagree with Defendant's proposed updates or amendments, Class Counsel shall state all objections in writing at least 30 days before the effective date of any updates or amendments. In the event that Defendant and Class Counsel do not agree on updates and amendments, the Court shall resolve any and all disputes before any updates or amendments become effective.

Paragraphs 21 and 22 are addressed together. The Department submitted the draft of the initial Implementation Plan within the required timeframes of the Consent Decree. However,

based on the Expert's and Class Counsel's review, the initial draft of the Plan was not adequate and the Department, in cooperation with the Expert and Expert's team, worked to revise and finalize the first Implementation Plan. The initial Implementation Plan was finalized in December 2019, just over 10 months after the 12-month anniversary of the signed Consent Decree. In this reporting period, the Department did provide an annual update to the Implementation Plan as required in Paragraph 22. The Department provided the Expert and the Class Counsel an opportunity to review the draft update to the Implementation Plan. Both the Expert and the Class Counsel provided input regarding the draft update to the Implementation Plan. This update to the Implementation Plan as drafted does not substantially change the direction of the Department's efforts to implement the N.B. Consent Decree. Rather, the update to the plan proposes changes to reflect the finalized Pathways Program, the updated federal authority under which Pathways services will be provided, and changes to some of the milestones and timeframes for achieving these milestones. Due to the delay in CMS approval of the 1915(i) SPA, the Department has not finalized the first update to the Implementation Plan. The Expert recommends the Department finalize the first update to the Implementation Plan within 30 days from obtaining CMS approval of the 1915(i) application.

In the first report, the Expert was to continue to assess the Department's staffing resources for the N.B. Consent Decree during the previous reporting period. Over the past year, the Department has added staff dedicated to the N.B. Consent Decree. These additional staff have demonstrated sufficient competencies in the knowledge of Class Members, Pathways Program services, and Medicaid managed care. These staff members have been instrumental in developing many of the deliverables discussed throughout this report.

VII. Named Plaintiffs and Class Members Who Received Preliminary Help or Interim Relief

24. After the Approval Date, any services granted to a Named Plaintiff or Class Member pursuant to any TRO or PI dissolved in accordance with Paragraph 23, or pursuant to a request made by Class Counsel without the entry of a court order during the pendency of this litigation prior to the Approval Date, shall continue until the services are either no longer necessary or the Class Member's needs are addressed in a manner consistent with the provisions of the Consent Decree and Implementation Plan. No later than 30 days after the Approval Date, Class Counsel shall provide a list identifying all individuals eligible for services pursuant to this Paragraph.

25. For each Named Plaintiff or Class Member who is receiving services pursuant to Paragraph 24, Defendant will assign a care coordinator, from an entity contracted by Defendant to provide such services, to manage the Class Member's case and provide care coordination services. The care coordinator will assist in developing an interim service plan in accordance with the Implementation Plan. Each Named Plaintiff or Class Member, and his or her family as necessary, shall cooperate with the care coordination service.

Paragraphs 24 and 25 are addressed together. According to the Class Counsel, there have been no identified service access issues for the original Class Members. It should be noted that many of the original Class Members are now 21 and older and therefore are no longer a Class

Member. For all Class Members continuing to receive Interim Relief services, the Department has assigned an Interim Relief Manager to manage the Class Member's case and coordinate services.

VIII. Benchmarks

35. Defendant is expressly permitted to implement the Model described in Paragraph 17 in phases. Defendant shall provide certification to the Court, Class Counsel and the Expert upon substantially meeting the following Benchmarks, pursuant to the standards that shall be established through timely amendment to the Implementation Plan as appropriate for each Benchmark:

> *A. Benchmark No. 1: Within five (5) years after approval of the Implementation Plan, Defendant shall accurately certify to Class Counsel, the Expert and the Court that substantially all systems and processes that Defendant intends to utilize to implement the Model in accordance with the Implementation Plan are at least operational as outlined in the Implementation Plan.*
>
> *B. Benchmark No. 2: Within two (2) years after the successful certification of Benchmark No.1, Defendant shall accurately certify to Class Counsel, the Expert and the Court that the Model is at a capacity to substantially serve the Class's needs for intensive home- and community-based services on a systemic level statewide. After successful certification of Benchmark No. 1, the Implementation Plan shall be amended (in accordance with the process set forth in Paragraph 22) to establish the standard for sufficient capacity that is necessary to substantially serve the Class's needs for intensive home- and community-based services on a systemic level statewide. Nothing in this Consent Decree shall be interpreted to require that the standard for Benchmark No. 2 guarantees that each Class Member will receive care or services precisely tailored to his or her particular needs.*

The provisions of this paragraph will be addressed in future Expert reports. However, the Expert does recommend that the Department identify measures that will be used to determine compliance with Benchmark One. Many of the measures recommended in paragraph 9 should be considered in the development of these benchmarks.

Major Expert Recommendations for Next Reporting Period

This report provides various recommendations for the Department over the next reporting period. However, many of these recommendations are contingent on several activities that are the implementation cornerstones of the N.B. Consent Decree. As indicated in several sections of this report, the delay in CMS approval of the 1915(i) SPA is a significant barrier. The Department must obtain approval from CMS for the Home and Community Based Services State Plan Amendment. This approval is necessary to give the Department the authority for implementing the proposed care coordination approach and the new services that were

established in the initial Implementation Plan. In addition, the Department must implement the Pathways Program. The Department has provided good communication regarding the program and clear referral protocols for child and youth to receive an IM+CANS. The Department should continue the network development strategy to support CCSOs and the providers of the new program's services. In addition, the Department should undertake the following Expert-recommended activities according to the timeframes set forth in this report.

Activity	Timeframe
Finalize the pending update to the Implementation Plan	Within 30 business days from obtaining CMS approval
Develop policies and processes for MCOs to review the plans of care	Within 90 days
Develop a quality assurance plan that includes the structural, process, and outcome measures for the Pathways Program	Within 90 days
Finalize the process flow for Class Members in DCFS custody	Within 90 days
Develop Communication Plan for first year of implementation of the Pathways Program	Within 90 days
Implement the workgroup to identify the behavioral health screening tool(s) for primary care practitioners	Within 90 days
Develop reporting requirements and mechanisms for CCSOs' key functions	Within 90 days
Perform the proposed record reviews for ensuring the quality of MCR	Within 180 days
Finalize selection of and begin training on the behavioral health screening tool	Within 180 days
Develop aggregate baseline data for ED visits and inpatient behavioral health admissions	Within 180 days