N.B., et al.

v.

Theresa Eagleson, et al.

Report of the Expert

Feb. 22, 2021

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

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Introduction

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

On February 13, 2014, the United States District Court for the Northern District of Illinois certified the case as a class action for the following individuals: "All Medicaid-eligible children under the age of 21 in the State of Illinois: (1) who have been diagnosed with a mental health or behavioral disorder; and (2) for whom a licensed practitioner of the healing arts has recommended intensive home- and community-based services to correct or ameliorate their disorders." While the Department is working to develop a specific projection for the number of children in the N.B. Class, it is estimated that 10,000 children in the N.B. Class will receive services in the first full year of implementation of new care coordination and services, projected to start in fall of 2021.

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

The N.B. Consent Decree also requires an Expert to evaluate, provide input, and report to the parties and the Court during implementation of its requirements. A specific provision of the Consent Decree requires the Expert to file a written report within sixty (60) days after the first anniversary of the approval of the Implementation Plan to the Court and parties. The report is to provide information regarding the Defendant's progress on implementing the requirements of this Consent Decree and the Implementation Plan as necessary to meet the Benchmarks in the Consent Decree. This is the first report of the Expert, encompassing the timeframe of December 2, 2019, through December 31, 2020.

Overview of Report

The report provides an assessment by the Expert regarding the progress the Department has made regarding key tasks and activities in the Implementation Plan that were to be completed in Calendar Year (CY) 2020 and the extent to which the Department is complying with the substantive paragraphs of the Consent Decree. The initial section of the report summarizes

progress on the Implementation Plan. The next section provides information regarding the Department's efforts to address the relevant paragraphs of the Consent Decree. This section also provides recommendations from the Expert to the Department regarding policy and additional implementation activities that the Expert believes will ensure the Department meets its goals and objectives within the timeframes set forth in the Implementation Plan and overall Consent Decree. The report concludes with a summary of critical areas the Department should focus on over the next reporting period.

Progress on Implementation Plan

The Department, in conjunction with the N.B. Consent Decree Expert and input from Class Counsel and additional stakeholders, developed an initial Implementation Plan during CY 2019, filed on December 2, 2019. The Consent Decree requires the Department to implement several provisions to ensure the availability of services, supports, and other resources of sufficient quality, scope, and variety to meet the obligations of the Consent Decree through the development of a Medicaid behavioral health delivery model ("Model") for Class Members. The Implementation Plan consisted of several sections that provide additional detail of the Model components, the action steps required to implement this plan, and the federal and state authorities under which the Model components are authorized and funded. This section of the report is structured to describe the activities the Department proposed for CY 2020, the progress made on those activities over the past year, and the Expert's recommendation for subsequent activities for CY 2021.

A major challenge for the Department to implement many of the activities set forth in the Implementation Plan has been the COVID-19 pandemic. Similar to other states, Illinois continues to be plagued by this pandemic, which has resulted in delays and interruption of the services and critical work that needed to get done over the past year. Leadership efforts in almost all state agencies were diverted to addressing the pandemic, delaying the development and implementation of policies and development of infrastructure necessary to meet the expectations of the Consent Decree. The Expert has been regularly informed regarding adjustments to the timelines of the Implementation Plan. Throughout this report, these adjustments are identified, and the Expert makes recommendations to complete these activities during the next reporting period.

A major change to the initial Implementation approach also occurred during this reporting period. Initially, the Department was pursuing a specific Medicaid authority to implement care coordination activities. Specifically, the Department had submitted and was seeking approval of a 2703 Medicaid Health Home State Plan Amendment (SPA) for these services, filed early in CY 2020. The Department was also in the process of amending other parts of the State's Medicaid program to add new services to the continuum of services that would be available to Class Members. These amendments were to be filed later in CY 2020 (late summer).

Mid-year, the Department completed an assessment of community-based services needed for individuals with complex needs, particularly those impacted by healthcare disparities and other unmet social needs highlighted by the COVID-19 pandemic. As a result, the Department determined that the 2703 authority would be re-focused on those individuals and would pursue a cohesive array of care coordination and services for N.B. Class Members utilizing a different federal authority. The Expert was involved in the discussion of alternatives to the initial 2703 SPA strategy. Based on these and additional inputs, the Department decided to pursue a different Medicaid authority, a 1915(i) Home and Community Based Services (HCBS) SPA, to implement a significant portion of the service continuum (including care coordination) for the N.B. Consent Decree. While this change has created additional implementation delays, the Expert supports this decision.

As proposed, the 1915i SPA provides several benefits. First, it allows the Department to cover a broader array of services than would be allowed under traditional Medicaid authorities. For instance, the Department is proposing to include Therapeutic Support Services and Individual Support Services, which will provide interventions such as art, dance/movement, and musical behavioral services. Second, this approach provides a singular quality framework for all services offered under the 1915i. The Centers for Medicare and Medicaid Services (CMS) requires states to develop a quality assurance structure for the delivery of these services. There is no such framework for services that are provided through traditional Medicaid authorities.

The Department submitted the 1915(i) HCBS SPA in December of 2020 and is anticipating they will receive approval by CMS in mid to late spring. The Expert understands that this has created a delay of 6-9 months for implementing the care coordination benefit but believes this approach will give the Department better tools to meet the needs of the N.B. Class Members.

While there were many tasks for the Department to complete during this reporting period, progress was made on the activities discussed below, despite the challenges presented by the ongoing COVID-19 pandemic. Below is a summary of activities the Department was to complete during the reporting period, the activities the Department undertook, and activities the Expert recommends for the next reporting period:

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

    - Proposed activities for CY 2020:
        i. Follow up with each managed care organization (MCO) regarding the implementation progress regarding their Family-Driven Care plan through regular and ongoing meetings with the MCO.
        ii. Require each MCO to develop a Family Leadership Council to promote and ensure child and family input to their annual goals, objectives, and activities related to family and child driven care.

iii. Develop and meet with the NB Subcommittee that consists of providers, provider and managed care trade associations, and family/community advocates. The N.B. Subcommittee addresses 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 to gather input on other areas of concern for providers.

iv. 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.

v. Develop a process flow that outlines the Model and how Class Members are connected to care coordination and other services and supports.

- Accomplished activities:
  i. The Department received, reviewed, and provided feedback to the MCOs regarding their initial Family Driven Care Plans.
  ii. The Department, on an ongoing basis, reviews the minutes of the MCO's Family Leadership Councils to ensure the committees are active and implementing their Family Driven Care Plans.
  iii. The Department has held four meetings of the N.B. Subcommittee since the initial implementation plan and provided feedback regarding care coordination training modules and the State's proposed Home and Community Based Services program.
  iv. The Illinois Department of Healthcare and Family Services (HFS) has developed two initial process flows with the Expert (separate flows for children and youth involved with the Department of Children and Family Services (DCFS) and for all other children and youth seeking services under the Consent Decree).
  v. HFS has developed an initial communication plan for the N.B. Consent Decree.
  vi. HFS has taken steps to establish the Children's Behavioral Health Family Leadership Workgroup, including the identification of potential members, but has not convened this group.
- Activities recommended for next 12 month period:
  i. Develop a charter and convene the Children's Behavioral Health Family Leadership Workgroup in the first quarter of 2021, specifically addressing the intersection of the N.B. Subcommittee and this workgroup.
  ii. Continue to convene the N.B. Subcommittee and provide additional opportunities to provide feedback on the Department's implementation

efforts regarding the HCBS initiative and other components of the N.B. Consent Decree and Implementation Plan.

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

iv. Finalize process flows and review with the N.B. Subcommittee, the Children's Behavioral Health Family Leadership Workgroup, DCFS, and other state child serving agencies.

2. Model Component #2-- Managed Care Organizations

- Proposed activities for CY 2020:
  i. Revise and enhance the expectations within the MCO model contract to clearly delineate the MCOs' responsibility for overseeing services and supports that are designed for Class Members.
  ii. Require each MCO to designate a Children's Behavioral Health (CBH) Program Manager responsible for managing the MCO's CBH programs and services, and for overseeing and training internal CBH staff.
  iii. Establish regular, frequent, ongoing meetings with the CBH Program Managers and other MCO staff to monitor and address MCO contract requirements.
  iv. Establish standards to be applied consistently across all MCOs for organizations providing care coordination and the additional behavioral health services that will be available to N.B. Class Members.
  v. Require all MCOs to utilize consistent eligibility criteria when reviewing service utilization for care coordination and for services that will be based on the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) as well as additional supporting information.
  vi. Establish specific performance and outcome standards related to Class Members.
  vii. Establish goals for the structural and process measures that MCOs must meet within required timelines to ensure that the Model infrastructure is being established in an efficient manner.
  viii. Develop a contract for an external vendor to provide administrative management of access to care coordination and other behavioral health services for Medicaid fee-for-service Class Members.
- Accomplished activities:
  i. The MCO's contract amendment has been drafted but is not yet final. The contract revisions will be updated to reflect the change in Medicaid authorities for care coordination and other services pending CMS approval.

ii. The Department has developed initial standards for care coordination services and new services, including Intensive Home-Based (previously In-Home) Services, Respite, Family Peer Support, Therapeutic Mentoring, Therapeutic Support Services, and Individual Support Services. These initial standards were reviewed by the Expert and the N.B. Subcommittee. The Department also solicited and received public comments on these services and standards prior to the submission of the HCBS State Plan Amendment to CMS.

- Activities recommended for next 12 month period:
  i. Develop rules and additional guidance for providers regarding care coordination and services set forth in the HCBS initiative.
  ii. Finalize and execute the MCO contract amendment by late spring to reflect the new benefit design and other processes included in the State's HCBS State Plan.
  iii. Develop Medical Necessity Criteria for services included in the HCBS initiative.
  iv. Develop an overall quality assurance plan that will include initial outcome measures, reporting frequency, data sources, and technical specifications by late summer.
  v. Finalize and implement the approach to connect children and youth in the N.B. Class who are not enrolled in managed care with care coordination and new services through the Model.

3. Model Component #3—Care Coordination (formerly Integrated Health Homes)

- Proposed activities for CY 2020:
  i. Establish three levels of care coordination intensity that organizations 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.
  ii. Develop and refine 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).
  iii. 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.
  iv. Develop and integrate with existing appeals mechanisms a process for review of stratification and service eligibility determinations.

v. Implement an electronic data portal to gather ongoing IM+CANS data for IM+CANS sharing and data collection for care coordination stratification.
vi. Begin to establish selection process for care coordination organizations.
vii. Establish the rates for the three care coordination service levels.

- Accomplished activities:
  i. As part of the pending 1915(i) application, the Department has established two levels of care coordination that vary in intensity. The third level that was specific to transition age youth has been incorporated into the high and more moderate care coordination approaches.
  ii. The Department has developed and implemented the electronic data portal to gather ongoing IM+CANS data for IM+CANS sharing and data collection for care coordination stratification.
  iii. The Department has developed initial IM+CANS decision support criteria that stratifies youth for several purposes, including the identification of N.B. Class Members and assignment to a care coordination tier. The Expert and the Plaintiff have reviewed and provided proposed changes to the decision support criteria. The Department has designed a plan for testing the decision support criteria that will include necessary participants.
  iv. The Department has established the care coordination eligibility criteria and competencies for care coordinators and their supervisors.
  v. The Department, with input from the Expert's team, has developed the necessary training modules for staff providing High Fidelity Wraparound and Intensive Care Coordination.
  vi. The State Plan Amendment for care coordination has been submitted to CMS.
  vii. The Department has begun the development of an application for care coordination and support organizations (CCSOs), including a framework for selecting CCSOs, a process for provider enrollment, and delineating the MCOs' role in the identification of potential care coordination organizations.
- Activities recommended for next 12 month period:
  i. The Department should continue to finalize efforts in the summer of 2021 to test and refine the decision support criteria to stratify Class Members.
  ii. The Department should engage N.B. Subcommittee, Children's Behavioral Health Family Leadership Workgroup, DCFS staff, and other state agencies serving children to review and provide input to the decision support criteria.
  iii. The Department should finalize the process and necessary documents (e.g., application materials and contracts) to select CCSOs. These processes and materials should be finalized by late spring. In early summer, the Department should meet with the MCOs to initiate the application and selection process.

iv. The Department should finalize the appeal process for the HCBS initiative and service eligibility determinations.
v. The Department should implement care coordination training for CCSOs in early fall.

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

- Proposed activities for CY 2020:
  i. Work with physician associations, psychiatric associations, the N.B Consent Decree expert, and stakeholders to determine and adopt nationally recognized screening tools that should be utilized by Primary Care Practitioners (PCPs) as a behavioral health screening tool.
  ii. 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 care coordination organizations.
  iii. Monitor the availability of the Medicaid 1115 Demonstration 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. If issues arise regarding access, the Department will work with CMS to make adjustments to the wavier or will determine other methods to ensure Class Members have access to this service.
  iv. Implement 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.
  v. Pilot respite services, under the 1115 waiver, 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.
  vi. Work with stakeholders and the N.B. Consent Decree Expert to develop formal service definitions and provider standards for Family Peer Support and Therapeutic Mentoring.
  vii. Draft Medicaid State Plan Amendments for new services offered under the Consent Decree.
  viii. Evaluate current rules and policies regarding Behavioral Health Clinics (BHC) 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.

ix. Review current rules, policies, and rates to ensure that there is sufficient support and flexibility to enhance access to services for Class Members.

x. Develop an appropriate process and electronic portal to allow sharing of IM+CANS assessment and treatment planning information across multiple providers.

xi. Develop a registration process to require providers to attend training, receive certification, and then register as an IM+CANS provider.

- Accomplished activities:
  i. The Chair for the PCP and the provider workgroup participants have been identified.
  ii. The Department has developed a training and certification process for providers to become certified in the IM+CANS. Since July 2018, 12,591 providers have attended the IM+CANS training, and currently there are 6,027 certified IM+CANS providers.
  iii. The Department drafted and submitted the HCBS State Plan Amendment for care coordination and all new services offered under the Consent Decree. These services include Intensive In-Home Services, Respite, Family Peer Support, Therapeutic Mentoring, Therapeutic Support Services, and Individual Support Services.
  iv. The Department implemented enhanced technical assistance for providers applying to become BHC and has increased the number of BHC providers by 30 with additional providers being identified for CY 2021.
  v. The Department has developed formal service definitions and provider standards for these HCBS services.
- Activities recommended for next 12 month period:
  i. The Department should convene the PCP and provider workgroup and ensure the PCP behavioral health screening tool(s) has been identified by the State.
  ii. The Department should develop Crisis Triage and Stabilization services during this reporting period. This should include reviewing and making any modifications to the definition, meeting with MCOs to develop and implement a network development plan for these services, developing the necessary medical necessity criteria to be applied for these admissions, and developing and implementing a process to track referrals and lengths of stays to ensure they are consistent with the State's intent for these services, post discharge referrals, and engagement in HCBS services.
  iii. The Department should work with the MCOs to develop and implement a network development strategy for the new services in the HCBS initiative.

5. Model Component #5--PRTFs

- Proposed activities for CY 2020:
    i. Continue to address the needs of Class Members demonstrating medical necessity for a Psychiatric Residential Treatment Facility (PRTF) level of care by developing and implementing a more formal Interim Relief process.
- Accomplished activities:
    i. Refined and implemented the interim relief process for members that needed a PRTF level of care.
- Activities recommended for next 12 month period:
    i. The Department should conduct a needs assessment to determine the initial volume and location of PRTF beds.
    ii. The Department, in cooperation with DCFS, should continue efforts to research the Building Bridges Initiative and the quality requirements from the Family First Preservation Services Act to determine how to best apply these to Illinois in-state PRTF development efforts.

6. Implementation Training and Technical Assistance

- Proposed activities for CY 2020:
    i. Develop a Children's Behavioral Health - Technical Assistance and Training (CBH-TAT) resource to ensure that the necessary training and technical assistance supports and resources are available to implement the services in the N.B. Consent Decree.
    ii. Develop a certification process for Wraparound facilitators and supervisors, for Intensive Care Coordination care coordinators, and for supervisors.
    iii. Work with the CBH-TAT resource to develop training and certification standards and technical assistance for providers who are seeking to provide the IM+CANS as well as behavioral health services under this Consent Decree.
    iv. Receive, review, and disseminate to MCOs 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.
    v. Develop new mandatory training for Mobile Crisis Response (MCR) and Crisis Stabilization service providers.
- Accomplished activities:
    i. The Department established a Technical Assistance and Training (CBH-TAT) resource through its intergovernmental agreement with the University of Illinois's Office of Medicaid Innovation and the School of Social Work.
    ii. The Department, through the University of Illinois's Office of Medicaid Innovation and the School of Social Work, developed and implemented

training and certification standards and technical assistance for providers who seek to provide the IM+CANS.

iii. The Department, through the University of Illinois's Office of Medicaid Innovation and the School of Social Work and in collaboration with the Expert's team, developed a four-module course for Mobile Crisis Response (MCR) and Crisis Stabilization providers. These trainings were implemented in September 2020.

iv. The Department, through the University of Illinois's Office of Medicaid Innovation and the School of Social Work and with the Expert's team, developed a certification process and training materials for High Fidelity Wraparound and Intensive Care Coordination for Care coordination staff and their supervisors.

- Activities recommended for next 12 month period:
  i. The Department should develop an overall training plan for new and existing services included in the N.B. Consent Decree Implementation Plan.
  ii. The Department, in cooperation with the Expert and the University of Illinois, should develop and implement the necessary training modules for new services with particular attention to Intensive In-Home, Family Peer Support, and Therapeutic Mentoring.

7. Cross-Agency Collaboration on Model Development and Implementation

- Proposed activities for CY 2020:
  i. Establish regular meetings with representatives from each of the State's child-serving agencies to ensure ongoing communication and engagement and solicit feedback from these agencies regarding policies, procedures, and rules that affect Class Members they serve.
  ii. Develop an approach to solicit feedback from DCFS regarding Model components to ensure there is coordination between the Model and child welfare processes that support both agencies' goals of serving Class Members.
  iii. Conduct regular regional trainings and meetings, in collaboration with the MCOs for DCFS Regional Administrators, foster parent associations, adoptive parent associations, juvenile court staff, case workers, and other state agency staff to address implementation and implementation issues.
- Accomplished activities:
  i. The Department has convened meetings monthly with other child-serving agencies including DCFS, DHS, Illinois State Board of Education, and Department of Juvenile Justice. These meetings have focused on resolving cross agency crises for specific children and youth, strategies to ensure new services offered through the HCBS program support do not duplicate existing services, and an initial review of the child and caregiver process flows.

ii. The Department has met with DCFS separately to discuss possible overlap of N.B. services and existing services purchased by DCFS. In addition, these meetings have focused on consent issues, strategies to inform caseworkers regarding N.B. services, and the implementation of the Youth Care managed care initiative.

- Activities recommended for next 12 month period:
  i. The Department should finalize the process flows specific to DCFS children, youth, and caregivers who will participate in the HCBS initiative.
  ii. The Department should develop education and training for care coordinators/caseworkers/case managers from other child service agencies on how children can access services in the 1915(i) initiative.
  iii. The Department, in cooperation with other state child-serving agencies should develop a cross agency training plan for their respective staff regarding the N.B. Consent Decree, the HCBS initiative, and the referral process for the HCBS Initiative.
  iv. The Department should solicit feedback from state child service agencies regarding the proposed outcome measures for the N.B. Consent Decree to ensure alignment with the State's overall approach for children's behavioral health services.

Progress on Key Provisions of the Consent Decree

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

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

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

The Department has developed a Model, laying the foundation for a systemic approach meeting the expectation of this paragraph. As described throughout the report, the Model sets

forth the services that will be developed and available for N.B. Class members. The Department has submitted the necessary state plan requests or changes to the Centers for Medicare and Medicaid Services (CMS) which will allow them to implement the design. The Department is hopeful that they will receive this approval in late spring or early summer—allowing it to continue with implementation efforts. The Department has also developed some of the necessary foundational documents (e.g., service definitions) that will guide their implementation effort. The Department will also develop requirements regarding access to Medicaid services for N.B. Class members. Once the Department receives approval from CMS, additional policies regarding network adequacy and other access standards can be finalized.

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

As set forth below in Paragraph 11, the Department has identified the array of services and supports that will be available to Class Members. There are several services the Department has implemented, including Integrated Assessment and Treatment Planning, Mobile Crisis Response. There was some limited implementation of Intensive In-Home as discussed in this report. The remaining services will be implemented later in CY 2021.

In 2018, the Department developed a standardized, statewide process that is used to assess the needs and strengths of all Illinois Medicaid-eligible children seeking behavioral health services, including N.B. Class Members, and to consistently integrate those needs and strengths into treatment planning and service delivery. The Department created a standardized assessment instrument, the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS), that provides a standardized framework for assessing the needs and strengths of Class Members who require mental health treatment. 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 into the assessment process.

All Medicaid enrolled providers who want to offer behavioral health services to Medicaid eligible children and families are required to be trained and certified annually to render the IM+CANS. The Department has engaged an external vendor to provide training, certification, and ongoing technical assistance support to providers who deliver this assessment. More information regarding the IM+CANS is provided in 17.d. From July 2018 through December 2020, there were 77,747 children and youth under the age of 21 who had an IM+CANS.

Given the number of projected N.B. Class members who will participate in the HCBS Initiative in the first year, the Expert is recommending the Department increase the number of Integrated Assessment and Treatment Planning (IATP) significantly over the next reporting period. At a

minimum, the Department should have a target of 30-45,000 IM+CANS to be performed for children and youth between now and October 2022, the first year of the Department's implementation of its Home and Community-Based Services program.

In 2003, the Department developed the Screening, Assessment, and Support Services (SASS) program 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. While the SASS program was designed to provide crisis services in the most appropriate and least restrictive setting 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, the Department revised the services to be more consistent with the original intention of SASS.

The new service, Mobile Crisis Response (MCR), includes face-to-face crisis screening; short-term intervention; crisis safety planning; brief counseling; consultation with other qualified providers to assist with the client's specific crisis; referral and linkage to community services; and, in the event that the client cannot be stabilized in the community, facilitation of a safe transition to a higher level of care. In addition, the Department has developed and implemented a training curriculum for MCR providers. The Expert's team has reviewed this curriculum and believes it is sufficient for the Department's initial training effort. From July 2018 through December 2020, there were 40,615 unduplicated children and youth under the age of 21 who received MCR.

In addition to MCR, Crisis Stabilization was introduced as a new component of the Department's crisis services array available to individuals following a Mobile Crisis Response event. Crisis Stabilization includes observing, modeling, coaching, supporting the implementation of the client's Crisis Safety Plan, performing crisis de-escalation, and responding to behavioral health crisis, when necessary. Crisis Stabilization is to be provided in the Class Member's home or other community setting where the crisis has occurred. From July 2018 through December 2020, there were 2,092 unduplicated children and youth under the age of 21 who received Crisis Stabilization.

The Expert recommends that the Department undertake the following activities in the next reporting period to increase access to MCR and Crisis Stabilization Services:

- Continue to implement the existing MCR training and specifically have a training plan for this service.
- Develop key reporting indicators and an MCR dashboard to ensure MCR services are provided on a timely basis.
- Based on these measures, develop a monitoring approach to identify access and timeliness issues.

- Develop a technical assistance approach to assist providers across the state to enhance access and timeliness.

Given the preponderance of children and youth enrolled in an MCO, the Expert recommends the Department work with the MCOs to assist in ongoing network development activities, including assisting the state to monitor access and timeliness of the services. To ensure there is a consistent approach to these efforts, the Department will need to take a leadership role to implement the recommendations above and assist the MCO to monitor the quality and access to MCR and Crisis Stabilization Services.

In October 2018, the Department piloted a fourth service, Intensive In-Home Services, which provides face-to-face, time-limited, focused interventions to stabilize behaviors that may lead to crisis or may result in inpatient hospitalizations or out-of-home care. Intensive In-Home Services 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 child and caregiver's home to help the child and caregiver implement the intervention plan. Over the past two years, there has been minimal use of these services. As of December 2020, fewer than 10 children and youth have received this service. The Department has indicated several reasons for this low utilization:

- Lack of a clarity regarding the service requirements and training for providers to deliver the service as designed.
- Providers had more incentives to use existing services in the Medicaid program (e.g., Community Support Team) to deliver intensive in-home services.
- Confusion and possible disincentives for providers regarding the reimbursement methodology for intensive in-home services.

As the Department monitored the service provision, it determined that it was not available statewide and did not have sufficient capacity to meet child and caregiver needs. Therefore, the Department determined that this service would be better suited under the 1915(i) benefit in order to align it with other services targeted toward the N.B. Class under a single authority instead of as a stand-alone service. By doing this, the Department is able to clarify service requirements, address training needs, and create a new rate methodology to better incentivize providers to offer this service.

Based on this initial information, the Department, in cooperation with the Expert Team, has reviewed various strategies for increasing the delivery of intensive in-home services over the next reporting period. These strategies include:

- Continue efforts to meet with providers and other stakeholders to identify and develop policies to increase access to intensive in-home services.

- Develop an adequate reimbursement methodology that incentivizes providers to offer this service.
- Develop clearer guidance to providers regarding the delivery of intensive in-home services.
- Develop and implement a training curriculum for intensive in-home services.
- Develop projections regarding the number of children, youth, and caregivers that will likely use the services in the first and subsequent years of the HCBS initiative.
- Develop a network development strategy, in cooperation with the MCOs, to adequately meet the needs of these children, youth, and caregivers.

There are additional services the Department will implement during the next reporting period. This includes care coordination (for various groups of children and youth), respite, family peer support services, therapeutic mentoring, therapeutic support services, and individual support services. These services are described in paragraph 11.

To ensure the array (existing and new services) is available to meet the obligations of this paragraph, it will be necessary for the Department to develop additional policies and processes. The Expert would recommend the Department develop the following policies that will set forth standards regarding access and timeliness of services:

- Develop member material that will provide information regarding the N.B. Consent decree, including specific information on Class Member eligibility, processes for determining whether a child or youth is a Class Member, appealing decisions regarding Class Member eligibility, services available, and methods for accessing services. The Expert recommends that the Department direct the development of this material to ensure consistency across MCOs.
- Develop consistent access standards for each service and support identified in paragraph 11. While federal managed care regulations will require MCOs to maintain a provider network that is sufficient to provide timely access to all medically necessary covered services (including N.B. Services) to members, the Department should develop access standards to be used by all MCOs. This could include various strategies (or a combination thereof) such as time and distance standards, requiring that plans contract with all providers of a certain service, and/or provider surveys to identify providers that are at capacity and may not be accepting any new referrals.
- Develop a strategy for monitoring access to services in paragraph 11. While federal regulations and MCO reports regarding access are valuable, they are not sufficient. The Department can use current strategies to monitor access, including grievances and complaints, to identify barriers that prevent an individual from receiving services. They have developed various discovery and remediation strategies identified in the HCBS SPA that will provide valuable information on whether a child/youth is receiving services in their plan. Additional access issues or service gaps should be solicited from the N.B. Subcommittee and the Children's Behavioral Health Family Leadership Workgroup. The Subcommittee and the Workgroup should

also work closely with the Department to develop strategies for addressing access issues.

The Department has not fully embarked on a process to identify and finalize measures for the N.B. Consent decree. It will be important to develop these measures to inform the standards necessary to meet paragraph 35 of the Consent Decree. The Expert recommends the Department develop measure sets for the following categories:

- Structural Measures that will ensure that the Model infrastructure is being established in an efficient manner. At a minimum, this should include information regarding the number of children projected to need select services (care coordination and intensive in-home) set forth in the HCBS initiative and the projected number of providers that will be necessary to ensure adequate access to these services. In addition, the Department should provide information quarterly on the number of individuals enrolled and participating in the HCBS initiative and the number of children receiving each service. The Department should also develop measures that are critical to determining if children and youth are using more intensive services including emergency department, psychiatric inpatient, and other out of home (and out of state) services.
- Process Measures that assess whether specific activities are implemented consistent with standards set forth by the Department. Process measures can also include an assessment of whether a particular service is being delivered consistent with a fidelity tool. The Department has developed process measures in the HCBS, including:
    - Service plans address assessed needs of HCBS participants.
    - Providers meet the qualifications for specific services.
    - Processes and instruments for determining HCBS eligibility are applied appropriately.

  While these measures are important, additional process measures should be developed to ensure that children, youth, and their caregivers receive the services consistent with their needs. Some of these measures specific to access and timeliness were recommended above. Additional process measures the Department should consider are:
    - Whether services identified in the assessment are reflected in service plans
    - Whether services are delivered consistent with the scope, amount, and duration as identified in the plan
    - Whether services are being delivered consistent with their evidenced base including High Fidelity Wraparound Care Coordination and Support
    - Rate of out of home placement
    - Lengths of stay in these out of home placements
    - Follow up after a hospitalization or an ED visit for mental health purposes.
- Outcomes measures that assess whether the Model is achieving its intended results. These measures are more challenging to develop since there is not a national set of outcome measures for some of these services. However, several states with similar approaches have developed outcome measures that include:
    - Increased school attendance

- Decreased involvement with the juvenile justice system
- Increases in a child or youth's functioning in key areas
- Satisfaction with services (child, family, and caregiver).

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

The Expert recommends the Department develop these measures during the next reporting period in cooperation with various stakeholder groups, state agency representatives, and MCOs who will likely be the conduit for data and other information to support these measures. These measures should be created prior to the start of the HCBS initiative.

Finally, it is recommended that the Department develop a quality assurance plan in the next six months that is specific to the Consent Decree. The plan should set forth the process to collect and analyze data on the measures developed for the Consent Decree and the processes the Department will use to improve the experience of care for children, youth, and caregivers participating in the HCBS initiative as well as to improve the quality of HCBS and other mental health and behavioral services.

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

The Governor's FY2022 budget has not been released at the writing of this report and the Expert cannot report on this paragraph.

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

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

13. The Model shall be developed and implemented in phases and the Medicaid services included in the continuum of care under the Model shall be set forth and defined in this Consent

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

Paragraphs 11 through 13 are addressed together. To meet the requirements of these paragraphs, the Department has initially developed a Model that sets forth the specific services and supports that will be provided to the N.B. Class. This Model was described in the Department's Initial Implementation Plan (12/2019). The Model was developed using information from other states that have developed a System of Care approach for children with significant mental health or behavioral disorders. The Department also uses an informational bulletin from the Centers for Medicare and Medicaid Services (CMS) that sets forth the services and supports that could be included in a State's Medicaid Plan to meet their EPSDT obligations[1]. Initially, the Department had included IATP, MCR, Crisis Stabilization Services, Intensive In-Home services (discussed above in paragraph 9), and the following two services and supports for the N.B. Class:

- Care Coordination—including three levels of care coordination intensity 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.
- Respite—including activities to relieve stress and ultimately maintain individuals in the home and community, as respite services provide safe and supportive environments on a short-term basis for children with mental health conditions when their families need relief.

During this reporting period, the Department, at the recommendation of the Expert, included additional services for the N.B. Class that were consistent in other states whose benefit design had demonstrated positive outcomes for children and their caregivers. The Department initially included the following services in the 2019 Implementation Plan and moved forward with some initial implementation activities:

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

- Family Peer Support—including activities that assist the family to engage in services and supports, assisting the family in self-advocacy, assisting in systems navigation, providing information about the child's behavioral health needs and strengths, identifying and building natural supports, and promoting effective family-driven practice.
- Therapeutic Mentoring—assists the child or youth to improve their ability to navigate various social contexts, observe and practice appropriate behaviors and key interpersonal skills that build confidence, assist with emotional stability, demonstrate empathy, and enhance positive communication of personal needs without escalating into crisis.

In addition to these services, The Department has added the following services for N.B. Class members during CY 2020:

- Therapeutic Support Services—help children and youth find a form of expression beyond words or traditional therapies in an effort to reduce anxiety, aggression, and other clinical issues while enhancing service engagement through direct activity and stimulation.
- Individual Support Services—including activities, services, and goods that serve as additional supports and are intended to promote health, wellness, and behavioral health stability through community stabilization and family stability.

In the opinion of the Expert, the Department has set forth the necessary possible services for the members of the N.B. Class. Once services are initiated and service planning commences, there will likely be additional services the Department may want to consider based on children, youth, and caregiver information and preferences. The Department has made a commitment to research and explore developing practices and services that may better inform or improve the Model for Class Members and has stated that future Implementation Plan reviews may include different or modified practices or services as necessary to improve the Model and better address the needs of Class Members.

The Department has yet to implement Psychiatric Residential Treatment Facilities (PRTF). A PRTF is an alternative to psychiatric hospitalization and provides intensive inpatient care designed to help stabilize the youth, provide for immediate treatment needs, and quickly return the youth to their prior care setting (often a lower level of residential care), in order to continue their course of treatment. PRTFs are unique to the Medicaid program, offering this benefit only to Medicaid-eligible individuals under the age of 21 who meet medical necessity criteria. Currently, the Medicaid program in Illinois does not yet include systemic coverage of behavioral health PRTFs, thus there is no behavioral health PRTF Medicaid provider network. The Department does reimburse children placed in PRTFs in other states. Currently, there are 15 children and youth from Illinois in these out-of-state facilities.

In their Implementation plan, the Department is phasing in in-state PRTFs after the home and community-based service delivery system has been built to sufficient capacity to effectively serve Class Members. The Expert agrees with that approach. The Department will develop

necessary PRTF policies, procedures, and administrative rules along with home and community-based services, according to the Implementation Plan. The Plan indicates that the Department will utilize clinical and treatment concepts from the Building Bridges Initiative and quality requirements from the Family First Preservation Act to develop the treatment expectations for time-limited PRTFs and will work in close collaboration with the Department of Children and Family Services in this process[2].

Similar to Illinois, there are several states that do not have a PRTF benefit and refer children and youth to out of state facilities. Several of these states, such as Ohio and New Hampshire, have made a commitment to divert or transition children and youth from out-of-state placements to their communities using similar approaches as Illinois. New Hampshire has specifically designed their procurement and policies for using the Building Bridges Initiative to inform the Department's PRTF approach[3]. Rather than reinvent the wheel, the Expert recommends the Department should consider a similar approach in their PRTF efforts. The Expert recommends during this next reporting period that the Department initiate efforts to identify the in-state PRTF capacity needed and continue efforts to explore other state's efforts to implement the Building Bridges Initiative as part of the design and specifications for this service.

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

Federal Medicaid policies require that services covered by a state's Medicaid program and rendered to an enrolled individual must be medically necessary. However, these policies do not set forth a definition of medical necessity; therefore, each state develops its own definition and application. The Department has developed various clinical decision and medical necessity criteria for some services included in the continuum for children, youth, and caregivers. However, the Department has yet to create similar criteria for new services. Paragraph 15 does not require the Department to develop medical necessity criteria for services in the continuum. However, the Expert recommends the Department develop standardized medical necessity

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

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

criteria for select services (Intensive In-home, PRTF) and require the MCOs and statewide Administrative Service Organization (ASO) to use these criteria.

Developing medical necessity criteria is important, but equally important is the process used to implement the criteria. In a traditional managed care model, providers request authorization for some or most services in the service plan. Often the provider will receive an authorization approval/denial for each service.

In the Expert's opinion, the approach the Department has developed may not lend itself to the traditional managed care model requiring review of medical necessity for each service in the Plan of Care. In the Model proposed by the Department, child and family teams, with the aid of the care coordinator (employed by the CCSO), assist with the treatment planning process. These teams will review the Individual Plan of Care at each meeting and the care coordinator will update it at least every 30 or 60 days depending on the child's intensity of care coordination, and as needs and strengths change. The Department has not yet developed a detailed approach for review by an external entity (e.g., MCO) of service plans. Nor has the Department identified what services, if any, will require a formal service authorization using medical necessity criteria.

The Expert recommends that the Department develop a process for reviewing the plans of care rather than having individual services reviewed for medical necessity. This review would:

- Ensure the plans adhere and support a child and family-centered care planning process consistent with System of Care Principles and with High Fidelity Wraparound practice when that method is used.
- Ensure the process is independent from the staff and organizational structure responsible for developing care plans.
- Closely coordinate with utilization management and the service authorization process to avoid duplication of review effort, to ensure a single voice in feedback to providers on care planning needs, and to ensure timeliness.
- Ensure staff conducting care plan reviews have credentials, training, and experience in System of Care principles.
- Provide feedback to the care coordinator through a method developed by the Department if the MCO cannot determine that a care plan meets requirements.
- Have clear timeframes for the review of the plans of care.

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

While the Department focuses initial implementation efforts on the development of home- and community-based services as required by Paragraph 13, it has and will continue to address the needs of Class Members demonstrating medical necessity for a PRTF level of care through the

current Interim Relief process. The Implementation Plan sets forth the specification of the Interim Relief Process. The Expert has reviewed this process and concurs with the Department's Interim Relief approach. During this reporting period there were 40 children and youth referred for PRTF using this process. 15 of the 40 received PRTF services in out-of-state facilities.

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

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

The Department, in consultation with the Expert, has developed the preliminary processes for engaging children, youth, and caregivers to receive the continuum of behavioral health services offered though the N.B. Consent Decree. As an initial step, the Department has developed two process flows that outline how children and youth are identified as a Class Member. Both flows also set forth a high level process for children and youth to be referred for specific care coordination tiers. One flow provides an overview of the referral and engagement process for care coordination for youth that are involved with DCFS. The other flow provides an overview of the referral and engagement process for care coordination for youth that are not involved with DCFS. These flows establish a pathway for children and youth who may have significant mental health and behavioral needs to be referred for an IM+CANS, determine if they meet the criteria for the N.B. Class, identify the care coordination tier, and set forth the activities CCSOs will undertake to provide outreach and engage the child, youth, and caregiver.

The Expert believes this is a good first step for designing the structure to link children, youth, and families to care coordination and to services that will be identified through the Child and Family Team process. The Expert recommends that the Department finalize these flows and meet with the N.B. Subcommittee and other child service agencies early in CY 2021, including DCFS, to discuss these flows and make any necessary changes based on those conversations. After these child and family flows are finalized, the Expert recommends the Department operationalize these flows by building the necessary infrastructure to ensure children and youth, once identified as an N.B. Class Member, will receive care coordination and other services and supports on a timely basis. The infrastructure should also take into account the communication strategy between The Department and DCFS caseworkers.

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

c) Provide notice to HFS-enrolled Primary Care Physicians ("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;

As indicated earlier in this report, under EPSDT, states are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT requires physicians and other practitioners to screen for certain conditions, including developmental and behavioral screening. These screenings are essential to identify possible delays in growth and development, as well as behavioral health challenges. Many states struggle with this screening requirement. Nationwide, in 2016, just under 60 percent of children or youth who should have received at least one initial or periodic screening received one[4]. Historically, many states have not addressed behavioral health issues in their EPSDT screening tools[5]. The N.B. Consent Decree recognizes the need to improve behavioral health screening for children and youth who may have mental health or behavioral issues and to create the necessary referral pathways for primary care practitioners to additional assessments or treatment and supports.

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

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

As a first step to operationalize the requirements in the Implementation Plan, the Department, during the previous reporting period, was to establish a workgroup to make recommendations regarding which nationally recognized behavioral health screening tools should be utilized by PCPs. Once the workgroup recommended a screening tool, the Department was going to adopt this tool and provide notification and launch training to PCPs on the utilization of the tool. The Department has indicated a delay in these activities due to the pandemic. During this reporting period, the Department has identified the workgroup and the various tools the work group should consider in their discussion. The Expert's team made recommendations to the Department regarding screening tools they should have the workgroup consider.

[4] https://www.macpac.gov/subtopic/epsdt-in-medicaid/
[5] https://pubmed.ncbi.nlm.nih.gov/12719507/

Early in this next reporting period, the Expert recommends the Department convene the workgroup and make the necessary decisions regarding a screening tool(s) by early spring. In addition, the Expert recommends that the Department develop and implement the necessary training for PCPs during this next reporting period. The Expert also recommends that the Department identify and implement additional strategies for using and tracking the use of these screening tools. While a standardized tool and training are important, they may not be sufficient to increase screening. Massachusetts, for instance, made various policy, reimbursement, and infrastructure changes early in their consent decree. The State experienced a 16% increase in the use of behavioral screening tools among PCPs[6]. The Expert recommends that the Department consider similar strategies to incent and track the behavioral screenings.

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;

In 2019, the Department developed and implemented a standardized assessment process to meet the intent of this paragraph. The standardized assessment tool created for this process is the Illinois Medicaid–Comprehensive Assessment of Needs and Strengths (IM+CANS). The IM+CANS integrates assessment and treatment planning into a single process. It contains a complete set of core items that assess function across multiple life domains such as risk behaviors, trauma exposure, behavioral/emotional needs, substance use, and cultural factors, as well as a physical health risk assessment. It was developed as the result of a collaborative effort between the Illinois Departments of Healthcare and Family Services (HFS), Human Services-Division of Mental Health (DHS-DMH), and Children and Family Services (DCFS). The IM+CANS is designed to reduce the duplicate collection of administrative and clinical data points needed to appropriately assess a client's needs and strengths, while establishing a commonality of language between clients, families, providers, and payer systems. The IM+CANS was built for Illinois in consultation with national expert Dr. John Lyons and his team.

The Expert and the team have reviewed the IM+CANS and believe the instrument and process the Department has developed for its use regarding the N.B. Consent Decree should support its intended goal. In addition, the Department, through its partnership with the University of Illinois, has developed and implemented the necessary training and certification process for providers to deploy the IM+CANS. Currently, there are 6,027 individuals that are IM+CANS certified.

[6]https://www.researchgate.net/publication/50304395_Increases_in_Behavioral_Health_Screening_in_Pediatric_Care_for_Massachusetts_Medicaid_Patients

The Department has also created the necessary infrastructure for providers to collect and submit information from the IM+CANS. As of July 2020, certified providers began direct data entry into a portal created specifically for IM+CANS. As of December 2020, 15,881 IM+CANS have been entered into this portal for children and youth under 21 who have behavioral health issues. Based on the number of IM+CANS certified providers, the Expert believes the Department has sufficient access for assessments as they begin to implement the 1915i initiative later this calendar year.

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

The Department is in the process of developing the necessary infrastructure to determine whether children and youth will be eligible N.B. Class Members and to assist with the assignment of the appropriate care coordination tier. Specifically, the Department has developed a decision support system using the IM+CANS to meet the intent of this paragraph. The IM+CANS serves as the foundation stratification approach.

In November 2020, the Expert, N.B. Class Counsel, the Department, and the developer of the IM+CANS instrument met to review the IM+CANS instrument and the stratification process to ensure that it is identifying cohorts of children with similar needs, strengths, and service utilization appropriate for each level of care coordination and service intensity. The Plaintiff provided comments and requested additional information regarding the instrument, the process for stratification, and information from other jurisdictions that had implemented CANS. The Department has begun and will continue testing the decision support criteria during the first half of CY 2021 and will work with the Expert, Class Counsel, and developer to finalize the decision support criteria.

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

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

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

Initially, the Department had proposed a third tier of Care Coordination for transition age youth 19 years old and older. This tier of care coordination was to focus on engaging these young adults in their healthcare, empowering them to make healthcare decisions, assisting them in applying for appropriate benefits, engaging them 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. While the Expert agrees that older youth and young adults may require a different approach to care coordination and may benefit from additional services, developing a separate tier for these individuals was not recommended.

First, the age range of transition age youth vary in many states; however, most states recognize that youth as young as 16 may benefit from services and supports for transition purposes. Second, the Expert was concerned regarding several assumptions. The age of 19 seemed arbitrary, given experience in other systems that had defined transition age youth younger than the age of 19. In addition, the Expert was concerned that youth who were receiving CCSW or CCSI would be transitioned to another level of care coordination, possibly discontinuing their relationship with the existing care coordinator. Finally, while some young adults will benefit from services tailored for adults with serious mental illness (SMI), many will not. Many transition age youth, especially young adults, may not need the services or intensity of services offered to adults with SMI. For instance, in other states, youth and young adults who experience their first episode of psychosis are offered a different benefit package than adults with SMI[7]. In addition, youth and young adults involved in the juvenile justice and child welfare system may need unique services and approaches that assist with transitioning from these systems and preventing involvement with adult criminal justice systems or preventing homelessness[8] [9]. In the most recent approach, the Department has merged the transition age tier of care coordination into the other two tiers to ensure the needs of transition age youth are addressed in an age-appropriate manner through the CCSW and CCSI tiers while maintaining continuity of care coordination.

[7] https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-10-16-2015.pdf
[8] https://www.ncsl.org/research/human-services/homeless-and-runaway-youth.aspx
[9] https://www.childwelfare.gov/topics/outofhome/independent/support/

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

The Department is in the process of developing standards that set forth timeframes for development and review of a child's or youth's plan of care. The Implementation Plan requires that the Child and Family Teams (discussed in the paragraph below) will meet on a regular basis (every 30 days for children and youth receiving CCSW and every 60 days for children and youth receiving CCSI). During these Child and Family Team meetings, the plan of care will be reviewed and amended as needed. In addition, the Department will require that a significant change in condition or situation experienced by a child or youth will warrant a review and possible changes to the individual plan of care. Additionally, the current HCBS State Plan Amendment requires service plans to address the assessed needs of HCBS initiative's participants and to be updated on an annual basis.

In addition, the Department, in cooperation with the Expert and the University of Illinois Office of Medicaid Innovation and the School of Social Work, developed a training package for care coordinators in CCSOs to ensure services that set forth the process for convening the child and family team and developing the plan of care. The training is consistent with both System of Care principles and national standards for Wraparound.

The Expert does not recommend that the Department develop a standardized format for the individual plan of care. Agencies that may be selected to provide care coordination may already have an appropriate format that includes components for individual plans of care as established in this paragraph. In addition, some of the agencies selected as CCSOs may have existing plan formats in their Electronic Health Records (EHRs). The Department should be cautious about large scale changes to a provider's EHR that may not produce a value added result. Rather, the Expert recommends that the Department provide more detail regarding the components for a plan of care. This could include, but is not limited to:

- Timeframe covered by the service plan
- Goals
- Objectives
- Recommended services

- Rendering provider for each service
- Amount and duration recommended for services.

In addition, the Expert recommends that the Department should develop reporting requirements and a tracking system for CCSOs regarding their efforts to comply with the standards for the development and review of individual plans of care. These requirements and tracking system should be developed by late summer.

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

The Department has included child and family teams (CFT) in their Model. Both tiers of care coordination, the High Fidelity Wraparound Level and the Intensive care Coordination Level, require the use of CFTs in the development of the Plan of Care. The Department has developed preliminary requirements for CFTs. While the development of these initial policies is a good start, the Expert recommends that additional policies and protocols will need to be developed or adopted by the Department to ensure that CFTs meet the provisions of this paragraph. This will include specific guidance to care coordinators regarding the protocols.

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

The Department has developed and implemented a Mobile Crisis Response Model as described in the review of paragraph 9.

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

There are several approaches the Department is currently undertaking (but has not yet implemented) to address this paragraph. In the Expert's response to paragraph 9, it is recommended that each MCO develop a network development plan for services set forth in the N.B. Implementation Plan. While the current MCO contract includes provisions for network adequacy and provider education, there are not specific provisions for developing new services included in the N.B. Implementation Plan. The Department should consider modifying the MCOs' contract to require a network development plan specific to N.B. Class Members, including a process for the MCOs to collaborate on their network development efforts. Since children and youth in the N.B. Class will be enrolled across all managed care plans, it is in the Department's best interest to ensure efficiency and standardization in identifying, recruiting, and developing providers to offer these services.

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

In early CY 2020, the Department developed a communication plan for the N.B. Consent decree. The communication plan had various activities (e.g., communication with various advisory groups and webpage development) that were helpful to launch the Department's efforts to exchange information regarding the N.B. Consent Decree. However, many of these activities were based on a pre-pandemic strategy and therefore were not completely implemented. In addition, several major changes to the Department's approach have occurred over the past six months and therefore the Expert recommends that the Department review and revise the initial Communication Plan to account for the ongoing pandemic and these changes.

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

The Department has not developed a specific procedure for addressing hospitalizations or out-of-home placements. The proposed care coordination approach uses a System of Care framework and has fidelity to wraparound, emphasizing that children and youth receive services in the least restrictive setting. The current training for care coordinators incorporates this framework and approach. The Department is drafting provider guidance for CCSOs that will also reinforce the minimal use of inpatient settings and other out-of-home placement. The Expert understands there will be admissions to these settings. For inpatient psychiatric services and PRTFs, the Expert assumes that MCOs will be required to review and approve these admissions and will work in close collaboration with the CCSOs to avoid preventable hospitalizations. The MCOs have the financial incentives and the clinical and operational protocols to prevent unnecessary admissions.

Other out-of-home placements are outside the purview of the Department or their contracted MCOs. Admissions to Qualified Residential Treatment Programs (QRTPs), foster care, and other residential facilities are overseen by other state agencies. For N.B. Class Members who are in out-of-home placements and funded by Medicaid, the Department should, in close collaboration with DCFS, develop a longer term strategy for preventing admissions to these placements. This approach should align with this paragraph of the N.B. Consent Decree and Family First Prevention Services Act (FFPSA)[10].

VI. IMPLEMENTATION

21. *Within nine (9) months after the Approval Date, Defendant shall provide Class Counsel and the Expert with a draft Implementation Plan. Class Counsel and the Expert will provide input*

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

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

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

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

Paragraphs 21 and 22 are addressed together. In November 2018 (ten months after the initiation of the Consent Decree), the Department submitted a draft implementation plan to the Expert and the Plaintiff's Counsel. The Expert and Plaintiff's counsel independently provided feedback to the Department regarding the Implementation Plan. In general, the Expert's review of the initial plan found information lacking to meet the intent of the N.B. Consent Decree. During CY 2019, the Expert recommended major changes to the Implementation Plan that

would better align with the Consent Decree, requiring the Department to implement sufficient measures, consistent with the preferences, strengths, and needs of the Class Members and to provide the services required by the terms of this Consent Decree.

The Department, in cooperation with the Expert and Expert's team, revised the Implementation Plan in CY 2019, finalizing it in December 2019. In the Expert's opinion, the revised Implementation Plan addresses the items in paragraph 21.The Expert expressed significant concern to Department's leadership in early 2019 regarding the staff resources that were dedicated to the N.B. Consent Decree. Having assisted other states with similar efforts, HFS did not initially have the staff to implement the N.B. Consent Decree. The Expert's team provided suggestions on staffing and competencies HFS should consider to enhance their staff. Over the past year, the Department has included additional staff resources to carry out activities in the Implementation Plan. The Expert will continue to assess the Department's staffing resources for the N.B. Consent Decree during the next reporting period.

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

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

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

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

VIII. Benchmarks

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

A. Benchmark No. 1: Within five (5) years after approval of the Implementation Plan, Defendant shall accurately certify to Class Counsel, the Expert and the Court that substantially all systems and processes that Defendant intends to utilize to implement the Model in accordance with the Implementation Plan are at least operational as outlined in the Implementation Plan.

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

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

Major Expert Recommendations for Next Reporting Period

This report provides various recommendations for the Department over the next reporting period. However, many of these recommendations are contingent on several activities that are the implementation cornerstones of the N.B. Consent Decree. If the following are not completed or initiated over the next reporting period, significant delays will occur and the services and supports that are necessary to meet the needs of children and youth in the Consent Decree will not be available. These implementation cornerstones include:

- Obtain approval from CMS for the Home and Community Based Services State Plan Amendment. This approval will give the Department the authority for implementing the proposed care coordination approach and the new services that were established in the initial Implementation Plan.
- Implement the Home and Community Based Services initiative. This will include ensuring good communication regarding the HCBS initiative, clear referral protocols for child and youth to receive an IM+CANS, and, most importantly, having a network development strategy in place and operationalized to stand up the new services.

- Finalize the decision support stratification process to ensure that children and youth are appropriately identified for the N.B. Class and the appropriate care coordination tier assignment is made.
- Develop measures and identify necessary operational changes to collect data for these measures. The Department must develop measures to have a true "north star" for the N.B. Consent Decree. In addition, it will need an overall quality improvement strategy that will provide the Department, the Plaintiffs, providers, and stakeholders with critical information on the efforts of the State to address the needs of children, youth, and caregivers who are receiving services through the N.B. Consent Decree.
- Enhance provider workforce development. The Department should work with the MCOs, providers, and other state child serving agencies to develop an overall workforce strategy. While the Department has invested a significant number of resources to develop provider trainings, this is not sufficient. The Department and its partners will also need to develop strategies for building staff competencies and for supporting providers to report information that will be critical for measuring access and other critical indicators.

The Department has made solid gains in finalizing the design on the N.B. Consent Decree over the past year despite the pandemic. This next year will be a year for implementation, which is exciting and daunting. However, if the State can accomplish the cornerstones set forth above, they will have a well-established foundation for the future.