N.B. CONSENT DECREE IMPLEMENTATION PLAN

Illinois Department of Healthcare and Family Services

December 2, 2019

PURPOSE

The Illinois Department of Healthcare and Family Services (HFS) has developed this Implementation Plan to satisfy the requirements of the N.B. v. Eagleson Consent Decree (Case: 1:11-CV-6866, Document No. 250, January 16, 2018).

CONTENTS

EXECUTIVE SUMMARY

The Department, in conjunction with the N.B. Consent Decree Expert and input from Class Counsel and additional stakeholders, has developed this Implementation Plan to address the requirements of the N.B. Consent Decree that was entered by the Court in January of 2018.

The Consent Decree requires the State 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 Model described in this initial Implementation Plan is grounded in evidence-based, evidence-informed and best practices known at the time of its finalization. However, the Department will continue to research and explore developing practices and services that may better inform or improve the Model for Class Members. In addition, the practices or services included in this initial Implementation Plan may be revised during future Implementation Plan reviews to include different or modified practices or services as necessary to improve the Model and better address the needs of Class Members.

The Model is described in the Implementation Plan through the following sections that provide a detailed discussion 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:

Section A provides a brief history and background of the lawsuit, describes how the Department will operationally identify Class Members, outlines each of the components of the Model required by the Consent Decree, describes how Class Members will experience the Model, and indicates where in the Implementation Plan each component of the Model is addressed.

Section B discusses the first component of the Model: Ongoing Class Member and Family Input into the development, implementation and ongoing functioning of the Model through the establishment of the Children's Behavioral Health Family Leadership Workgroup and requirements of managed care organizations.

Section C discusses the second component of the Model: Managed Care Organizations (MCOs) that will offer access to medically necessary services for Class Members, development of provider networks that include necessary behavioral health providers to meet the needs of Class Members, clinical oversight, utilization review, quality improvement functions and other activities to ensure that Class Members are receiving the right service, in the right amount, at the right time.

Section D discusses the third component of the Model: Integrated Health Homes (IHH) that will provide care coordination for Class Members through either High Fidelity Wraparound, Intensive Care Coordination or Care Coordination for Transition Age Class Members (starting at age 19). This section also describes the stratification algorithm that the Department will use to determine which Class Members with which combination of needs, strengths and service utilization will benefit most from these levels of care coordination.

Section E discusses the fourth component of the Model: New Services, Providers and Policies to Enhance Access to Behavioral Health Services. This section covers behavioral health screenings by Primary Care Physicians, Mobile Crisis Response, Crisis Stabilization, Intensive In-Home Services, Crisis "Beds", Respite and Integrated Assessment and Treatment Planning, as well as proposed services of Family Peer Support and Therapeutic Mentoring. This section also describes new providers of behavioral health services and other policies designed to expand access to services.

Section F discusses the fifth component of the Model: Psychiatric Residential Treatment Facilities (PRTF) that will be phased in upon sufficient implementation of MCOs, IHHs and the new behavioral health services as necessary to support discharge and diversionary efforts.

Section G discusses the Implementation Training and Technical Assistance that the Department will offer MCOs, IHHs and other providers of children's behavioral health services by establishing a Children's Behavioral Health Technical Assistance and Training resource.

Section H discusses Cross-Agency Collaboration on Model Development and Implementation to ensure that all child-serving agencies are able to provide input on the development and implementation of the Model. The Department will emphasize collaboration with the Department of Children and Family Services to ensure that processes included under this Implementation Plan appropriately address the needs of DCFS Youth in Care who are also Class Members and support collaboration between systems.

Section I offers an overview of the Implementation Steps and Timelines that will be utilized to implement the Model, including identification of federal and state approvals that must be obtained to implement the Model.

Section J discusses the Benchmarks for demonstrating compliance with the Consent Decree.

Section L discusses the Personnel Necessary to Implement the Consent Decree including the staffing of the Bureau of Behavioral Health and coordination with other bureaus within the Department.

A. OVERVIEW OF CONSENT DECREE AND MODEL

Beginning in September 2011, nine (9) children with behavioral health conditions and their next friends brought the N.B., et al. v. Eagleson class action lawsuit, No. 11-CV-6866 in the Northern District of Illinois, against the Director of the Department of Healthcare and Family Services (HFS), seeking declaratory and injunctive relief pursuant the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of the Medicaid Act, 42 U.S.C. § 1396a(a)(43), 1396d(r), and Title II of the Americans with Disabilities (ADA) Act, 42 U.S.C. § 12132, and the parallel provision of the Rehabilitation Act (RA), 29 U.S.C. §794. The Plaintiffs asserted that Illinois did not provide medically-necessary mental and behavioral health services as required under EPSDT, including home- and community-based services in the most integrated setting appropriate to their needs, as required under the ADA and RA. The Plaintiffs sought declarative and injunctive relief so as to implement appropriate screening and treatment alternatives to the acute care offered in general and psychiatric hospitals.

In February of 2014, the Court certified a Class defined as:

"All Medicaid-eligible children under the age of 21 in the State of Illinois:

1. Who have been diagnosed with a mental 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."

On January 16, 2018, the Court entered the Consent Decree, requiring the State 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. These services and supports shall constitute a continuum of care that will be provided through the development of a Medicaid behavioral health delivery model ("Model") for Class Members, as provided in the Consent Decree.

The purpose of the Consent Decree and Implementation Plan is to set forth a systemic approach to provide Class Members and their families with medically necessary Medicaid behavioral health services through the Model. In order for the State to serve such a broad Class on a systemic level, HFS will utilize a referral and Model-required assessment process to operationally identify Class Members and their needs consistent with Paragraph 17 of the Consent Decree.

Systematic identification of Class Members individually and as a population within the Illinois Medical Assistance Program will be essential to ensuring Class Members receive appropriate and timely access to the Model. The systemic data available from the identification will also be essential for monitoring the progress of implementation and the functioning of the system throughout the life of the Consent Decree.

Therefore, consistent with the assessment and stratification requirements of the Model in Paragraph 17(e), this process will identify all Medicaid-eligible children under the age of 21 (i.e., child or children) for whom: 1) an LPHA has completed the standardized, HFS approved Integrated Assessment and Treatment Planning (IATP) instrument (e.g., IM-CANS) indicating that the child has a mental or behavioral health diagnosis; and 2) supporting information, including but not limited to, claims or other utilization data, if available, indicates that the child meets eligibility criteria for intensive home and

community-based services coordinated by an Integrated Health Home (IHH). These Class Members and their families will be identified to receive medically necessary services provided through the Model. Any Medicaid-eligible child under the age of 21 that may be a Class Member and is brought to the Department's attention will be connected with an appropriate provider for a LPHA to complete the IATP instrument to identify need for intensive home and community-based services as outlined below.

The Model described in this initial Implementation Plan is grounded in evidence-based, evidence-informed and best practices known at the time of its finalization. However, the Department will continue to research and explore developing practices and services that may better inform or improve the Model for Class Members. In addition, the practices or services included in this initial Implementation Plan may be revised during future Implementation Plan reviews to include different or modified practices or services as necessary to improve the Model and better address the needs of Class Members.

The Model will be comprised of the following overarching components: Ongoing Class Member and Family Input; Managed Care Organizations (MCO); Integrated Health Homes (IHH); New Services, Providers and Policies to Enhance Access to Behavioral Health Services; and, Psychiatric Residential Treatment Facilities (PRTF) that will be phased in upon sufficient implementation of MCOs, IHHs and the new behavioral health services as necessary to support discharge and diversionary efforts.

While the Implementation Plan will address each area of the Model separately, as outlined in Table 1 below, Class Members and their families should have a consistent experience of receiving timely treatment and supports regardless of the entry point from which they access the service system established through the Model. There will be multiple entry pathways through which children with behavioral health challenges will be identified and then referred for an assessment to determine eligibility for services. These pathways include: Parents/caregivers or legal guardians accessing community mental health providers for services; identification by Primary Care Physicians through regular, periodic screening; Managed Care Organization determinations; Mobile Crisis Response interventions; referrals from system partners including schools, child welfare, and juvenile justice; and any other way in which a child presenting with behavioral health needs comes to the attention of the Department or its system partners.

All of these pathways will ensure that a Medicaid-eligible child experiencing behavioral health challenges is referred to a provider who has been certified in the completion of the IM-CANS, or successor instrument.

The provider will complete the IM-CANS with the child and family and will enter that information into the statewide assessment data system. The assessment information will be processed through the Department's stratification algorithm with supporting information to determine the child's qualification for services as provided in Paragraph 17(e) of the Consent Decree and to operationally identify Class Members, as referenced above. The development and implementation of the assessment data system and the stratification algorithm with supporting information is discussed in depth in Section D.

If the child is identified by the State as a Class Member and is enrolled in an MCO, the Department will notify the MCO of the child's status as a Class Member. The MCO will contact the family to notify them of the child's status as a Class Member and will offer the Class Member and their family the opportunity to have and select an IHH. The MCO will work with the Class Member and their family to connect them with the IHH that will engage the family in care coordination, as discussed in Sections C and D.

For children not enrolled in an MCO, the Department will contract with an external vendor to provide similar administrative management to facilitate access to an IHH, or other care coordination entity. If the child is determined to be a Class Member and is not enrolled in an MCO, the Department will notify the external vendor of the child's status as a Class Member and the external vendor will notify the family about the child's status as a Class Member and will offer the Class Member and their family the opportunity to have and select an IHH that will engage the family in care coordination, as discussed in Section D.

For Class Members who have co-occurring mental or behavioral health disorders and Intellectual / Development Disability (I/DD), services will be available through the Model to assist in amelioration of their mental or behavioral health condition. For youth who are diagnosed with I/DD only, there are current State service delivery systems that have longstanding relationships with these youth, their families and community. The Department is currently developing additional specialized services to better meet the needs of youth with I/DD, both with and without co-occurring mental or behavioral health diagnoses. The Department will ensure that Class Members who require I/DD specialized services are connected to these services through their Integrated Health Home to support but not supplant existing and developing I/DD service delivery systems.

Table 1 provides a crosswalk of the Model components to the specific provisions in the Consent Decree.

Table 1: Model Components Crosswalk from Consent Decree to Implementation Plan

Consent Decree Paragraph Reference	Provision included in Consent Decree	Model Component that addresses Consent Decree Provision
17(a)	Include a structure to link Class Members to medically necessary services on the continuum of care;	Model Component #2: Managed Care Organizations Model Component #3: Integrated Health Homes
17(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;	Model Component #2: Managed Care Organizations Model Component #3: Integrated Health Homes Model Component #4: New Services and Provider Types

Consent Decree Paragraph Reference	Provision included in Consent Decree	Model Component that addresses Consent Decree Provision
17(c)	Provide notice to HFS-enrolled Primary Care Physicians ("PCPs") 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;	Model Component #4: New Services and Provider Types
17(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;	Model Component #3: Integrated Health Homes Model Component #4: New Services and Provider Types
17(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;	Model Component #3: Integrated Health Homes Model Component #4: New Services and Provider Types
17(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;	Model Component #3: Integrated Health Homes Model Component #4: New Services and Provider Types

Consent Decree Paragraph Reference	Provision included in Consent Decree	Model Component that addresses Consent Decree Provision
17(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;	Model Component #3: Integrated Health Homes
17(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;	Model Component #3: Integrated Health Homes
17(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;	Model Component #4: New Services and Provider Types
17(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;	Model Component #2: Managed Care Organizations Model Component #3: Integrated Health Homes

Consent Decree Paragraph Reference	Provision included in Consent Decree	Model Component that addresses Consent Decree Provision
17(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	Model Component #1: Ongoing Class Member and Family Input
17(l)	Contain procedures to minimize unnecessary hospitalizations and out of home placements.	Model Component #1: Ongoing Class Member and Family Input Model Component #2: Managed Care Organizations Model Component #3: Integrated Health Homes Model Component #4: New Services and Provider Types

The sections below offer a detailed discussion of each Model component and also include the following details, as required in Paragraph 21(a):

- the specific tasks, timetables, goals, programs, plans, strategies and protocols describing the State's approach to fulfilling all of the requirements of the Consent Decree;
- the activities required to support the development and availability of services, and;
- 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.

B. MODEL COMPONENT #1: ONGOING CLASS MEMBER AND FAMILY INPUT

First and foremost, the Implementation Plan will outline how Class Members and their families will be continually engaged in the development and implementation of the Model to ensure it is built in a manner that meets their needs. The term "family" as used for purposes of the Model is inclusive of the child's biological family, adoptive family, guardian and/or authorized caregiver, as appropriate to each child's needs and situation.

Because nearly all Class Members will be enrolled with MCOs, the Department has established several feedback and input processes for them and their families by requiring MCOs' to establish plans for Family Driven Care, Family Leadership Councils and Quality Management Committees, further described below.

The Department required each MCO to submit a plan for Family-Driven Care that addressed how the MCO will establish and maintain a behavioral health service delivery system that is youth and family

centric, how they will promote and ensure child and family input across the State, and their annual goals, objectives, and activities related to family and child driven care through the establishment of a Family Leadership Council (FLC).

The FLC is co-chaired by a young adult, the parent or guardian of a child with lived experience within public child-serving systems (e.g., mental health, welfare, education, etc.), and a member of the MCO's leadership team who has the authority to speak to program design and issues. Membership of the FLC is comprised of, at a minimum of fifty-one percent (51%), children and parents/guardians of children from across the State who have lived experience with public child-serving systems.

The plans for Family Driven Care were submitted to HFS in early 2018 and were reviewed with each MCO. MCOs are currently implementing their plans for Family Driven Care, and HFS will be following up with each plan regarding their implementation progress through regular and ongoing meetings between the Department and the MCOs' Children's Behavioral Health Program Managers, as described in Section C, to ensure that the implementation of plans for Family Driven Care and services for Class Members are consistent across all of the MCOs.

Additional Class Member and family feedback is provided by each MCO's Quality Management Committee (QMC), responsible for semi-annual consumer satisfaction, performance, and outcome data review and reporting. The Department will establish specific performance and outcome standards related to Class Members and will monitor MCOs' QMC reports to ensure quality improvements are made in accordance with the report. Penalties and/or sanctions will be assessed to MCOs that do not perform in accordance with the established standards for Class Members, as required in the MCO contracts.

As noted in Section A, for Class Members not enrolled in an MCO, the Department will contract with an external vendor to connect those Class Members to an IHH. The Department will also require the external vendor to assist in organizing a FLC for the children and families served outside of MCOs. The external partner will help identify children and parents/caregivers who could be co-chairs for the FLC along with a Departmental staff member and will assist the Department in contacting potential members. The FLC membership requirements and meeting schedule will be the same as the FLCs under the MCOs.

As another avenue to solicit feedback from families and other stakeholders, the State established an N.B. Subcommittee of the Medicaid Advisory Committee in July of 2018. The Subcommittee consists of providers, provider and managed care trade associations, and family/community advocates. Four N.B. Subcommittee meetings have been held and comments from the Subcommittee and others have been considered to ensure integration of the feedback from the Subcommittee and stakeholders into the development of this Implementation Plan.

The N.B. Subcommittee meetings will continue on a regular basis to continue to allow provider and other stakeholder input throughout the implementation of the Model. The Department will use this information to address implementation concerns or barriers that providers and other stakeholders may experience, to gather feedback on the design of Model components to ensure that providers can implement them, to identify additional areas in which providers may need additional training or technical assistance and gather input on other areas of concern for providers.

Within six months of the approval of the Implementation Plan, the Department also will establish a new Children's Behavioral Health Family Leadership Workgroup through which Class Members and their families can partner directly with the Department to offer ongoing input into the development, implementation and overall quality of the Model.

This workgroup will be co-chaired by an HFS staff member, who has the authority to address program design and implementation issues, a young adult, and the parent/guardian of a child with lived experience accessing services through the publicly funded children's behavioral health system. Membership of this workgroup shall be comprised of the co-chairs of the Family Leadership Councils from each MCO and the Department's external vendor along with a maximum of five additional family and child advocates or organizations.

The Children's Behavioral Health Family Leadership Workgroup will be responsible for tasks such as the following:

- Reporting to the Department key findings from each Family Leadership Council, identifying high priority issues for Departmental consideration to improve services for Class Members and other children with behavioral health concerns and making recommendations for improvements in the organization and coordination of Family Leadership Councils;
- Reporting on quality of care elements (e.g., Class Member and family happiness/satisfaction with services, providers, MCOs and quality of life improvement measures) gathered from Class Members enrolled with each of the MCOs;
- Utilizing data provided from each MCO in a consistent format required by the Department to develop a publicly available report card for providers who are serving Class Members, grading providers in areas such as ongoing engagement with families, quality of service offered to Class Members, overall progress experienced by Class Members, Quality of Life improvements experienced during and after working with the providers, etc.;
- Providing specific information to improve and enhance the outreach to Class Members and their families to educate Class Members and families regarding the Model, how Class Members and families can advocate for services that they need, how Class Members and families can access support, guidance and connection to other supportive family resources, as needed; and,
- Providing input in other areas related to Class Members services and other children's behavioral health services identified by the Workgroup.

The co-chairs of the Children's Behavioral Health Family Leadership Workgroup will be members of the N.B. Subcommittee to ensure ongoing communication between the two groups. In this manner, the Subcommittee and the workgroup will function as the conduit for ongoing communication between HFS, MCOs and Class Members, families and stakeholders about the service delivery system, as required in Paragraph 17(k).

C. MODEL COMPONENT #2: MANAGED CARE ORGANIZATIONS

Under the statewide Medicaid managed care program, HealthChoice Illinois, the State contracts with five MCOs, that are each responsible for monitoring care for a segment of the population. Thus, HFS is

tasked with overseeing five MCOs rather than directly overseeing the care for over two million individuals.

The HealthChoice Illinois MCOs were chosen through a competitive Request for Proposal process and began serving Medicaid-eligible individuals in January 2018. The MCOs receive an actuarially-sound, monthly capitation payment and are "at risk" for managing enrolled individuals' needs and Medicaid covered services. MCOs complete Health Risk Screenings and Health Risk Assessments that identify physical and behavioral health needs of individuals and are also responsible for care monitoring, engagement of individuals, utilization review, prior authorization, and maintaining a network of physical and behavioral health providers pursuant to specific access requirements to ensure individuals have access to physical and behavioral health services.

Because MCOs hold financial risk for the health care costs of their enrollees, they have additional responsibility and incentives to focus on high-needs enrollees such as Class Members. High-needs enrollees tend to utilize high-cost services, such as hospital emergency department and inpatient care. MCOs are incentivized to reduce reliance on these highly restrictive, high intensity services by providing effective preventive care and home- and community-based services.

Paragraph 15 of the Consent Decree provides that the State may require Class Members to enroll with a managed care entity for any or all care coordination, care management and services. Therefore, HFS has elected to utilize HealthChoice Illinois MCOs as the foundation for the structure to link Class Members to medically necessary services for those Class Members that are enrolled in managed care plans, as required in Paragraph 17(a). For Class Members who are enrolled in managed care, the MCOs will facilitate linkage to Integrated Health Homes (IHH) to engage the Class Member and family in care coordination, as discussed in Section D.

In addition, a specific HealthChoice Illinois program has been developed for DCFS Youth in Care and Former Youth in Care that is tailored to the specific needs of these youth, their guardians, caseworkers, foster parents, adoptive parents, and other people involved in their care. This program is called YouthCare and is being developed through extensive collaboration between HFS, DCFS and relevant stakeholders to ensure that the healthcare services provided under YouthCare are complimentary of DCFS processes and to ensure that all parties involved in the care of DCFS Youth have a thorough understanding of their ongoing role with the DCFS Youth. Class Members who are enrolled in YouthCare will have access to the network of services and providers available for Class Members who are enrolled in other MCOs.

While Illinois is expecting to enroll 80% of Medicaid-eligible individuals, including the majority of Class Members, into a HealthChoice Illinois MCO, it is important to note that Class Members who are not enrolled in managed care and are covered under fee-for-service will be provided with access to the same components of the Model and services. For Class Members who are not enrolled in an MCO, the Department will contract with an external vendor to provide administrative management of access to IHHs and Family Leadership Council participants, as described in Section B. The external vendor will facilitate the linkage to the IHH that will provide the foundation for the structure to link Class Members to medically necessary services.

While Children's Behavioral Health requirements are contained in Attachment XXII of the current MCO contract, the Department intends to revise and enhance the expectations within the model contract and within Attachment XXII to clearly delineate the MCOs' responsibility for overseeing services and

supports that are designed for Class Members. The following contract language establishes the Department's authority to require such revisions: "Contractor shall consult and cooperate with the State in meeting any obligations the State may have under any consent decree… Contractor shall modify its business practices, as required by the State, in performing under the Contract in order for the State to comply with such consent decrees and, if necessary, enter into any amendments to the Contract…"

Utilizing this clause in the MCO contract, the Department will work with MCO plans to amend the current contract to include specific requirements in the following areas:

Key Position to Manage Children's Behavioral Health Programming

Section 2.3 of the model contract designates Key Positions that must be identified by the MCO to cover specific programmatic areas. The Department will require each MCO to designate a Children's Behavioral Health (CBH) Program Manager responsible for managing the MCO's CBH programs and services, and overseeing and training internal CBH staff. This position will be required to obtain certification in the IM-CANS and in the Wraparound process, as described in Sections D and E, and will ensure that CBH staff are knowledgeable and adhere to the requirements of the CBH program with special attention to requirements of the N.B. Consent Decree. This position shall ensure that each MCO submits to the Department timely and accurate reports and other information specific to the N.B. Class Membership, including but not limited to, provider network adequacy for specific Class Member services, service gaps, process and quality outcomes and other reports or information requested by the Department. The CBH Program Manager will be required to meet regularly with the Department and with other MCOs' CBH Program Managers to ensure that Class Members are receiving consistent services across all of the MCOs.

Integrated Health Homes and Other Services Access Standards

HFS requires MCOs to meet federally required access-to-care standards that set minimum requirements in areas such as the adequacy of the MCO's network of contracted providers, the distance and time that a Class Member must travel to receive a service, the accessibility of provider buildings for Class Members with disabilities, and how long Class Members may wait to get an appointment with a provider. The Department will also ensure development of IHHs and additional services to address Class Members' needs consistent with the applicable federal access standards. These additional services include, but are not limited to, Intensive In-Home, Family Peer Support, Respite and Therapeutic Mentoring.

In addition, MCOs will be required to identify and ameliorate gaps in service access to ensure that all required services are available to Class Members within the required access-to-care standards. HFS will also work in conjunction with MCOs to address the ongoing need to further develop provider capacity and workforce adequacy, as these issues are identified. MCOs will be required to report regularly on their compliance with access-to-care standards and to provide detailed corrective plans for identified gaps in service access. The Department will monitor to ensure the corrective plans are implemented and the gaps in service access are addressed by the MCO.

Consistent Standards and Eligibility Criteria for IHH and Services

The Department will, in collaboration with MCOs and the N.B. Consent Decree Expert, establish standards to be applied consistently across all MCOs for IHHs and the additional behavioral health

services that will be available to Class Members, as outlined in Section D and Section E. The Department will also establish consistent eligibility criteria for IHHs and for services that will be based upon the IM-CANS, or successor instrument, and supporting information, consistent with Paragraphs 15 and 17 of the Consent Decree. All HealthChoice Illinois MCOs will be required to utilize this consistent eligibility criteria when reviewing service utilization for Class Members.

The Department will review MCO policies and procedures for compliance with Department approved standards, will regularly monitor and audit through record reviews and claims data, and will solicit survey data from Class Members and their families to confirm that each MCO is implementing Provider Standards and Eligibility Criteria uniformly for Class Members.

Integrated Health Home Network Development and Support

To build a statewide network of IHHs, the Department will establish a process for recruitment and selection of IHHs, in collaboration with the MCOs. To qualify, the potential IHHs will have to provide sufficient documentation and other information to demonstrate that they meet all of the Departmental required Provider Standards for IHHs, outlined in Section D.

Once the IHHs have been selected, the Department, in collaboration with MCOs, the Department's External Quality Review Organization and/or other Department vendor, will conduct readiness reviews of the IHHs to verify their capacity to serve Class Members prior to Class Members receiving services. It is anticipated that this will be an ongoing process, since IHH providers will need to be replaced or added over time as necessary to maintain a sufficient network of IHHs to serve the Class.

MCO Role

MCOs will work with the Department to develop the provider network for IHHs and other services and will be required to contract with an appropriate number of IHHs to comply with service access standards. The role of the MCO will be maintaining the provider network, reimbursing providers for covered services and ensuring that Class Members have access to services and providers. The role of the IHH will be to coordinate the services made available to Class Members through the MCOs (or fee-for-service basis), as more fully described in Section D. MCOs will be required to reimburse IHHs for care coordination services provided to their enrolled Class Members. The Department will include funding for IHHs in the MCOs' monthly rates and will include specific requirements regarding payment of IHHs in the MCOs' contract.

MCOs will also be required to assist the Department in providing ongoing training, support and technical assistance to the IHHs and other service providers. The MCO contracts currently require MCOs to identify staff who are certified as IM-CANS trainers available to assist the Department in training providers on the utilization of the IM-CANS instrument. These MCO identified IM-CANS trainers are already working with the Department's external vendor to train community mental health providers on the use of the IM-CANS. The Department will determine whether the MCO contracts should be amended to require MCOs to hire additional staff to assist in other training and technical assistance areas related to Class Member services.

Additionally, MCOs will be responsible for utilizing Departmental guidelines when monitoring the care of their enrolled Class Members. The MCO will employ staff who are trained in and required to utilize the

IM-CANS, or successor instrument, in accordance with Departmental guidelines, when reviewing service utilization for Class Members. The utilization of consistent Departmental guidelines across all MCOs will ensure that utilization criteria are applied consistently for all Class Members.

Quality and Outcome Measures for Class Members

Attachment XXII of the MCO contract includes requirements related to community stabilization, admission, discharge and transition planning for Class Members that are hospitalized or in other residential treatment facilities along with requirements for priority access to a psychiatric resource for consultation and medication management services. The MCO contracts will be amended to require regular reports regarding each of the Attachment XXII requirements as well as additional specific quality and outcome measures for Class Members, may include out-of-home placement rates, length of stay in residential/PRTF, school attendance/performance, increase in identified strengths, decrease in identified needs, etc.

MCOs also will be required to submit reports on structural and process measures related to system functions (e.g., how many service providers have been trained in new services, how many providers are actually offering the services, how many Class Members have been engaged and have Individual Plans of Care completed, etc.). The Department will establish goals for the structural and process measures that the MCOs must meet within required timelines to ensure that the Model infrastructure is being established in an efficient manner. HFS will also work in conjunction with MCOs and sister agencies such as DCFS to address the ongoing need to further develop provider capacity and workforce adequacy, as these issues are identified.

The Department will also require MCOs to submit regular reports related to quality outcomes (e.g., how many Class Members' school attendance improved), utilization of services and expenditures for Class Members. Additional reporting measures for Class Members will be determined with the input of MCOs, stakeholders and the N.B. Consent Decree Expert.

The Department will establish regular, frequent, ongoing meetings with the CBH Program Managers and other MCOs staff to monitor and address the above-mentioned requirements, IHH implementation, access-to-care standards and to reinforce the MCOs' role in the performance of the system as a whole. If deficiencies are identified, the Department will work with the MCO to remedy those deficiencies. However, if deficiencies in any of these areas persist, there may be financial penalties or suspension of new enrollments for the MCO enforced until the deficiencies are addressed.

An overview of HealthChoice Illinois can be located at this link for reference: https://www.illinois.gov/hfs/healthchoice/Pages/default.aspx.

The Model Contract can be located at: https://www.illinois.gov/hfs/SiteCollectionDocuments/2018MODELCONTRACTadministrationcopy.pdf.

D. MODEL COMPONENT #3: INTEGRATED HEALTH HOMES (CARE COORDINATION PROVIDERS)

Integrated Health Homes (IHH)[1] will provide many of the key components of the Model required by Paragraph 17 and Paragraph 21(e) of the Consent Decree for Class Members enrolled in managed care and Class Members covered under Medicaid fee-for-service. While the Department is considering utilizing the Integrated Health Home option under Section 2703a of the Affordable Care Act as the authority to provide the level of care coordination required for Class Members, the Department will explore other available federal authorities for the required care coordination. The Implementation Plan will refer to Integrated Health Homes as the entities that will provide the required care coordination and will outline the care coordination activities that will be provided to Class Members regardless of the federal authority under which the care coordination is covered.

Integrated Health Homes (IHH) for Class Members will reflect current best practice approaches and system of care principles including interagency collaboration; individualized strengths-based care; cultural competence; child and family involvement; community-based services; and accountability. System of care values and practices establish an organizational framework for providing supports and services for children, youth, and young adults with a serious emotional disturbance and their families/guardians/caregivers. System of care philosophy encourages collaboration across agencies and promotes the active involvement of families, children, youth, and young adults in the design and implementation of individualized, strength-based Individual Plans of Care. [https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf]

IHHs are structured to address key Model components including establishing tiers of care coordination, preparing and implementing Individual Plans of Care, establishing Child and Family Teams, coordination among providers regarding the delivery of services and minimizing lengths of stay and unnecessary hospitalizations and residential treatment. The IHH will also ensure that medically necessary physical, mental and behavioral health services are coordinated and accessible as authorized under EPSDT for Class Members, and will assure ongoing communication with Class Members, families and stakeholders.

IHH Care Coordination Levels and Requirements

The Department will establish three levels of care coordination intensity that IHHs will provide to meet the behavioral health needs of Class Members: High Fidelity Wraparound (high intensity level); Intensive Care Coordination (moderate intensity level); and Care Coordination for Transition Age Class Members Starting at Age 19.

High Fidelity Wraparound Level

High Fidelity Wraparound is a structured approach to service planning and care coordination that adheres to specified procedures for engagement, individualized care planning, identifying and leveraging strengths and natural supports, and monitoring progress and process. The High Fidelity Wraparound approach incorporates a dedicated full-time Wraparound Facilitator

[1] The term Integrated Health Home is used for consistency with the Federal terminology in Section 2703a of the Affordable Care Act to describe a provider of comprehensive care coordination, not a physical home or location.

working with a small number of Class Members and families with access to family peer support, as needed for the family. [https://www.nwic.org]

Wraparound Facilitators engage Class Members and their families to build their own Wraparound team to develop and monitor a strengths-based Individual Plan of Care. Wraparound Teams will function as the Child and Family Team for the High Fidelity Wraparound Level and will address Class Member and family/caregiver strengths and needs holistically across domains of physical and behavioral health, social services, natural supports, etc. Through the team-based planning and implementation process, High Fidelity Wraparound facilitates the development of problem-solving skills, coping skills, health and wellness, and self-efficacy of the young person and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network. [https://nwi.pdx.edu/pdf/WrapROI.pdf]

The High Fidelity Wraparound level will require a Wraparound Facilitator to Class Member ratio of 1:10. At a minimum, this level requires monthly face-to-face Wraparound team meetings; additional face-to-face contact with the Class Member and family; additional phone contacts as necessary to assist the Class Member and family in stabilizing behavioral health issues and addressing identified needs.

The Wraparound team will review the Individual Plan of Care at each meeting and the Wraparound Facilitator will update it at least every 30 days, and as needs and strengths change. The IHH will develop a Crisis Safety Plan (CSP) with the Class Member and family within seven days of their enrollment into the Wraparound level that will be reviewed, at a minimum, monthly at the Wraparound team meetings, and updated as necessary.

Every IHH staff member who will be providing or who will be supervising staff who are providing High Fidelity Wraparound will have to complete training in the High Fidelity Wraparound process provided by a Department identified and approved organization, as described in Section I. Additionally, the supervisors will have to be certified as Wraparound coaches by a Department identified and approved organization.

A Wraparound Facilitator, who has been certified in the Wraparound process, will be responsible for facilitating the Wraparound team that will consist of the Class Member, the family, family identified supportive individuals and other professional staff needed to meet the behavioral, physical and social needs of the Class Member (e.g., Family Peer Support provider, Nurse Care Manager, PCP Consultant, Wellness Coach, Hospital Liaison, etc.).

If the Class Member is a DCFS Youth in Care, the Wraparound team will function as the "Child and Family Team" for the DCFS Youth in Care. The Wraparound Facilitator will work collaboratively with the DCFS caseworker in facilitating this team and will assist the caseworker in identifying and providing access to all medically necessary Medicaid covered services for the DCFS Youth in Care Class Members. DCFS and the caseworker will retain relevant decision-making authority in the Child and Family Team process as the guardian of DCFS Youth in Care Class Members.

Class Members who meet criteria for High Fidelity Wraparound will receive an initial six (6) months of service at the level. Continued High Fidelity Wraparound will be provided if the Class Member continues to meet the eligibility criteria for this level of care coordination.

Intensive Care Coordination Level

The Intensive Care Coordination level will also be built on System of Care principles including interagency collaboration; individualized strengths-based care; cultural competence; child and family involvement; community-based services; and accountability. However, the Intensive Care Coordination level will serve Class Members that do not meet the medical necessity for High Fidelity Wraparound but will benefit from an intensive level of care coordination to assist them in maintaining stability in the community. This level will also provide a "step down" option for Class Members who have completed the High Fidelity Wraparound process outlined above and meet the eligibility criteria for the Intensive Care Coordination level to continue to support their stabilization in their home and community.

The Intensive Care Coordination level will require a care coordinator to Class Member ratio that is less intensive than the High Fidelity Wraparound level. The Department will collaborate with the N.B. Consent Decree Expert and will review existing research to determine the appropriate ratio or ratios for this level of care coordination.

At a minimum, this level requires face-to-face Child and Family Team meetings a minimum of every 60 days; additional face-to-face contact with the Class Member and family; additional phone contacts as necessary to assist the Class Member and family in stabilizing behavioral health issues and addressing identified needs.

The Child and Family Team at the Intensive Care Coordination level will review the Individual Plan of Care at each meeting and the care coordinator will update it at least once every 60 days, and as strengths and needs change. The IHH will develop a Crisis Safety Plan (CSP) with the Class Member and family within seven days of their enrollment into Intensive Care Coordination that will be reviewed, at a minimum, every 60 days at the Child and Family Team meeting and updated as necessary.

Every IHH staff member who will be providing or who will be supervising staff who are providing Intensive Care Coordination will have to complete training in the Intensive Care Coordination process provided by a Department identified and approved organization, as described in Section I.

A care coordinator, who has been trained in the Intensive Care Coordination process, will be responsible for facilitating the Child and Family Team that will consist of the Class Member, the family, family identified supportive individuals and other professional staff needed to meet the behavioral, physical and social needs of the Class Member (e.g., Family Peer Support provider, Wellness Coach, etc.).

If the Class Member is a DCFS Youth in Care, the Intensive Care Coordination team will function as the "Child and Family Team" for the DCFS Youth in Care. The care coordinator will work collaboratively with the DCFS caseworker in facilitating this team and will assist the caseworker

in identifying and providing access to all medically necessary Medicaid covered services for the DCFS Youth in Care Class Member. DCFS and the caseworker will retain relevant decision-making authority in the Child and Family Team process as the guardian of DCFS Youth in Care Class Members.

Class Members who meet criteria for Intensive Care Coordination will receive an initial six (6) months of service at this level. Continued Intensive Care Coordination will be provided if the Class Member continues to meet the eligibility criteria for this level of care coordination.

Care Coordination for Transition Age Class Members (Starting at Age 19)

For Transition Age Class Members (starting at age 19), care coordination will focus on engaging these Class Members in their healthcare, empowering them to make healthcare decisions, , assisting them in applying for appropriate benefits, engaging in healthy behaviors to manage their healthcare needs, engaging them in life-skills development to ensure ongoing independence as they approach adulthood, and engaging them in transitional services to ensure a smooth entry into the adult healthcare system upon turning 21.

An IHH serving Class Members ages 19 and over will be a team anchored by engagement specialists/care coordinators with access to other healthcare professionals to assist in assessing Class Members needed physical and behavioral health services. The emphasis of the IHH will be on the engagement specialist and peer advocates having the majority of direct contact with these Class Members. Although the IHH must have access to clinical care consultants, the goal is to have the IHH engage the Class Member's primary care provider(s), specialists and behavioral health service providers in the IHH's team approach to care coordination. The engagement specialist/care coordinator must be able to communicate with professionals who are involved in the treatment of the Class Member, identify gaps in the care, obtain feedback from other professionals in the IHH related to the Class Member’s care.

Care coordinators and engagement specialists responsibilities will be to find hard to locate Class Members, engage them in developing a plan of care, bring together appropriate professionals needed to address Class Member’s issues, encourage and assist Class Members to go to physical and behavioral health appointments, ensuring the appointments are available, coordinate information between providers to ensure all providers have required information, communicate with MCOs about the Class Member's needed service, identify areas of progress for the Class Members and adjust the plan, as needed.

Stratification Process and Associated Services

As required in Paragraph 17(e) of the Consent Decree, the Department will develop a stratification process to determine the type and intensity of both services and care coordination that Class Members will require through utilization of information from the IM-CANS and other supporting documentation (e.g. claims/encounter information).

The IM-CANS instrument will serve as the foundation of the stratification approach, as it reports both the needs and the strengths of the child and the family. Existing IM-CANS data, in combination with national data and service trends identified in consultation with national experts will be utilized to

develop the stratification algorithm. The Department will analyze combinations of needs, strengths in the IM-CANS and service utilization of the child, if available, through the use of the stratification algorithm to determine if the child will require intensive services coordinated through an IHH. The Department will then further refine the stratification algorithm to identify which children would require care coordination at the High Fidelity Wraparound level, Intensive Care Coordination level or Care Coordination for Transition Age Class Members.

Prior to beginning the utilization of the stratification algorithm, the Department will work with stakeholders, DCFS staff, the N.B. Consent Decree Expert, N.B. Class Counsel, and the developer of the IM-CANS instrument to test and refine this stratification algorithm 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.

In addition, the Department will establish a process by which an individual can request that a youth's stratification be reconsidered if they disagree with the outcome of the stratification or if extenuating circumstances arise, such as a Mobile Crisis Response, a hospitalization, or other deterioration in functioning. This process may be used for youth who were not stratified into an IHH or for Class Members who are being served in an IHH but may require a different level of care coordination.

Twelve months after the algorithm has been developed, tested and implemented, the Department will conduct a review to determine if any adjustments to the algorithm are required. Every two years thereafter, the Department will review the algorithm to ensure it continues to accurately reflect the service needs of Class Members and other youth in the Illinois behavioral health system.

Responsibilities of IHH

IHH will be required to meet specific staffing, training, coaching and care coordination standards that are necessary to provide High Fidelity Wraparound, Intensive Care Coordination and Care Coordination for Transition Age Class Members.

The IHH must have professional staff capable of providing the following core services, further described below: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support, and Referral to Community and Social Support Services.

Comprehensive care management (assessment, evaluation, planning and facilitation)

Comprehensive Care Management for Class Members and their family includes completing an assessment of presenting issues, needs and strengths; developing an Individual Plan of Care that includes goals and interventions associated with specific, meaningful outcomes; reviewing and revising the Individual Plan of Care on a regular basis, and identifying resources and services that will effectively address the Class Members needs while building on their strengths.

The assessment utilized for comprehensive care management services will be the Department approved Integrated Assessment and Treatment Plan (IATP) instrument, the Illinois Medicaid – Comprehensive Needs and Strengths (IM-CANS), or its successor instrument.

The IHH will ensure that each child (for Class Members 18 and under) has an individualized Wraparound or Child and Family Team, which will utilize the completed IM-CANS, any other assessment or treatment

information available, and the Team's deliberations to complete the Class Member's Individual Plan of Care that includes the following: treatment goals, objectives, and timetables for achieving these goals and objectives; the specific services that will be provided to the Class Member and family in the least restrictive setting appropriate for the Class Member and that will assist the Class Member in moving to less intensive levels of service, including family and other natural supports; the frequency, intensity and providers of the identified services; the justification for specialized medical, psychiatric or psychological evaluations; and identification of any additional areas of support that the Class Member or family may require.

The facilitator, care coordinator or engagement specialist (for Transition Age Class Members) will utilize this information to implement the Individual Plan of Care and monitor the Class Member's progress in engaging in identified services and supports.

The IHH will ensure ongoing communication and collaboration between the Class Member's primary care, specialty health care (when necessary), behavioral health and other necessary child-serving agencies identified as key partners in the Individual Plan of Care, as part of comprehensive care management. For Class Members who are also DCFS Youth in Care, particular attention will be paid to the collaboration between the DCFS Caseworker and the IHH regarding coordinated service planning and service provision.

Care Coordination (organizing / coordinating services, sharing information):

For Class Members under the age of 18, the IHH is responsible for High Fidelity Wraparound and Intensive Care Coordination that includes a Wraparound Facilitator or a care coordinator acting as the single point of accountability for ensuring that medically necessary services and supports are accessed, coordinated, and delivered in a strengths-based, individualized, family/youth-driven, culturally, and linguistically relevant manner to address the Class Member's needs. High Fidelity Wraparound and Intensive Care Coordination are both designed to facilitate a collaborative relationship among a Class Member, his/her family, and involved systems to support the parent/caregiver in meeting the Class Member's needs.

The Wraparound team and Children and Family Team process requires that the Wraparound Facilitator or care coordinator organize care across providers and child serving systems to enable the Class Member to be served in their home and/or community. In addition, for Class Members who are also DCFS Youth in Care, the Wrap Facilitator / care coordinator will be required to collaborate with the DCFS caseworker in all service planning and service provision for those Class Members, recognizing that DCFS and the caseworker will have all relevant decision-making authority as the guardian for DCFS Youth in Care.

This requires Wraparound Facilitators to spend considerable time in face-to-face interactions with Class Members, families and their Wraparound teams to identify services and supports as needed, monitor, assess, and help families navigate systems. Care coordinators will also be required to have face-to-face interactions with Class Members and their Child and Family Teams to ensure that services and supports are accessed, but on a less frequent basis.

Wraparound Facilitators, care coordinators and engagement specialists (for Transition Age Class Members) are responsible for coordinating with management entities (i.e., MCOs and administrator for

FFS), multiple providers and settings, and other systems in which children may be involved to assist Class Members in accessing medical, behavioral and other individualized supportive services. They are also responsible for sharing the completed or revised IM-CANS with other behavioral health providers who are providing services to Class Members, as well as incorporating additional information into the IM-CANS as needed.

Health Promotion:

Health promotion enables people to increase control over their own health. It covers a wide range of social and environmental interventions that are designed to benefit and protect an individual's health and quality of life. The goal is to address and prevent the root causes of ill health, not focusing solely on the treatment of illness once it has been identified. [https://www.who.int/features/qa/health-promotion/en/]

The IHH will be responsible for engaging Class Members in health promotion activities including:

- Providing opportunities and activities for promoting wellness and preventing illness by including wellness goals in the Individual Plan of Care;
- Educating Class Members and their families regarding activities that will support the Class Members' physical and emotional development, including the importance of immunizations and screenings;
- Linking Class Members with screening, in accordance with the EPSDT periodicity schedule;
- Monitoring usage of psychotropic medications through report analysis and follow up with outliers; and,
- Identifying Class Members in need of immediate or intensive care management for physical health needs.

Comprehensive transitional support from inpatient and other non-community settings, including appropriate follow up:

Transitional support will be provided for Class Members who have been hospitalized or placed in other non-community settings, such as psychiatric residential treatment facilities, who are transitioning back into home and community services.

The Wraparound Facilitator, care coordinator or engagement specialist (for Transition Age Class Members) will collaborate with all parties required (including the facility, primary care physician, community providers, etc.) to ensure a seamless transition into the community to prevent subsequent re-admission(s).

Transitional support applies to transitions for Class Members regardless of setting including, but not limited to, transitions from institutional care, from and to school-based services, from pediatric services to adult services.

The IHH will work with MCOs to develop formal relationships with regional hospital(s), residential providers, and other institutional providers within the MCOs' networks to ensure a formalized structure for transitional care planning and to facilitate communication regarding inpatient admissions and discharges of Class Members. The IHH will work closely with the local Mobile Crisis Response provider and other partners to identify Class Members not yet connected to the IHH who access crisis response or emergency department services.

The IHH will perform the required continuity of care coordination between inpatient and outpatient care, including establishment or reestablishment of community resources and necessary follow-up visits.

For Class Members who are also DCFS Youth in Care, the IHH will work collaboratively with the DCFS Caseworker recognizing that DCFS has authority to determine the placement arrangements for the DCFS Youth in Care. The IHH will work to establish all medically necessary covered services to support the DCFS Youth in Care in their placement after transition.

Individual and family support:

With consent of the family, youth, or guardian as applicable, the IHH will act as an organizer, information source, guide, advocate, and facilitator for the youth and family assisting with navigating child-serving systems including, but not limited to, behavioral health, physical health, education, substance use disorder, juvenile justice, child welfare, social and family support services.

This type of support may include attending appointments with the Class Member to support their participation, accompanying the Class Member to community events to support their social integration, attending appointments with family members to support their participation in the Class Member's treatment, and other similar support activities.

Referral to community and social support services:

The IHH will provide referral to community and social support services as identified in the Individual Plan of Care and will include information about formal and informal resources beyond the scope of services covered by Medicaid. These include but are not limited to supports available through other parents, family members, community-based organizations, family or youth-run organizations, service providers, social programs, school-based services, faith based organizations, etc. Additionally, the IHH will provide information regarding support grants and other funding options.

The IHH will offer Class Members and their families opportunities and supports that are closest to home, in the least restrictive setting and that promote integration in the home and community. The IHH will emphasize the use of informal community supports in conjunction with medically necessary services as a primary strategy to assist Class Members and their families.

Rate Setting for IHH

The Department will utilize staffing information and other rate setting methodology approved by federal CMS to establish the rates for IHH care coordination service levels.

E. MODEL COMPONENT #4: NEW SERVICES, PROVIDERS AND POLICIES TO ENHANCE ACCESS TO BEHAVIORAL HEALTH SERVICES

Behavioral Health Screening by Primary Care Physicians

While Primary Care Physicians (PCP) are currently required to offer behavioral health screenings for all routine and periodic medical appointments, reinforcement and further support of this requirement will be provided by the Department.

The Department will work with physician associations, psychiatric associations, the N.B Consent Decree expert and stakeholders to determine which nationally recognized screening tools should be utilized by PCPs as behavioral health screening tools. The Department also will work with MCOs, physician associations and other partners to conduct education and training for PCPs who serve Medicaid-eligible youth and families regarding the requirement to offer screening at all routine and periodic medical appointments, the screening tools that should be utilized, how the PCPs are to notify MCOs of the screening results, how PCPs can make referrals to community mental health providers if a screening indicates further assessment may be appropriate, and on the role and functions of the IHHs.

New Services

The array of Medicaid Community Mental Health Services (MCMHS) available under the Medicaid Rehabilitation Option and Targeted Case Management in Illinois at the time the Consent Decree was finalized included the following: Mental Assessment, Individual Treatment Plan Development, Review and Modification, Psychological Evaluation, Medication Administration, Medication Monitoring, Medication Training, Assertive Community Treatment (ACT), Psychosocial Rehabilitation (PSR), Intensive Outpatient, Community Support (Team, Group and Individual), Crisis Intervention, Therapy/Counseling, Client-Centered Consultation, and Transition Linkage and Aftercare. Pre-hospitalization screening services for children under the age of 21 were also provided under Screening Assessment and Support Services (SASS) contracts to determine if children in crisis could be referred to community-based services rather than psychiatric hospitalization. Moving forward, this function will be assumed by Designated Service Area providers of Mobile Crisis Response.

As required in Paragraph 17(b), 17(d) and 17(i), HFS has received CMS approval to add Integrated Assessment and Treatment Planning (IATP), Mobile Crisis Response (MCR) and Crisis Stabilization to the approved array of MCMHS in the Illinois State Plan. The Department has also promulgated rules for the new services of IATP, MCR and Crisis Stabilization in revisions to 89 Illinois Administrative Code Part 140 (Rule 140) in May 2019.

HFS has also secured approval of an 1115 waiver with pilots of Intensive In-Home, Crisis Stabilization (i.e., Crisis “beds”) and Respite, which will be available to Class Members if they meet eligibility criteria for these waiver pilot services. The Department will be monitoring the availability of waiver pilot services to ensure that Class Members have access to these services on a statewide basis and will address any access issues if they arise. While these services are currently authorized under an 1115 waiver, the Department will be exploring other federal authorities that may be more appropriate for covering these services for Class Members.

Additionally, the Department will work with stakeholders and the N.B. Consent Decree Expert to develop formal service definitions, provider standards and eligibility criteria for Family Peer Support and Therapeutic Mentoring to add to the continuum of MCMHS available to Class Members.

New Provider Types

As required in Paragraph 21(d), HFS recognizes that while the above-mentioned services were included in the Medicaid service array, certain geographies did not have enough providers available to offer these services for all Class Members that may require them. To establish additional providers of MCMHS, HFS has promulgated revisions to Rule 140 that allows Independent Practitioners (i.e., Psychiatrist, Licensed Clinical Psychologists, Licensed Clinical Social Worker) and Behavioral Health Clinics to provide certain MCMHS. The Department will evaluate current rules and policies regarding Behavioral Health Clinics to ensure that requirements for this new provider type are structured to support development of new providers and expanded access to services for Class Members. The Department will also review current rules, policies and rates to ensure that there is sufficient support and flexibility to enhance access to services for Class Members.

Included below is an overview of each of the new State Plan Amendment services, as adopted in revisions to Rule 140, and the 1115 waiver services that are applicable to Class Members.

1. Integrated Assessment and Treatment Planning

As required in Paragraph 17(d), the Department of Healthcare and Family Services (HFS) obtained State Plan Amendment approval and revised Rule 140 to include the service of Integrated Assessment and Treatment Planning (IATP). This service establishes a standardized, statewide assessment process that will be used to assess the needs and strengths of Class Members, and consistently integrate those needs and strengths into treatment planning and service delivery. In order to be reimbursed for IATP, providers must utilize an HFS-approved standardized assessment instrument.

HFS has designated the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS) as the approved IATP standardized, statewide assessment instrument. The IM-CANS serves as the foundation of Illinois' efforts to transform its publicly funded behavioral health service delivery system. It was developed collaboratively by the Illinois Departments of Healthcare and Family Services (HFS), Human Services-Division of Mental Health (DHS-DMH), and Children and Family Services (DCFS). The comprehensive IM-CANS assessment provides a standardized, modular framework for assessing the global needs and strengths of Class Members who require mental health treatment.

The IM-CANS will be utilized to determine the level of care coordination and intensity of services that will be provided to each Class Member. A full description of this utilization can be found in Section D of this Implementation Plan.

The IM-CANS incorporates:

- A complete set of core and modular CANS items, addressing domains such as Risk Behaviors, Trauma Exposure/Adverse Childhood Experiences, Behavioral/Emotional Needs, Life Functioning, Substance Use, Developmental Disabilities, and Cultural Factors;

- A fully integrated assessment and treatment plan;
- A physical Health Risk Assessment (HRA); and,
- A population-specific addendum for youth involved with the child welfare system.

The IM-CANS is based on the Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA) tools and contains items that identify a Class Member's strengths and needs using a '0' to '3' scale. These items are then used to support care planning and decision-making, facilitate quality improvement initiatives, and assist in monitoring service outcomes.

The IM-CANS also includes a Health Risk Assessment (HRA), developed to support a holistic, wellness approach to assessment and treatment planning by integrating physical health and behavioral health in the assessment process. The HRA is a series of physical health questions for the Individual that is designed to: 1) assess general health; 2) identify any modifiable health risks that can be addressed with a primary health care provider; 3) facilitate appropriate health care referrals, as needed; and 4) ensure the incorporation of both physical and behavioral health needs directly into care planning. A copy of the IM-CANS can be found on the Department's website. [https://www.illinois.gov/hfs/SiteCollectionDocuments/IM+CANSLifespanVersion11FinalUpdate92418.pdf]

The definition of IATP that was included in the revisions to 89 Illinois Administrative Code Part 140 can be found in Rule 140 [http://www.ilga.gov/commission/jcar/admincode/089/089001400D04530R.html]

Each Class Member will have only one IM-CANS completed even if the Class Member is involved with multiple providers. The IM-CANS will be shared across providers through the IHH ensuring that services are consistently authorized and completed in a coordinated manner. The Department is currently developing an appropriate process and electronic portal to allow sharing of IM-CANS assessment and treatment planning information across multiple providers, including MCOs and IHHs, without requiring that a paper copy be shared.

IM-CANS Training and Certification Process

Transitioning to a new, standardized, statewide assessment for all Class Members and other Medicaid-eligible individuals receiving IATP has required an investment in additional resources to train and support providers to correctly implement the assessment. The Department has engaged an external vendor to provide training, certification and ongoing technical assistance support to providers delivering IATP services.

All Medicaid enrolled providers who want to offer MCMHS to Medicaid eligible children and families are required to attend a one-day, in-person training and must also complete annual certification to utilize the IM-CANS provided by the Department's external vendor. This recertification process is designed to ensure that the IM-CANS continues to be consistently administered to all Class Members across many different providers. The external vendor's staff are also available to answer questions for providers and to offer ongoing technical assistance and support, as needed.

The Department is also working to develop a registration process to require providers to attend training, receive certification and then register as a provider through the Department's provider enrollment

system before submitting billings for IATP services. This process will ensure that providers who are utilizing the IM-CANS and billing for IATP services are properly trained and certified.

The Department has also engaged the expertise of John Lyons, the developer of the IM-CANS, for ongoing support and technical assistance regarding training, certification, and use of the IM-CANS. John Lyons will offer expert oversight of the development of the algorithm to be used for stratification of children with behavioral health needs, as described in Section D.

Additional trainings such as developing treatment goals, clinical interviewing, and engagement are also being developed to assist providers in not only completing the IM-CANS but also improving their clinical assessment skills. As other growth areas are identified, the Department will work with the external vendor to develop additional training and technical assistance for providers.

2. Mobile Crisis Response and Crisis Stabilization

Paragraph 17(i) of the Consent Decree required the Department of Healthcare and Family Services (HFS) to develop a Mobile Crisis Response model consistent with, or as the successor to, the Screening, Assessment and Support Services ("SASS") program.

Illinois developed the SASS program in response to the Children's Mental Health Act of 2003 to ensure that all children received a crisis screening to determine if they could be safely served by community-based providers rather than being admitted to a psychiatric hospital for stabilization services. The SASS program provides a single point of entry for all children requiring crisis screening through the Crisis And Referral Entry Service (CARES) hotline that ensures dispatch of a SASS screener to the child regardless of the child's location in the state. The SASS program was designed to provide crisis services in the most appropriate and least restrictive setting but over time, the utilization of the program has indicated more screening and hospitalization and less stabilization in the community than desired.

To address this issue with the SASS program and to comply with Paragraph 17(i), the Department obtained CMS approval and revised Rule 140 to introduce Mobile Crisis Response as a statewide, Medicaid covered service. This will allow any Medicaid behavioral health provider who is qualified to offer Mobile Crisis Response services, thereby expanding access to this service. However, the Department will maintain the CARES hotline and the dispatch of a designated Mobile Crisis Response provider to ensure that all children will receive a crisis screening and additional services to help stabilize a crisis.

The proposed definition of Mobile Crisis Response included activities that are tailored to the needs of the client, require face-to-face crisis screening, and may include: 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.

The full definition of MCR in Rule 140 can be found here:
[http://www.ilga.gov/commission/jcar/admincode/089/089001400D04530R.html]

The Department also introduced a new reimbursement methodology for MCR making reimbursement more commensurate with the time actually spent completing a crisis assessment and then allowing for

billing of Crisis Intervention, if the individual was still experiencing crisis symptoms that needed to be stabilized.

In addition to MCR, Crisis Stabilization was introduced as a new component of Illinois' 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 behavioral health crisis, when necessary. Crisis Stabilization is to be provided in the Class Member's home or other community setting where crisis have occurred.

The definition of Crisis Stabilization can be found in Rule 140 here: [http://www.ilga.gov/commission/jcar/admincode/089/089001400D04530R.html]

IATP, MCR and Crisis Stabilization were introduced as of August 1, 2018, and are being implemented by providers statewide at this time. It is anticipated that full implementation of these services for all Class Members who require them will take some time to be fully realized. HFS will be working with MCOs as part of their network adequacy strategy, using claims data to evaluate which areas of the state have implemented Crisis Stabilization and which areas may need more technical assistance and support from MCOs, IHHs and HFS to fully establish this new service.

3. Intensive In-Home Services

HFS is also implementing Intensive In-Home Services as a pilot program under the 1115 waiver as part of the service continuum for Class Members. Because it is being implemented as a pilot under the 1115 waiver, the specifications for the pilot are included in the Special Terms and Conditions that were approved by federal Centers for Medicare and Medicaid Services and are subject to fiscal and census limitations. However, the Department will monitor the service provision to ensure that it is available statewide and with sufficient capacity to meet Class Members' needs. If fiscal or census limitations are met, the Department will work with federal CMS to make adjustments to the wavier limitations or will determine other methods to ensure Class Members have access to this service.

Intensive in-home services include 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. The service contains two components: Clinical and Support. The Clinical component includes the development of a specific intervention plan by a licensed clinician. The Support component includes a trained mental health staff person working directly in the Class Member's home to help the Class Member and the family implement the intervention plan. This service can be provided by Community Mental Health Centers or Behavioral Health Clinics.

The specific definitions of Intensive In-Home services, eligibility criteria as well as fiscal and census limitations are included in the Special Terms and Conditions that can be found here [https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-behave-health-transform-ca.pdf]

HFS will work with MCOs to collect data to measure the effectiveness of the pilot including IM-CANS data for pilot enrollees to determine if needs decrease and if strengths increase, contact with law

enforcement declines, if applicable, and information related to Quality of Life improvements. Throughout the course of the pilot, HFS may determine that additional data points should be gathered to determine pilot effectiveness. Most of these are included in the IM-CANS, but others may require other forms of data gathering, such as surveys. HFS will communicate with MCOs and providers of this pilot service regarding any additional data points that may be needed.

Enrollment of individuals into this pilot program began on October 1, 2018. The Department will be monitoring the availability of this pilot service to ensure that Class Members have access to this service on a statewide basis and will address any access issues, if they arise.

4. Crisis Triage and Stabilization Services

HFS is also implementing Crisis Triage and Stabilization services, also known as "Crisis Beds", as a pilot program under the 1115 waiver as part of the service continuum for Class Members. "Crisis Beds" are short-term, inpatient or residential services designed to support stabilization, rapid recovery, and discharge of the individual experiencing psychiatric crisis. These services are available to individuals aged six (6) through 21 who are experiencing a psychiatric crisis and require stabilization and support, including 24-hour clinical supervision and observation. These beds can be located in hospitals, community residential providers or Psychiatric Residential Treatment Facilities (PRTF), once those facilities are developed in accordance with the timelines in this Implementation Plan.

The specific definitions of "Crisis Beds" as well as the pilot eligibility criteria are included in the Special Terms and Conditions that can be found here [https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-behave-health-transform-ca.pdf]

Enrollment of Class Members into this pilot program will begin after November 2019.

5. Respite

Respite, also a pilot under the 1115 waiver, is designed to assist in reducing caregiver stress and improving the ability to respond to Class Member needs by providing a short, planned break from the home environment for the child or family. Respite services can help 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. These services will be provided by staff with a bachelor's degree, or associates' degree with a minimum of one year of experience.

The specific definitions of Respite as well as the pilot eligibility criteria are included in the Special Terms and Conditions that can be found here [https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-behave-health-transform-ca.pdf]

Enrollment of individuals into this pilot program is scheduled to begin on or after July 2020. The Department will be monitoring the availability of this pilot service to ensure that Class Members have access to this service on a statewide basis and will address any access issues if they arise.

POTENTIAL NEW SERVICES

The Department had identified additional gaps in the service array that will be addressed through the development of a minimum of two additional services, Family Peer Support and Therapeutic Mentoring, subject to federal approval. These two services have been shown to be critical service components in supporting the stabilization of children in the community and in supporting families with developing positive supportive skills to help address the children's behavioral health challenges.

6. Family Peer Support

Family Peer Support is generally described as the instrumental, social and informational support provided from one parent to another in an effort to reduce isolation, shame and blame, to assist parents in navigating child serving systems and to provide other relevant life experiences. Family Peer Support providers work to normalize the Class Member's family's experiences and to offer a framework for families to begin to see that they can develop skills and strengths to help stabilize the Class Member and themselves.

Family Peer Support is typically provided by individuals with lived experience as a parent or primary caregiver who is raising or has raised a child receiving mental, behavioral, mental health or substance use needs and has received services on behalf of their child/youth who receives specialized training and ongoing coaching and supervision in the provision of Family Peer Support.

The Department with work with stakeholders and the N.B. Consent Decree Expert to develop eligibility criteria, a formal definition and implementation steps for Family Peer Support to be a Medicaid covered service available to Class Members, subject to federal approval.

7. Therapeutic Mentoring

Therapeutic Mentoring is generally described as services that help support youths' success in navigating various social contexts, learning new skills and making functional progress. The Therapeutic Mentor provides support, coaching, training in age-appropriate behaviors, interpersonal communication, problem-solving, conflict resolution, and relating appropriately to others in various social and community activities.

Therapeutic Mentoring is typically provided by a paraprofessional staff who has completed a State approved training curriculum in the provision of Therapeutic Mentoring to children with behavioral health challenges.

The Department will work with stakeholders and the N.B. Consent Decree Expert to develop eligibility criteria, a formal definition and implementation steps for Therapeutic Mentoring to be a Medicaid covered service available to Class Members, subject to federal approval.

F. MODEL COMPONENT #5: PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

As stated in Paragraph 13 of the Consent Decree, "…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 ("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…".

Psychiatric Residential Treatment Facilities (PRTF) are any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21 (psych under 21 benefit)." [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/WhatisaPRTF.pdf]

PRTF Development and Implementation Approach

The Department will develop necessary PRTF policies, procedures and administrative rules along with home and community-based services. However, the phase-in of in-state PRTFs will occur only after the home and community-based service delivery system has been built to sufficient capacity to effectively serve Class Members.

The Department will develop and pursue a state administrative rule that will be based upon similar requirements for state funded residential treatment as currently provided in Title 89, Illinois Administrative Code, Section 139 (Rule 139). Admissions to PRTFs shall be subject to individual-level Certifications of Need, Prior Authorization, Utilization Controls and Continued Stay Reviews, based upon data collected through an evidence-based needs assessment, such as the IM-CANS or other Departmental approved tool. Bed capacity limitations, payment mechanisms, staffing ratios, clinical orientation of services, staffing credentials and other key elements also will be established in rule. The Department will utilize clinical and treatment concepts from the Building Bridges Initiative [https://www.buildingbridges4youth.org/] and quality requirements from the Family First Preservation Act to develop the treatment expectations for PRTFs and will work in close collaboration with the Department of Children and Family Services in this process. MCOs will be required to adopt the above-mentioned requirements to ensure that requirements will be consistently applied across all MCOs.

If an admission to PRTF is necessary to stabilize the Class Member, the MCO and the IHH will work with the Class Member, their family and the PRTF at the time of admission, to orient the PRTF to the Class Member's Individual Care Plan and to develop a discharge and transition plan. The IHH will continue to coordinate care throughout the Class Member's stay.

Ongoing and frequent review of the Class Member's Individual Plan of Care will occur with PRTF staff and the IHH Wraparound team to ensure that the Class Member is progressing in treatment, that the family is engaged in the Class Member's treatment, and that plans for discharge and transition are progressing so that they may be implemented immediately upon discharge.

MCOs will be required to report to the Department on a quarterly basis the number of PRTF admissions, the length of stay of each admission, identifying any admission that is 90 days or longer, and other data points that may be deemed necessary for Departmental review. The Department will review these reports with the MCO's CBH Program Managers to monitor MCO's oversight of PRTF treatment. For Class Members not enrolled in MCOs, the Department will run a similar report on a quarterly basis and will review the report findings with the IHHs that are serving the Class Members who are admitted to PRTFs.

The Department will work with the N.B. Consent Decree Expert, MCOs and other appropriate stakeholders to develop policies, procedures and rules to ensure that PRTFs are implemented and that capacity is developed based on a data-driven strategic process, once the home and community-based services system has been sufficiently established.

Process for obtaining PRTF Services for Class Members meeting the requirements of Interim Relief

While the Department focuses initial implementation efforts on the development of home- and community-based services as required by Paragraph 13, it will continue to address the needs of Class Members demonstrating medical necessity for a PRTF level of care through the current Interim Relief process described below. This process may be revised or updated as appropriate in future annual reviews of the Implementation Plan.

The Department currently identifies and pays for PRTFs out-of-state via contractual arrangements. During this first iteration of the Implementation Plan, the Department will continue to address the needs of Class Members requiring PRTF services through similar arrangements and will maintain the current Interim Relief process as follows:

- The Department will develop a process by which family members who believe that their child may be a Class Member in need of PRTF services on an emergent basis can submit an Interim Relief Emergent Services Packet to a designated Department representative. This process will provide the necessary information for the Department to understand the needs of the child, determine if the child is a Class Member appropriate for the Interim Relief process and, if so, identify the most appropriate services and providers to meet their emergent needs.
- The Interim Relief Emergent Services Packet shall be submitted for any Class Member seeking PRTF services on an emergent basis and must include all required information to determine and establish medical necessity and Class Membership status for Interim Relief services.
- Class Members and their legally responsible parent or guardian will be required to cooperate with HFS and its agents as necessary to provide and coordinate services.
- The Department has contracted with the University of Illinois Urbana Champaign – School of Social Work (UIUC-SSW) to serve as Interim Relief Manager for Class Members under the Interim Relief process. The Interim Relief Manager will be responsible for oversight of the process for all Class Members and shall work closely with Class Members and their families and relevant service providers to ensure the Interim Relief process is implemented consistent with the requirements of the Consent Decree.

Class Members referred to the Interim Relief process may continue to receive coordination services through the Interim Relief Manager for a period of up to 180 days after the Class Member is discharged

from a PRTF. The Department will review Class Member eligibility on a monthly basis to verify ongoing eligibility for services.

G. IMPLEMENTATION TRAINING AND TECHNICAL ASSISTANCE

The Department recognizes that implementation of the Model through the development of IHHs, implementation of High Fidelity Wraparound and Intensive Care Coordination, establishment of a standardized assessment to support a stratification algorithm, development of new services and enhanced oversight from MCOs will take a good deal of time and very close partnership with Class Members, families, providers and other stakeholders.

To ensure that the necessary training and technical assistance supports and resources are available, the Department will develop a Children's Behavioral Health - Technical Assistance and Training (CBH-TAT) resource. The CBH-TAT resource, under the direction of the Department, will develop a certification process for Wraparound facilitators and supervisors, a certification process for Intensive Care Coordination care coordinators and supervisors, ongoing training and technical assistance on the IM-CANS, a full spectrum of trainings on all new services, and other areas of training, technical assistance or support that are necessary to support the implementation and effectiveness of the Model.

The Department also will work with the CBH-TAT resource to develop training and certification standards for providers who are seeking to provide behavioral health services under this Consent Decree. The Department will receive monthly reports from the CBH-TAT resource regarding providers who have requested and attended training and who have met certification standards for provision of the service. The Department will share these reports with MCOs notifying them of new providers who are certified to provide these services. The Department will also monitor service access reports from MCOs that specifically address IHHs and other behavioral health service providers.

The Department may implement mandatory trainings in response to identified deficits in quality outcomes as the new services included in the Implementation Plan are implemented. The Department will work in collaboration with IHHs, MCOs and an external training vendor to identify such areas and design effective training strategies.

The Department will also utilize the CBH-TAT resource for data analysis, research into best and evidence-based practices and other areas as needed to support the Department in implementation of the Model.

H. CROSS-AGENCY COLLABORATION ON MODEL DEVELOPMENT AND IMPLEMENTATION

The Department recognizes that Class Members may be served by multiple child-serving agencies including the Departments of Children and Family Services, Human Services – Divisions of Mental Health, Substance Use Prevention and Recovery, Developmental Disabilities, and Juvenile Justice as well as State and local education authorities.

The Department will establish regular meetings with representatives from each of these child-serving agencies to ensure ongoing communication and engagement with other agencies as the Model is being implemented. The Department will also request feedback from sister agencies on policies, procedures and rules that affect Class Members they serve.

In particular, the Department will seek to collaborate with the Department of Children and Family Services toward processes under this Implementation Plan that appropriately address the needs Class Members who are also DCFS Youth in Care and support collaboration between systems. Model components are being developed including coordination with DCFS to ensure that the Model and child welfare processes coordinate, in support of both program goals of serving Class Members.

Particular attention will be paid to interactions between DCFS caseworkers and IHH staff who are facilitating the Wraparound team or the Children and Family Team process. Both High Fidelity Wraparound and Intensive Care Coordination emphasize inclusion of child serving system partners and providers on the Wraparound team or Child and Family Team. It is therefore expected and required that IHH staff assist DCFS caseworkers and coordinate closely with them in planning and decisions regarding services and supports for Class Members who are DCFS Youth in Care.

IHH staff will also communicate regularly with DCFS caseworkers regarding the involvement of the foster parents, and biological parents, of a DCFS Youth in Care, as applicable and appropriate to the child's needs. Child serving agency partners including, but not limited to, DCFS caseworkers, probation officers, school personnel, etc., will be oriented to the High Fidelity Wraparound process and the Intensive Care Coordination process so that they have a full understanding of what to expect and how they are to collaborate with the IHH staff.

The Department along with MCO CBH Program Managers will conduct regular regional trainings and meetings with DCFS Regional Administrators, foster parent associations, adoptive parent associations, juvenile court staff, case workers, and other state agency staff to ensure that implementation issues are addressed, communication regarding the process is clear, and that the Model components are being developed and implemented such that they support and do not supplant child welfare processes and goals.

I. IMPLEMENTATION STEPS AND TIMELINES

The implementation of the Model will involve multiple steps with timelines that will begin upon the finalization of the Implementation Plan. Key steps and timelines will sequence from the effective date of the Implementation Plan with many requiring federal and state approvals of variable timelines. Therefore, Table 2 below outlines proposed timelines that are based upon obtaining these required approvals. It should be noted that the Department will continue to work with Class Members, their families, the N.B. Consent Decree Expert, MCOs, providers, and stakeholders while completing the activities listed below.

Table 2: Implementation Steps and Timelines

Timeline	Activity
February 2020	Gather stakeholder input on Implementation Plan and establish Children's Behavioral Health Family Leadership Workgroup. Establish regular meeting schedule for Subcommittee and Workgroup for ongoing input into implementation of the Model.
January 2020	Finalize Implementation Plan
April 2020	Draft and submit State Plan Amendments (SPAs) for IHH, Family Peer Support and Therapeutic Mentoring
May 2020	Revise MCO contracts according to requirements in the Implementation Plan and begin regular meetings with MCOs regarding implementation of new contract requirements
March 2020	Establish the CBH-TAT resource
September 2020	Implement electronic data portal for IM-CANS
June 2020	Develop and test stratification algorithm
May 2020	Establish selection process for IHHs
April 2020	Identify PCP behavioral health screening tools and train PCPs on their utilization
After Approval of SPA	Promulgate rulemaking in Rule 140 to include IHH, Family Peer Support and Therapeutic Mentoring
After completion of rulemaking	Implement the IHH selection process and begin training IHH staff on High Fidelity Wraparound and Intensive Care Coordination once IHHs are selected
After completion of rulemaking	Begin training providers on Family Peer Support and Therapeutic Mentoring and other services or subject areas identified by the Department
After completion of rulemaking	Utilize stratification algorithm to identify Class Members and assign to identified level of care coordination through the IHHs that are ready to serve Class Members
After completion of rulemaking	Complete IHH readiness reviews and begin enrollment of Class Members for IHH determined to be ready
After completion of rulemaking	Monitor provider network adequacy for IHHs and other services

J. BENCHMARKS

The State will certify to the Court, Class Counsel, and the Expert two (2) benchmarks demonstrating compliance with the Consent Decree:

Benchmark No. 1: Within five (5) years after approval of the Implementation Plan, Defendant shall 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 shall be at least operational as outlined in the Implementation Plan.

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 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.

Objectively measurable standards will be established for Benchmark No. 2 and added as an amendment to the Implementation Plan.

K. PERSONNEL NECESSARY TO IMPLEMENT CONSENT DECREE

As required in Paragraph 21(b), HFS has hired and will continue to hire as necessary, personnel who will be responsible for implementing, overseeing and monitoring the implementation of the Consent Decree. HFS established the Bureau of Behavioral Health in August 2016 to oversee the implementation of the anticipated Consent Decree as well as assist in the overall behavioral health transformation. The Bureau Chief is responsible for overseeing the execution of the Implementation Plan and has two sections within the bureau to support this task, one for Federal Compliance and Client Relations and the other specifically related to Program and Policy. Staff within this bureau has experience in designing, developing and implementing behavioral health services, particularly emphasizing children's services. The Department is actively staffing this bureau to ensure that there are sufficient personnel for development, implementation and ongoing oversight of the Model.

The Bureau Chief of Behavioral Health will collaborate with the Bureau of Managed Care to oversee services for Class Members who are enrolled in MCOs. The Bureau of Managed Care has a designated N.B. Liaison who will work directly with the Bureau Chief of Behavioral Health related to the implementation of the managed care requirements for Class Members.

In addition, the Bureau of Managed Care has Account Managers who have responsibilities for the comprehensive oversight of assigned MCOs to ensure the long term success of HealthChoice Illinois and the Class Members served in that program. Account Managers are tasked with three primary duties, performance management, programmatic improvement and relationship governance. Performance

management requires Account Mangers to utilize MCO Score Cards, reporting, and quality reviews to assess contract performance and to hold the MCO accountable to contractual performance requirements. Programmatic improvement utilizes outcomes and performance data to help develop MCO capabilities, and to encourages MCOs to implement innovative ideas. Relationship governance aligns MCO management strategies with HFS internal resources, assigns internal roles and responsibilities and establishes effective MCO review governance.

In addition, Account Managers have continual communication with MCOs through regular internal and external meetings, including weekly Account Management meetings where the Account Managers discuss contract compliance issues, day-to-day operations, and a variety of agenda items from the MCOs or HFS. Monthly Operational Review meetings include discussion of issues such as network development, transitions of care, day-to-day operational issues, reporting, and care coordination efforts. Quarterly Business Reviews focus on the opportunity for MCOs to highlight strengths, weaknesses, opportunities and threats, provide pertinent program updates for both the MCOs and HFS, and identify and assign actions, owners and due dates. In Annual Relationship Reviews, the annual performance scorecard, unsolved and critical escalations, and important MCO updates are reviewed and discussed. Annual Relationship Governance Review confirms HFS roles and participants, reviews MCO relationship strategy, trends and issues, and ensures alignment of MCO management strategy within HFS Bureaus and Divisions. The Bureau of Behavioral health will work closely with the Bureau of Managed Care in all of these meeting and processes to monitor quality and performance expectations specifically related to the N.B. Class.