N.B. CONSENT DECREE FIRST REVISED IMPLEMENTATION PLAN

Illinois Department of Healthcare and Family Services

October 24, 2022

PURPOSE

The Illinois Department of Healthcare and Family Services (HFS or the Department) has made this update to the initial Implementation Plan dated December 2, 2019, to continue to satisfy the requirements of the N.B. v. Eagleson Consent Decree (Case: 1:11-CV-6866, Document No. 250, January 16, 2018).

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EXECUTIVE SUMMARY

The Department, with input from the N.B. Consent Decree Expert and Class Counsel, has completed this first update to the initial N.B. Implementation Plan (dated December 2, 2019). This First Revised Implementation Plan shall serve to replace and update the initial Implementation Plan, detailing the ways the Department continues to address the requirements of the N.B. Consent Decree that was entered by the Court in January of 2018.

The N.B. Consent Decree requires the State to implement several provisions to ensure the availability of services, supports and other resources of sufficient quality, scope and variety to meet the obligations of the Consent Decree through the development of a Medicaid behavioral health delivery model ("Model") for Class Members.

This First Revised Implementation Plan outlines progress that the Department has made as well as updated plans for the continued implementation of the Model required by the Consent Decree. Despite the significant impact of the COVID-19 public health emergency on timing and resources for implementation beginning March 2020, the Department has continued to make progress on implementation as well as research and explore developing practices and services that may improve the Model for Class Members. It is also important to note, the practices or services included in this First Revised Implementation Plan may be further revised during future Implementation Plan reviews to include different or modified practices or services as necessary to address the needs of Class Members.

Progress and plans for continued implementation of the Model are described in the following sections that provide a detailed discussion of the Model components, the action steps planned or completed, and the federal and state authorities under which the Model components are authorized and funded:

Section A provides a brief history and background of the lawsuit, the operational identification of Class Members, each of the components of the Model required by the Consent Decree, and where in the First Revised Implementation Plan each component of the Model is addressed.

Section B discusses the first component of the Model: Ongoing Class Member and Family Input into the development, implementation and ongoing functioning of the Model through the establishment of the N.B. Subcommittee and requirements for managed care organizations.

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

Section D discusses the third component of the Model: care coordination for Class Members through either High-Fidelity Wraparound or Intensive Care Coordination. This section also describes the Department's updated plan to provide care coordination through the Pathways to Success program that will include Care Coordination and Support Organizations (CCSO) authorized under the federal 1915(i) authority rather than utilizing Integrated Health Homes under the federal 2703a authority, as planned in the previous Implementation Plan. Explanation of this shift in federal authority, as well as detailed description of the decision support criteria that the Department has developed and tested, is also included.

Section E discusses the fourth component of the Model: New Services, Providers and Policies to Enhance Access to Behavioral Health Services. This section covers behavioral health screenings by Primary Care Physicians, and explains the several services planned for the Model including: Mobile Crisis Response; Crisis Stabilization; Intensive Home-based Services (previously described as Intensive In-Home Services); Crisis "Beds"; Respite; Integrated Assessment and Treatment Planning; Family Peer Support; and Therapeutic Mentoring. Under the federal 1915(i) authority, the Department has also added Therapeutic Support Services and Individual Support Services. This section also describes new providers of behavioral health services and other policies designed to expand access to services.

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

Section G discusses the Implementation Training and Technical Assistance that the Department will offer MCOs, care coordination entities and other providers of children's behavioral health services by establishing the Provider Assistance and Training Hub (PATH) at the University of Illinois Champaign-Urbana, School of Social Work.

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

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

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

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

A. OVERVIEW OF CONSENT DECREE AND MODEL

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

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

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

1. Who have been diagnosed with a mental or behavioral disorder; and
2. For whom a licensed practitioner of the healing arts has recommended intensive home- and community-based services to correct or ameliorate their disorders."

On January 16, 2018, the Court entered the N.B. Consent Decree, requiring the State to implement several provisions to ensure the availability of services, supports and other resources of sufficient quality, scope and variety to meet the obligations of the Consent Decree. These services and supports shall constitute a continuum of care that will be provided through the development of a Medicaid behavioral health delivery model ("Model") for Class Members, as provided in the Consent Decree.

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

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

Therefore, consistent with the assessment and stratification requirements of the Model in Paragraph 17(e), this process will identify N.B. Class Members as all Medicaid-eligible children under the age of 21 (i.e., child or children) for whom: 1) an LPHA has completed the standardized, HFS approved Integrated Assessment and Treatment Planning (IATP) instrument (e.g., IM+CANS or successor instrument) indicating that the child has a mental or behavioral health diagnosis; and 2) the stratification process, through the application of decision support criteria, indicates that the child meets eligibility criteria for class membership and is in need of intensive home and community-based services coordinated by a Care Coordination and Support Organization (CCSO).

These Class Members and their families, once identified, will receive medically necessary care coordination and behavioral health services provided through the Model. In addition, any Medicaid-eligible child under the age of 21 that may be a Class Member and is brought to the Department's attention will be connected with an appropriate provider for the completion of the IATP instrument to determine if the child is a Class Member eligible for intensive home and community-based services, as outlined below.

The Model described in this First Revised Implementation Plan is grounded in evidence-based and evidence- informed best practices known at the time of its finalization. It is important to note, that the Department recognizes the diverse population of children who will be Class Members and that their diverse population health needs will require tailored approaches for children in historically underserved communities that may have higher rates of unmet behavioral health needs. Therefore, the Department will continue to research and explore developing practices and services that may better inform or improve the Model for Class Members. In addition, the practices or services included in the First Revised Implementation Plan may be revised during future Implementation Plan reviews to include different or modified practices or services as necessary to improve the Model and better address the needs of Class Members.

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

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

The provider will complete the IATP with the child and family and will enter that information into the statewide IATP data system. The IATP data will be processed through the Department's decision support criteria to determine individuals' eligibility for services, as provided in Paragraph 17(e) of the Consent Decree, and to operationally identify Class Members, as referenced above. The development and implementation of the IATP data system and the decision support criteria is discussed in Section D.

If the child is identified by the Department as a Class Member, the Department or its agent will send a letter to the family to notify them of the child's status as a Class Member and that they are eligible to enroll with a CCSO. If the child is enrolled in an MCO, the Department will notify the MCO that the child is a Class Member and will instruct the MCO to contact the Class Member and their family to connect them with the CCSO that will engage the family in care coordination, as discussed in Sections C and D.

For children determined to be Class Members that are not enrolled in an MCO, the Department, or its agent, will facilitate access to CCSOs and will offer Class Members and their families the opportunity to engage in care coordination through the CCSOs, as discussed in Section D.

For Class Members who have co-occurring mental or behavioral health disorders and Intellectual / Developmental Disability (I/DD), services will be available through the Model to assist in amelioration of their mental or behavioral health condition. For youth who are diagnosed with I/DD only, there are current State service delivery systems that have longstanding relationships with these youth, their families and community. In addition, the Department has implemented additional specialized services to better meet the needs of youth with I/DD, both with and without co-occurring mental or behavioral health diagnoses. The Department will ensure that Class Members who require I/DD specialized services are connected to these services to support but not supplant existing and developing I/DD service delivery systems. CCSOs will work with families and Class Members to identify the most appropriate medically necessary services and supports across the Illinois child serving systems and facilitate and coordinate referral, linkage and access to these services.

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

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

Consent Decree Paragraph Reference	Provision included in Consent Decree	Model Component that addresses Consent Decree Provision
17(a)	Include a structure to link Class Members to medically necessary services on the continuum of care;	Model Component #2: Managed Care Organizations Model Component #3: Care Coordination
17(b)	Provide statewide medically necessary mental and behavioral health services and supports required and authorized under the EPSDT requirement of the Medicaid Act that are sufficient in intensity and scope and appropriate to each Class Member's needs consistent with applicable law;	Model Component #2: Managed Care Organizations Model Component #3: Care Coordination Model Component #4: New Services and Provider Types

Consent Decree Paragraph Reference	Provision included in Consent Decree	Model Component that addresses Consent Decree Provision
17(c)	Provide notice to HFS-enrolled Primary Care Physicians ("PCPs") who perform periodic and medically necessary inter-periodic screenings to offer Class Members and families the opportunity to receive a mental and behavioral health screening during all periodic and inter-periodic screenings;	Model Component #4: New Services and Provider Types
17(d)	Implement a standardized assessment process, including an assessment tool that shall be utilized statewide, for the purpose of determining Class Members' strengths and needs and informing treatment planning, medical necessity, intensity of service, and, as applicable, appropriate services for Class Members;	Model Component #3: Care Coordination Model Component #4: New Services and Provider Types
17(e)	Establish a stratification methodology of identifying which Class Members qualify for particular services (including sub-acute care), the intensity of service delivery, and the intensity of care coordination, based upon the standardized assessment process and consistent with the requirements of the Consent Decree;	Model Component #3: Care Coordination Model Component #4: New Services and Provider Types
17(f)	Establish tiers of care coordination consistent with the requirements of the Consent Decree, with caseloads and service intensity consistent with the stratification and assessment process. The Implementation Plan may provide that Class Members demonstrating the greatest needs and qualifying for intensive community services and sub-acute inpatient services shall qualify for intensive care coordination, such as High-Fidelity Wraparound services, as defined by the National Wraparound Initiative (http://nwi.pdx.edu/). To the extent Class Members qualify for the services set forth in this Paragraph, such services will be provided in a timely manner;	Model Component #3: Care Coordination Model Component #4: New Services and Provider Types

Consent Decree Paragraph Reference	Provision included in Consent Decree	Model Component that addresses Consent Decree Provision
17(g)	Prepare and implement with reasonable promptness Individual plans of care for each Class Member to serve the Class Member in the least restrictive setting appropriate to meet the Class Member's treatment goals. Individual plans of care shall describe the Class Member's treatment goals, objectives, and timetables for achieving these goals and objectives, including moving to less intensive levels of service, and that set forth the specific services that will be provided to the Class Member and family, including the frequency, intensity and providers of such services. The Individual plans of care shall be reviewed at least annually and updated as needed to reflect the changing needs of the Class Member and family, using, as necessary, re-assessment and other clinical instruments to identify the changing needs of the Class Member and family. Individual plans of care may be prepared by or in conjunction with one or more MCEs;	Model Component #3: Care Coordination
17(h)	Establish child and family teams, including the group people chosen by the Class Member and family with the aid of the care coordinator to assist with the treatment planning process;	Model Component #3: Care Coordination
17(i)	Establish a Mobile Crisis Response ("MCR") model, including the development of crisis stabilizers, to provide behavioral health crisis response on a twenty-four hour a day, seven day a week basis; the MCR shall be established consistent with, or as the successor to, the Screening, Assessment and Support Services ("SASS") program;	Model Component #4: New Services and Provider Types
17(j)	Include a plan to coordinate among providers the delivery of services and supports to Class Members in order to improve the effectiveness of services and improve outcomes;	Model Component #2: Managed Care Organizations Model Component #3: Care Coordination

Consent Decree Paragraph Reference	Provision included in Consent Decree	Model Component that addresses Consent Decree Provision
17(k)	Establish a process to communicate with Class Members, families, and stakeholders about the, service delivery, service eligibility, and how to gain access to the Model, regardless of the point of entry or referral source; and	Model Component #1: Ongoing Class Member and Family Input
17(l)	Contain procedures to minimize unnecessary hospitalizations and out of home placements.	Model Component #1: Ongoing Class Member and Family Input Model Component #2: Managed Care Organizations Model Component #3: Care Coordination Model Component #4: New Services and Provider Types

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

- the specific tasks, timetables, goals, programs, plans, strategies and protocols describing the State's approach to fulfilling all of the requirements of the Consent Decree;
- the activities required to support the development and availability of services, and;
- any Medicaid-authorized services or supports anticipated or required in Service Plans developed pursuant to this Consent Decree that are not currently available in the appropriate quantity, quality or geographic location.

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

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

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

The Department required each MCO to submit a plan for Family-Driven Care that addressed how the MCO will establish and maintain a behavioral health service delivery system that is youth and family-centric, how they will promote and ensure child and family input across the State, and their annual goals, objectives, and activities related to family and child driven care through the establishment of a Family Leadership Council (FLC).

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

The plans for Family Driven Care were first submitted to HFS in early 2018 and are required to be updated annually thereafter. HFS has reviewed the plans and has worked with each of the MCOs to improve the plans and their implementation strategies. In addition, HFS is working with a local family-run organization to assist the MCOs in improving their implementation of their Family Driven Care plans. The family-run organization is working to support each MCO's Family Leadership Council, develop more family leaders within their membership and assist those family leaders in understanding their roles.

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

As another avenue to solicit feedback from families and other stakeholders, the State established the N.B. Subcommittee of the Medicaid Advisory Committee in July of 2018. The Subcommittee consists of providers, provider and managed care trade associations, and family/community advocates. The N.B. Subcommittee meetings were held on a quarterly basis in calendar year 2020 and monthly during calendar year 2022 to ensure that feedback is gathered from the subcommittee throughout the implementation of the Model. The Department is using this feedback to address implementation concerns or barriers, to gather feedback on the design of Model components, to identify areas in which stakeholders may need additional training or technical assistance and gather input on other areas of concern for stakeholders.

The Department also is in the process of expanding the membership of the N.B Subcommittee to include the co-chairs of the Family Leadership Councils from each MCO, merging the previously planned Family Leadership Workgroup with the N.B. Subcommittee, consistent with N.B. Expert recommendation.

With this expanded membership, the N.B. Subcommittee will perform tasks such as the following:

- Provide feedback to the Department on ways to improve materials and communication methods utilized to provide families information regarding the N.B. Consent Decree, including specific information on Class Member eligibility, processes for determining whether a child is a Class Member, appealing decisions regarding Class Member eligibility, services available, and methods for accessing services.
- Providing specific information to improve and enhance the outreach to educate Class Members and families regarding the Model, how Class Members and families can advocate for services that they need, how Class Members and families can access support, guidance and connection to other supportive family resources, as needed.
- Reporting to the Department key findings from each Family Leadership Council, identifying high priority issues for Departmental consideration to improve services for Class Members and other children with behavioral health concerns and making recommendations for improvements in the organization and coordination of Family Leadership Councils;

- Reporting on quality of care elements (e.g., Class Member and family happiness/satisfaction with services, providers, MCOs and quality of life improvement measures) gathered from Class Members enrolled with each of the MCOs; and,
- Providing input in other areas related to Class Members services and other children's behavioral health services identified by the Workgroup.

C. MODEL COMPONENT #2: MANAGED CARE ORGANIZATIONS

Under the statewide Medicaid managed care program, HealthChoice Illinois, the State contracts with five MCOs, that are each responsible for monitoring care for a segment of the population. In addition, a HealthChoice Illinois program has been implemented for DCFS Youth in Care and Former Youth in Care that is tailored to the specific needs of these youth, their guardians, caseworkers, foster parents, adoptive parents, and other people involved in their care. Thus, HFS is tasked with overseeing five MCOs and a specially designed plan for DCFS youth, rather than directly overseeing the care for over three million individuals.

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

Because MCOs hold financial risk for the health care costs of their enrollees, they have additional responsibility and incentives to focus on high-needs enrollees such as N.B. Class Members. High-needs enrollees tend to utilize high-cost services, such as hospital emergency department and inpatient care. MCOs are incentivized to reduce reliance on these highly restrictive, high intensity services by providing effective preventive care and home- and community-based services. This role of the MCOs is a key support to the Consent Decree intent of implementing a system that serves Class Members with effective community-based services and in the least restrictive setting possible.

Paragraph 15 of the Consent Decree provides that the State may require Class Members to enroll with a managed care entity for any or all care coordination, care management and services. Therefore, HFS has elected to utilize HealthChoice Illinois MCOs as the foundation for the structure to link Class Members to medically necessary services for those Class Members that are enrolled in managed care plans, as required in Paragraph 17(a).

However, it is critical that the MCOs implement the requirements for Class Members in a consistent fashion to ensure that all Class Members have access to the services included in the Model. Therefore, in June 2022, the Department amended its contract with the MCOs to include the following requirements:

1) Adding Children's Behavioral Health Program Manager as a Key Position

Section 2.3 of the MCO model contract designates Key Positions that must be identified by the MCO to cover specific programmatic areas. The Department formalized the requirement of a Children's Behavioral Health (CBH) Program Manager as a Key Position in the amendment to the MCO contracts. The Department worked with each MCO to designate a CBH Program Manager responsible for managing the MCO's CBH programs and services as well as overseeing and training internal CBH staff. The CBH

Program Managers are required to obtain certification in the IATP tool and to attend training in the Wraparound process and other services available to Class Members, as described in Sections D and E. CBH Program Managers play a key role in ensuring that CBH staff are knowledgeable of and adhere to the requirements of the N.B. Consent Decree. They also will ensure that each MCO submits timely and accurate reports consistent with the Quality Assurance Plan. The Department convenes regular meetings with all MCOs' CBH Program Managers to ensure that services for Class Members are delivered consistently across all of the MCOs. The CBH Program Managers also participate in the Family Leadership Councils to gather direct feedback from Class Members and families.

2) Consistent Eligibility and Medical Necessity Criteria

As discussed in Section A, and consistent with Paragraphs 15 and 17 of the Consent Decree, the Department has developed a stratification process utilizing decision support criteria from the IATP to identify Class Members who are eligible to receive care coordination and services under the Model. While the Department will manage administration of the decision support criteria and Class Member eligibility determinations, the MCO contracts have been amended to require MCOs to accept and serve individuals in the N.B. Class in accordance with the Department's determinations of eligibility to receive services under the Model. In addition, the Department has established medical necessity criteria for the 1915(i) services that will be available for Class Members. Services that will require prior authorization will include Respite services that are requested to extend beyond seven (7) hours per day, 21 hours per month or 200 hours annually, Therapeutic Support Services, Individual Support Services as well as Psychiatric Residential Treatment Facility services. The MCOs are required to adopt the Department's medical necessity criteria and will not be allowed to establish any other eligibility criteria or medical necessity criteria for 1915(i) services or care coordination for Class Members.

Additionally, MCOs are responsible for utilizing Departmental requirements when monitoring the care of their enrolled Class Members. The MCO Utilization Management or other quality oversight staff will be trained in and required to utilize the IATP and Individual Plan of Care, in accordance with Departmental requirements, when reviewing service utilization for Class Members. The utilization of consistent Departmental guidelines across all MCOs will ensure that Class Members have a consistent experience of utilization management regardless of the MCO in which they are enrolled. The Department will review MCO policies and procedures for compliance with Department approved standards, will regularly monitor and audit through record reviews and claims data, and will solicit survey data from Class Members and their families to confirm that each MCO is implementing utilization management and prior authorization uniformly for Class Members.

3) CCSO and other Class Member Services Provider Network Requirements

The Department collaborated with the MCOs in the selection of a statewide network of CCSOs, as described in Section D. The MCO contracts have been amended to require the MCOs to execute provider network agreements with all selected CCSOs to ensure that all Class Members have access to the CCSO in their area regardless of the MCO with which they are enrolled, thereby ensuring consistent service access standards across all MCOs. The Department has established provider network adequacy requirements for the MCOs to ensure that Class Members who are enrolled in MCOs have adequate access to required Class Member services.

4) Service Reimbursement

MCOs are required to maintain the established provider network, reimburse CCSOs and other service providers for Class Member services and ensure that Class Members have access to services. The

Department also has established and published rates for services required in this Implementation Plan and is finalizing the process of including the overall costs of the services in the MCO monthly capitation rates.

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

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

Class Members Served Under Fee-For-Service (not enrolled in MCOs)

While Illinois has enrolled over 80% of Medicaid-eligible individuals, including the majority of Class Members, into a HealthChoice Illinois MCO, it is important to note that Class Members who are not enrolled in managed care and are covered under fee-for-service will be provided with access to the same components of the Model and services. The Department will establish a joint oversight process with the managed care plans, with support from a university partner, to monitor the development of the provider network and to monitor quality and outcome measures for all Pathways to Success services for all Class Members regardless of Medicaid payer (i.e., MCO or fee-for-service).

Quality Assurance Plan

The Department will develop an overall quality assurance plan that addresses structural, process and outcome measures that are expected from the Model and that encompasses both MCOs and fee-for-service. The quality assurance plan has been updated consistent with N.B. Expert recommendations. The plan will include, but not be limited to, the following:

- The purpose of the quality assurance plan;
- The use of data to inform HFS quality assurance activities;
- Table Shells for all measures;
- Process that HFS will deploy to review and act on the data;
- Process that HFS will use to provide the data to stakeholder committees and the public-at large;
- Initial estimates / projections regarding the number and locations of Class Members that may use services in the first and subsequent years;
- Projections regarding how many providers may be needed to serve those Class Members;
- Baseline information regarding:
    - emergency department usage,
    - psychiatric inpatient admissions / lengths of stay,
    - out-of-home placements/lengths of stay; and
    - follow-up after an emergency department visit or hospitalization for mental health purposes;
- Quality and outcome measures to be analyzed and reported after the first year of implementation and annually thereafter, including, but not limited to:
    - decreased psychiatric inpatient admissions / lengths of stay;
    - decreased out-of-home placements/lengths of stay;
    - increased school attendance;
    - decreased juvenile justice system involvement;
    - increases in the youth's functioning in key areas; and
    - overall family, caregiver and youth satisfaction with service delivery;

- Key structural and process measures such as:
  - The number of Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) performed for individuals under the age of 21 in CY 2022;
  - The number of class members in High-Fidelity Wraparound
  - The number of class members in Intensive Care Coordination;
  - The number of providers approved to offer each of the Pathways to Success Services;
  - The number of care coordinators (providing each level of care coordination) by CCSO;
  - The number of providers for each service in the Pathways to Success program by Designated Service Area;
  - The number of service providers and staff who have been trained to provide each of the Pathways to Success services;
  - The number of class members and their families that used each Pathways to Success service;
  - The number of class members that received Mobile Crisis Response;
  - The average number of units per month of service per class member for each Pathway to Success service (except CCS;
  - Average length of time that class members utilized each Pathways to Success service;
  - Total Pathways to Success expenditures to date and expenditures per service, per class member
- the data sources to support required reporting and their technical specifications; and
- quality measures required to be implemented as part of the 1915(i) State Plan Amendment.

The Quality Assurance Plan will be reviewed with the N.B. Subcommittee before being finalized to gather their feedback. After the initial plan is finalized, it will be reviewed on an annual basis to determine if any measures should be revised. The Department will utilize the data gathered to provide CCSOs with information regarding the performance of their care coordination and mobile crisis responsibilities to improve the quality of these activities, will develop reporting on quality measures and ongoing progress toward meeting the established goals in the Quality Assurance plan and will make those publicly available.

D. MODEL COMPONENT #3: CARE COORDINATION

In the initial Implementation Plan dated December 2, 2019, the Department indicated that Integrated Health Homes (IHH) authorized under Section 2703a of the Affordable Care Act would provide key care coordination components of the Model required by Paragraph 17 of the Consent Decree. However, as also provided in the initial Implementation Plan, the Department has explored other available federal authorities to most effectively cover the care coordination and service aspects of the Model for N.B. Class Members. In response to the COVID-19 public health emergency, the Department concluded that Integrated Health Homes would be better suited to address health disparities that were highlighted by the public health emergency, focusing IHH on a different population than N.B. Class Members.

While the Department will still cover all aspects of care coordination required by the Consent Decree, it has determined that a State Plan Amendment under the federal 1915(i) authority will allow for a cohesive service and care coordination benefit for Class Members. The 1915(i) authority will also allow the Department to include additional services and supports for Class Members not available under the Section 2703a authority or other previously planned authorities for coverage of new services.

Therefore, the Department developed and, in December 2020, submitted to federal Centers for

Medicare and Medicaid (CMS) a 1915(i) State Plan Amendment application that detailed several of the key Model components, including two tiers of care coordination, High-Fidelity Wraparound and Intensive Care Coordination, and community-based services, including Intensive Home-Based, Family Peer Support, Therapeutic Mentoring, Respite, Therapeutic Support Services and Individual Support Services. At the end of March 2021, CMS requested that the Department withdraw the 1915(i) State Plan Amendment due to CMS requiring the Department to also amend its 1915(b) Waiver. The 1915(b) Waiver is not specific to N.B. implementation but addresses enrollment of special needs children in Managed Care. As services for the N.B. Class will also be provided to special needs children in Managed Care, the Department was required to update the 1915(b) Waiver to account for the new 1915(i) services. Federal CMS requested that the Department submit the 1915(b) Waiver update and the 1915(i) State Plan Amendment for concurrent review. After many months of working with CMS to respond to inquiries and make adjustments to the 1915(i) application, the Department was able to formally resubmit the 1915(b) Waiver and 1915(i) application to CMS in early June 2022 and received approval for both on June 27, 2022. The Department has also completed promulgation of the administrative rule through the Joint Committee on Administrative Rules (JCAR) to implement the 1915(i) State Plan Amendment and Pathways to Success Program including care coordination and services. The rule was promulgated at Title 89 Illinois Administrative Code Part 141 (Rule 141) following the August 2022 JCAR hearing.

Care Coordination and Support Organization Network Development and Support

Two tiers of care coordination will be provided by Care Coordination and Support Organizations that will be required to employ care coordination staff who have been certified through the Department's approved process. Utilizing the Systems of Care principles and philosophy, CCSOs and care coordination staff will establish and facilitate Child and Family Teams that will prepare and implement Individual Plans of Care, and will coordinate the delivery of services to minimize lengths of institutional stays and unnecessary hospitalizations.

System of care philosophy encourages collaboration across agencies and promotes the active involvement of families, children, youth, and young adults in the design and implementation of individualized, strength-based Individual Plans of Care. https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf The CCSO will be structured to ensure that medically necessary behavioral health services are coordinated and accessible as authorized under EPSDT for Class Members and will be responsible for facilitation of ongoing communication with Class Members, families and stakeholders.

To build a statewide network of CCSOs, the Department completed a process for selection of CCSOs, in collaboration with the MCOs, to serve identified geographic regions as Designated Service Area (DSA) providers. The Department released a Request for Qualifications for potential CCSOs to submit required application materials. The Department, in collaboration with the MCOs, reviewed and selected CCSOs that met the Department's required Provider Standards for CCSOs, outlined in this Section.

The selected CCSOs will be required to enroll in the Department's Provider Enrollment System (IMPACT) and will be required to join the provider networks of each MCO. The Department, or its designee, in collaboration with MCOs, will conduct readiness reviews of the CCSOs to verify their capacity to serve Class Members prior to Class Members receiving services. The Request for Qualification process will occur every five (5) years during which all CCSOs that wish to continue serving Class Members will re-apply and new CCSOs also may apply. This 5-year application cycle is intended to ensure that providers maintain quality standards set by the Department. If any CCSO ceases operations or cannot consistently

meet quality standards set by the Department, then a selection process will occur for that CCSO's service areas to find another CCSO outside of the 5-year application cycle.

Care Coordination Tiers and Requirements

The two tiers of care coordination that the Department has established are High Fidelity Wraparound (high intensity tier) and Intensive Care Coordination (moderate intensity level). Despite the change in design from IHHs to CCSOs, these two tiers of care coordination will remain predominantly the same as described in the initial Implementation Plan. These two tiers are described below:

High Fidelity Wraparound

High Fidelity Wraparound is a structured approach to service planning and care coordination that adheres to specified procedures for engagement, individualized care planning, identifying and leveraging strengths and natural supports, and monitoring progress and process. The High Fidelity Wraparound approach incorporates a dedicated full-time Wraparound Facilitator working with a small number of Class Members and families with access to family peer support, as needed for the family. https://www.nwic.org

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

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

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

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

A Wraparound Facilitator, who has been certified in the Wraparound process, will be responsible for facilitating the Wraparound team that will consist of the Class Member, the

family, family identified supportive individuals and other professional staff needed to meet the behavioral, physical and social needs of the Class Member.

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

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

Intensive Care Coordination Level

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

The Intensive Care Coordination level will require a care coordinator to Class Member ratio of 1:25. As provided in the initial Implementation Plan, this ratio was determined pursuant to research and in collaboration with the N.B. Expert. At a minimum, this level requires face-to-face Child and Family Team meetings a minimum of every 60 days; additional face-to-face contact with the Class Member and family; additional phone contacts as necessary to assist the Class Member and family in stabilizing behavioral health issues and addressing identified needs.

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

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

A care coordinator, who has been trained in the Intensive Care Coordination process, will be responsible for facilitating the Child and Family Team that will consist of the Class Member, the family, family identified supportive individuals and other professional staff needed to meet the

behavioral, physical and social needs of the Class Member.

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

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

Transition-Age Class Members

The two tiers of High Fidelity Wraparound and Intensive Care Coordination will address the care coordination needs of all Class Members, including transition-age class members (age 19-20), consistent with each Class Member's need for intensity of care coordination identified through the stratification methodology. Through collaboration with the N.B. Expert, the Department has decided to modify previous plans to establish a separate tier for transition-age Class Members. Instead, the care coordination needs of these youth will be addressed within the High Fidelity Wraparound and Intensive Care Coordination tiers, allowing all Class Members to maintain continuity of care coordination relationships while also addressing developmentally-appropriate care coordination needs. Care coordinators will focus on ensuring that, in addition to other care coordination activities, adult life skills are being addressed with children starting around the age of 16, depending on each Class Member's developmental abilities and particular needs. These adult life skills areas include, but are not limited to, engaging Class Members in their healthcare, empowering them to make healthcare decisions, assisting them in applying for appropriate benefits, engaging in healthy behaviors to manage their healthcare needs, engaging them in life-skills development to ensure ongoing independence as they approach adulthood, and engaging them in transitional services to ensure a smooth entry into the adult healthcare system upon turning 21 or no longer requiring care coordination through a CCSO.

Responsibilities of CCSO

CCSOs will work with the Class Member and the family to review the existing IATP to ensure that it accurately represents presenting issues, needs and strengths. The CCSO will utilize that information to develop an Individual Plan of Care, will review and revise the Individual Plan of Care on a regular basis, and will identify resources and services that will effectively address the Class Members needs while building on their strengths.

The Individual Plan of Care will include: treatment goals, objectives, and timetables for achieving these goals and objectives; the specific services that will be provided in the least restrictive setting appropriate for the Class Member and to assist the Class Member in moving to less intensive levels of service; the frequency, intensity and providers of the identified services; the justification for specialized medical, psychiatric or psychological evaluations; and identification of any additional areas of support that the Class Member or family may require.

The CCSO will ensure ongoing communication and collaboration between the Class Member's MCO (as applicable), primary care, specialty health care (when necessary), behavioral health and other necessary child-serving agencies identified as key partners in the Individual Plan of Care. For Class

Members who are also DCFS Youth in Care, particular attention will be paid to the collaboration between the DCFS Caseworker and the CCSO regarding coordinated service planning and provision.

The CCSO will work in collaboration with a child's MCO to ensure that medically necessary services and supports are accessed, coordinated, and delivered in a strengths-based, individualized, family/youth-driven, culturally, and linguistically relevant manner to address the Class Member's needs. The CCSO will organize care across providers and child serving systems to enable the Class Member to be served in their home and/or community. In addition, for Class Members who are also DCFS Youth in Care, the CCSO will collaborate with the DCFS caseworker in all service planning and service provision for those Class Members, recognizing that DCFS and the caseworker will have all relevant decision-making authority as the guardian for DCFS Youth in Care.

CCSOs will also be required to provide health promotion through a wide range of social and environmental interventions that are designed to benefit and protect an individual's health and quality of life. The goal is to address and prevent the root causes of ill health, not focusing solely on the treatment of illness once identified. https://www.who.int/news-room/q-a-detail/health-promotion

The CCSO will be responsible for engaging Class Members in health promotion activities including, but not limited to:

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

CCSOs will also focus on ensuring that Class Members have the necessary support when transitioning from inpatient and other non-community settings, such as hospitals or psychiatric residential treatment facilities, when transitioning between tiers of care coordination, when transitioning between CCSOs and when transitioning out of CCSO services and back to care coordination provided by their MCO, as appropriate. The CCSO will collaborate with all parties required (e.g., the facility, primary care physician, community providers, new care coordinator, new CCSO, child's MCO, child's CFT,) to ensure a seamless transition into the community to prevent subsequent re-admission(s), to a new CCSO, or to a new care coordinator to ensure continuity of care coordination and service provision.

The CCSO will work with MCOs to develop formal relationships with regional hospital(s), residential providers, and other institutional providers within the MCOs' networks to ensure a formalized structure for transitional care planning and to facilitate communication regarding inpatient admissions and discharges of Class Members.

CCSOs shall establish a Community Stakeholder Council, comprised of customers served and community stakeholders from across the CCSO's Designated Service Area (DSA), whose purpose is to advise and provide feedback to the CCSO on the implementation of its services. The Community Stakeholder Council shall: be open to participation from all stakeholders; include customer and family

representation; have a customer or family representative serving as a co-chair of the council; and meet on a standardized meeting schedule that meets no less frequently than once every quarter.

CCSOs shall establish a Community Resource Directory within the first six months of operation that will include information about formal and informal resources beyond the scope of services covered by Medicaid. These include but are not limited to supports available through other parents, family members, community-based organizations, family or youth-run organizations, service providers, social programs, school-based services, faith-based organizations, etc. The CCSO will work with community partners to continue to update the Community Resource Directory every six months to ensure that information is up to date and that new community and information supports are included.

The CCSO will offer Class Members and their families opportunities and supports that are closest to home, in the least restrictive setting and that promote integration in the home and community based on the child's need. The CCSO will emphasize the use of informal community supports in conjunction with medically necessary services as a primary strategy to assist Class Members and their families. The CCSO will work toward the goal of having informal and natural supports represent the majority of the services in each child's IPOC, as appropriate to the individual's progress through the Pathways to Success program.

Rate Setting for CCSO

The Department utilized staffing information and other rate setting methodology approved by federal CMS to establish the rates for CCSO care coordination service levels. These rates will be included in the Pathways to Success Services Fee Schedule and will be posted on the Department's website.

Stratification Process Development and Testing

As required in Paragraph 17(e) of the Consent Decree, the Department has developed and finalized a stratification process based on the standardized state-wide assessment to determine eligibility for Class membership and the type and intensity of care coordination and services that each Class Member will require.

As described in the initial Implementation Plan dated December 2, 2019, the Department obtained State Plan Amendment approval and revised Title 89 Illinois Administrative Code Part 140 (Rule 140) in May 2019 to include the service of Integrated Assessment and Treatment Planning (IATP). This service established a standardized, statewide assessment process that has been implemented to assess the needs and strengths of all children who are accessing Medicaid Community Mental Health Services. In order to be reimbursed for IATP, providers must utilize the HFS-approved standardized assessment instrument, currently the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS). This IATP instrument indicates both the needs and strengths of the child and family and serves as the foundation of the stratification approach, as described in Section E.

To gather statewide IATP data necessary to identify and stratify Class Members, the Department implemented a statewide IATP Provider Portal in July 2020. All providers of Medicaid Community Mental Health Services are now required to upload data from all IATPs completed on or after July 2020.

While the IATP Provider Portal was being implemented, the Department worked with Dr. John Lyons, and other staff from the Center for Innovation in Population Health at the University of Kentucky (U of K) to develop the initial stratification decision support criteria based on the IATP instrument, the IM+CANS. Dr. John Lyons is the creator of underlying principles and foundations of the Child and

Adolescent Needs and Strengths (CANS) assessment and Adult Needs and Strengths Assessment (ANSA) on which Illinois' identified IATP instrument, the IM+CANS, is based. The decision support criteria will be utilized to stratify Class Members into either High-Fidelity Wraparound or Intensive Care Coordination by analyzing information gathered through the IATP instrument in a number of areas including: 1) clinical, 2) social determinants of health, 3) trauma, and 4) other healthcare factors to determine service and intervention intensity.

The decision support criteria first considers the child's treatment need by analyzing the child's identified behavioral/emotional needs, paying particular attention to any concerns related to psychosis and adjustment to trauma. It then considers the functioning needs and risk behaviors of the child. Those children with high and moderate treatment and functioning needs are identified as Class Members and are eligible for either High Fidelity Wraparound or Intensive Care Coordination, as appropriate to meet their needs.

The Department has completed the process of testing and finalizing the decision support criteria. As a first step in this process, the Department collaborated with U of K to review the IM+CANS and identify items to be included in the decision support criteria, determining the combination of those items that would appropriately identify a child that requires High Fidelity Wraparound or Intensive Care Coordination. This initial version of the decision support criteria was based on upon Dr. Lyons' international clinical research and findings utilizing the specific items included in the IATP instrument. The initial draft of the decision support criteria was then reviewed by the N.B. Expert and Class Counsel who suggested revisions. These revisions were included in a new draft of the decision support criteria that was analyzed through several phases of testing.

The first testing phase included the initial loading of the IATP data from the Provider Portal into the Department's internal data system and programming the decision support criteria into the Department's internal data system. The programming for the decision support criteria was then verified though a manual review process to ensure that the programming was applying the decision support criteria appropriately. Several programming revisions were made during this phase until the programming was adjusted and the decision support criteria were applied correctly.

The second testing phase focused on the clinical soundness of the decision support criteria through the development and implementation of a Clinical Testing Workgroup (CTW) facilitated by the Department in conjunction with the U of K. The CTW included psychiatrists and other licensed clinical professionals serving Illinois children with behavioral health needs. The CTW members reviewed de-identified IATPs and recommended High Fidelity Wraparound, Intensive Care Coordination, or Outpatient Services based on their clinical judgment of the information included in the IM+CANS. The CTW was then told which tier each individual was assigned to through application of the decision support criteria and discussed discrepancies between the tier assigned by the decision support criteria and the tier recommended by the CTW. Members of the CTW suggested items to add to the decision support criteria that specifically address risk behaviors and life functioning when determining clinical need, including the addition of the Sleep and School items. It is anticipated that the Clinical Testing Workgroup will continue to meet on semi-annual basis to continue the clinical review and potential revision of the decision support criteria, as appropriate. In addition, the Department will conduct a review to determine if any adjustments to the decision support criteria are required after six (6) months of implementation, again after 12 months and then every two years.

All IATP data that is uploaded to the IATP Provider Portal will flow into the Department's internal

data system and will have the decision support criteria applied. If the outcome of the application of the decision support criteria indicates that a child is a Class Member requiring either High Fidelity Wraparound (HFW) or Intensive Care Coordination (ICC), the child and family will be notified and will be enrolled with a CCSO. Individuals will also be able to submit a request directly to the Department for a determination regarding Class Member eligibility.

For Class Members who are being served in a CCSO but want to request a different tier of care coordination, this process would be initiated through the Child and Family Team. If the request for the new tier assignment is approved, the CCSO will be responsible for ensuring that the child's existing care coordinator transitions the child's care to the new care coordinator by reviewing the existing Individual Plan of Care and other clinical documentation with the new care coordinator, introducing the child and family to the new care coordinator and facilitating a transition Child and Family Team to introduce the new care coordinator to the team ensuring that everyone involved with the child is informed of the transition.

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

Behavioral Health Screening by Primary Care Physicians

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

The Department has worked with the N.B Consent Decree Expert to develop an initial list of which nationally recognized behavioral health screening tools may be utilized by PCPs. The Department has also identified members of a PCP Behavioral Health Screening Tool Workgroup to further evaluate the listed tools and determine which one or ones should be approved by the Department for use by PCPs. The workgroup will also assist the Department in: crafting plans 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; and, the most efficient way for PCPs to notify MCOs of the screening results, make referrals to community mental health providers if a screening indicates further assessment may be appropriate, and on the role of the CCSOs.

New Services

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

As required in Paragraph 17(b), 17(d) and 17(i), the Department received CMS approval in 2019 to add Integrated Assessment and Treatment Planning (IATP), Mobile Crisis Response (MCR) and Crisis

Stabilization to the approved array of MCMHS in the Illinois State Plan, and promulgated rules for these new services through revisions to 89 Illinois Administrative Code Part 140 (Rule 140).

As described in the initial Implementation Plan (dated December 2, 2019), the Department also previously secured approval of an 1115 waiver with pilots to further develop the services of Intensive In-Home, Crisis Triage and Stabilization (i.e., Crisis Beds) and Respite. However, the Department continued exploring other federal authorities for covering Intensive In-Home and Respite for Class Members and determined that the federal 1915(i) authority was better suited to cover these services in a cohesive package with Family Peer Support, Therapeutic Mentoring and two additional services called Therapeutic Support Services and Individual Support Services. Crisis Triage and Stabilization services (i.e., Crisis Beds) will continue to be developed under the 1115 waiver.

Included below is an overview of each of the new State Plan Amendment services, as adopted in revisions to Rule 140, the services the Department is implementing under the 1915(i) authority, and the 1115 waiver pilot that will be applicable to Class Members.

1. INTEGRATED ASSESSMENT AND TREATMENT PLANNING

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

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

The IM+CANS will be utilized to determine the stratification, including care coordination tier that will be provided to each Class Member. A full description of the tiers of care coordination can be found in Section D of this First Revised Implementation Plan.

The IM-CANS incorporates:

- A complete set of core and modular CANS items, addressing domains such as Risk Behaviors, Trauma Exposure/Adverse Childhood Experiences, Behavioral/Emotional Needs, Life Functioning, Substance Use, Developmental Disabilities, and Cultural Factors;
- A fully integrated assessment and treatment plan;
- A physical Health Risk Assessment (HRA); and,
- A population-specific addendum for youth involved with the child welfare system.

The IM+CANS is based on the Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA) tools and contains items that identify a Class Member's strengths and needs using a '0' to '3' scale to rate the immediacy of intervention needed in each area (e.g., intervention needed urgently/immediately; now but not urgent/immediate; or not needed at this time). These items are then used to support care planning and decision-making, facilitate quality improvement

initiatives, and assist in monitoring service outcomes.

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

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

IM-CANS Training and Certification Process

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

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

Additional trainings such as developing treatment goals, clinical interviewing, and engagement have also been implemented to assist providers in not only completing the IM+CANS but also improving their clinical assessment skills. As other growth areas are identified, the Department will continue to provide training and technical assistance opportunities for providers.

IATP became a recognized Medicaid service as of August 1, 2018, and the IM+CANS was fully implemented as the Department's standardized IATP instrument February 2019.

2. MOBILE CRISIS RESPONSE AND CRISIS STABILIZATION

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

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

To address this issue with the SASS program and to comply with Paragraph 17(i), the Department

obtained CMS approval and revised Rule 140 to introduce MCR as a statewide, Medicaid covered service. This allows any qualified Medicaid behavioral health provider to offer MCR services, thereby expanding access to this service. However, the Department maintains the CARES hotline and the dispatch of a designated MCR provider to ensure that all children receive a crisis screening and additional services to help stabilize a crisis.

The definition of MCR includes activities that are tailored to the needs of the client, require face-to-face crisis screening, and may include: short-term intervention; crisis safety planning; brief counseling; consultation with other qualified providers to assist with the client's specific crisis; referral and linkage to community services; and, in the event that the client cannot be stabilized in the community, facilitation of a safe transition to a higher level of care.

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

In addition to MCR, Crisis Stabilization was introduced as a new component of Illinois' crisis services array available to individuals following a MCR event. Crisis Stabilization includes: observing, modeling, coaching, supporting the implementation of the client's Crisis Safety Plan, performing crisis de-escalation, and responding to behavioral health crisis, when necessary. Crisis Stabilization is to be provided in the Class Member's home or other community setting where crisis has occurred.

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

IATP, MCR and Crisis Stabilization were introduced as of August 1, 2018, and have been implemented by providers statewide at this time. Many providers are continuing to implement MCR and Crisis Stabilization services within their currently existing programs. It is anticipated that full implementation of these services for all Class Members who require them will take some time to be fully realized.

HFS has been working with MCOs as part of their network adequacy strategy, using claims data to evaluate which areas of the state have implemented Crisis Stabilization and which areas need more technical assistance and support from MCOs, CCSOs and HFS to fully establish new services.

Effective July 1, 2022 the Department increased the rate for Crisis Stabilization to incentivize delivery of this service. Additionally, CCSOs are required to ensure access to crisis stabilization services for N.B. Class Members. HFS will be working to provide technical assistance to CCSOs to develop this capacity as needed within their local communities.

3. INTENSIVE HOME-BASED SERVICES

The Department has revised the Intensive In-Home Services, previously planned as a pilot through the 1115 waiver, and has included this service in the federal 1915(i) State Plan Amendment as Intensive Home-Based Services.

Intensive Home-Based Services are face-to-face, individualized, time-limited, focused services provided directly to children and their caregivers in home and community settings to: 1) improve child and family functioning; 2) improve the family's ability to provide effective support for the youth; and 3) promote healthy family functioning. Interventions are designed to enhance and improve the family's capacity to

maintain the child within the home and community, and to prevent the child's admission to an inpatient hospital or other out-of-home treatment setting. Intensive Home-Based Services are delivered in two

components: Intensive Home-Based Clinical services and Intensive Home-Based Supportive services.

Intensive Home-based Clinical (IHBC) is a strengths-based, individualized, and therapeutic service driven by evidence-informed clinical intervention plan that is focused on symptom reduction. Provision of IHBC services must be consistent with the PracticeWise system guidelines or another HFS approved evidence-based practice.

Intensive Home-based Supports (IHBS) are an adjunct service that may only be provided in conjunction with Intensive Home-Based Clinical (IHBC) services. The goal of IHBS is to support the child and family in implementing the therapeutic interventions, skills development, and behavioral techniques outlined in the IHBC clinical intervention plan that are consistent with PracticeWise guidelines or another Departmental approved evidence-based practice. IHBS services must be provided under the clinical direction of an IHBC clinician, must be recommended by an LPHA, in collaboration with the Child and Family Team, and recorded on the Individual Plan of Care.

The definition of Intensive Home-Based services is included in the Pathways to Success program administrative Rule 141, available here: [https://www.ilga.gov/commission/jcar/admincode/089/089001410B02200R.html]

4. CRISIS TRIAGE AND STABILIZATION SERVICES

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

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

5. RESPITE

Respite is another service the Department has decided to transition from the 1115 waiver to the 1915(i) State Plan Amendment. Respite is a time-limited, supervised individualized service that provides families scheduled relief to help prevent stressful situations, including avoiding a crisis or escalation within the home. Services shall be provided in the home and in locations within the child's community with the intent of providing both child and caregiver supportive time apart to reduce stress and increase the likelihood of the child remaining safely at home and in the community.

As approved in the 1915(i) State Plan Amendment, respite shall not exceed seven (7) hours per event, 21 hours per month, or 200 hours annually without authorization. Respite is not a stand-alone service and must be provided in conjunction with other treatment services. This service must be planned, recommended by an LPHA, in conjunction with the CFT, and recorded on the Individual Plan of Care.

The definition of Respite is included in the Pathways to Success program administrative Rule 141 available here: [https://www.ilga.gov/commission/jcar/admincode/089/089001410B02200R.html].

6. FAMILY PEER SUPPORT

Family Peer Support, as provided in the 1915(i) State Plan Amendment, is defined as a structured, strengths-based, individualized, medically necessary service provided to a parent, legal guardian, or primary caregiver of a Class Member.

Family Peer Support services are directed toward the well-being and benefit of the child and provided by staff who have lived experience caring for a child with behavioral health issues or who have accessed other child-serving systems. Family Peer Support is designed to enhance the caregiver's capacity to manage the child's behavioral health needs by improving the capacity of the caregiver to understand the child's behavioral health needs, to support the child in the home and community, and to advocate for services and supports for the child and family. Family Peer Support consists of activities that include, but are not limited to, assisting the caregiver to engage in services and supports, assisting the caregiver in self-advocacy, assisting in systems navigation, providing information about the child's behavioral health needs and strengths, identification and building of natural supports, and the promotion of effective family-driven practice. Family Peer Support must be recommended by an LPHA, in collaboration with the child and family team, and recorded on the Individual Plan of Care.

The definition of Family Peer Support is included in Rule 141, available here: [https://www.ilga.gov/commission/jcar/admincode/089/089001410B02200R.html].

7. THERAPEUTIC MENTORING

Therapeutic Mentoring, also now included in the 1915(i) State Plan Amendment, is defined as a structured, strengths-developing, individualized, medically necessary service provided to children, under the age of 21, that present with behavioral health needs and require support in recognizing, displaying, and using pro-social behavior in the home and community setting. Therapeutic Mentoring is designed to assist the individual by improving 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.

This service will be authorized for Class Members for whom an LPHA, in collaboration with the CFT, recommends Therapeutic Mentoring services on the Individual Plan of Care. Therapeutic Mentoring services are to be rendered consistent with frequency, duration, and scope recommended on the plan.

The definition of Therapeutic Mentoring is included in Rule 141, available here: [https://www.ilga.gov/commission/jcar/admincode/089/089001410B02200R.html].

8. THERAPEUTIC SUPPORT SERVICES

HFS has received approval from federal CMS to cover Therapeutic Support Services (TSS) pursuant to the 1915(i) authority as these services would not typically be available as Medicaid-covered services under other authorities. TSS, as provided in the 1915(i) State Plan Amendment, is adjunct therapeutic modalities to support individualized goals as part of the child's service plan. TSS are designed to help participants 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. TSS interventions include techniques that can be used for self-expression and

personal growth and aid in the healing and therapeutic process.

TSS examples may include, but are not limited to, the following types of interventions:

- Art Behavioral Services
- Dance/Movement Behavioral Services
- Equine-Assisted Behavioral Services
- Horticultural Behavioral Services
- Music Behavioral Services and
- Drama Behavioral Services

Therapeutic Support Services shall not exceed $3000 per state fiscal year per child and are subject to Prior Authorization. The specific TSS interventions must be documented as a recommended service by the authorizing LPHA, in collaboration with the CFT, on the child's service plan.

The definition of Therapeutic Support Services is included in Rule 141, available here: [https://www.ilga.gov/commission/jcar/admincode/089/089001410B02200R.html].

9. INDIVIDUAL SUPPORT SERVICES

HFS has received approval from federal CMS to cover Individual Supports and Services (ISS) pursuant to the 1915(i) authority as these services would not typically be available as Medicaid-covered services under other authorities. ISS, as proposed in the pending 1915(i) application, is habilitative activities, services and goods that serve as adjunct supports to the therapeutic interventions and supports for children with significant behavioral health issues. ISS are intended to promote health, wellness and behavioral health stability through community stabilization and family stability. ISS services may only be provided for the direct benefit of the child and may not be provided to family members or other collaterals involved with the child's care.

ISS may include, but is not limited to, the following categories:

- Physical wellness activities and goods that promote a healthy lifestyle through physical activity;
- Special or therapeutic youth development programs offered by a community-based organization;
- Strengths-developing activities (i.e., music lessons, art lessons, therapeutic summer camp);
- Sensory items ordered by an Occupational Therapist, Speech-Language Pathologist, Physical Therapist, or Licensed Practitioner of the Healing Arts as defined in 89 Ill. Adm. Code 140.453(b)(3); and
- Parent education and training.

Individual Supports shall not exceed $1500 per state fiscal year and are subject to Prior Authorization. The specific ISS interventions must be documented as a recommended service by the authorizing LPHA, in collaboration with the CFT, on the child's Individual Plan of Care and must be directly tied to supporting the achievement of one or more goals on the child's plan.

The definition of Individual Support Services is included in Rule 141, available here: [https://www.ilga.gov/commission/jcar/admincode/089/089001410B02200R.html].

New Provider Types

As required in Paragraph 21(d), HFS recognizes that certain geographies have not historically had enough providers available to offer services for all Class Members that may require them. To establish additional providers to offer existing and new services, HFS revised Rule 140 to allow Independent Practitioners (i.e., Psychiatrist, Licensed Clinical Psychologists, Licensed Clinical Social Worker) and Behavioral Health Clinics to provide most existing and new services. Implementation of Behavioral

Health Clinics was limited in early 2020, leading the Department to increase the level of technical assistance offered to providers interested in becoming a BHC. As a result, the number of approved BHCs has increased from none in 2019 to over 30 as of the date of the First Revised Implementation Plan. The Department will continue monitoring the number of providers gaining approval as BHCs to determine if additional technical assistance is needed to continue developing this provider type.

Development of Administrative Rules and Rates for New Services

The Department has promulgated Rule 141 through the Joint Committee on Administrative Rules (JCAR) to implement the 1915(i) State Plan Amendment and Pathways to Success program, including care coordination and services. Rule 141 was finalized and adopted following a JCAR hearing in August 2022. The Department utilized rate setting methodology approved by federal CMS to establish the rates for new services that do not already have rates established.

F. MODEL COMPONENT #5: PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

As stated in Paragraph 13 of the Consent Decree, "…The continuum of care available to Class Members shall include all medically necessary home and community based services and supports as well as inpatient psychiatric services in a 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…".

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

PRTF Development and Implementation Approach

The Department will develop necessary PRTF policies, procedures and administrative rules along with the implementation of home and community-based services. However, the phase-in of in-state PRTFs will occur only after the home and community-based service delivery system has been built to sufficient capacity to effectively serve Class Members. While the Model is being developed and implemented, the Department will conduct a statewide assessment to begin to gauge the potential need for this level of treatment among Class Members and then determine the capacity and locations of PRTFs that may be appropriate to fully support these Class Members.

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

Act to develop the treatment expectations for PRTFs and will work in close collaboration with the Department of Children and Family Services in this process. MCOs will be required to adopt the above-mentioned requirements to ensure that requirements will be consistently applied across all MCOs.

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

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

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

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

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

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

At the time of the initial Implementation Plan, the Department covered PRTF services for certain Class Members presented by Class Counsel by identifying and paying for PRTFs out-of-state via contractual arrangements. The Department has continued to address the needs of Class Members requiring PRTF services on an emergent basis through similar contractual arrangements but has established a more formal, accessible Interim Relief process as follows:

- The Department has developed a process through which family members who believe that their child may be a Class Member in need of PRTF services on an emergent basis can submit an Interim Relief Application directly to the Department. This process provides the necessary information for the Department to understand the needs of the child, determine if the child is a Class Member appropriate for the Interim Relief process and, if so, identify the most appropriate services and providers to meet their emergent needs.
- The Interim Relief Application must be submitted for any Class Member seeking PRTF services on an emergent basis and must include all required information to determine medical necessity and Class Membership status for Interim Relief services. If the Interim Relief Application does not include all of the necessary information, the Department attempts to work with the family to obtain the missing information so that the Application can be processed.

- Class Members and their legally responsible parent or guardian are required to cooperate with the Department, and its agents, as necessary to provide and coordinate services.
- The Department has previously had arrangements with the University of Illinois for Interim Relief Management and is now working on arrangements with the University of Illinois at Chicago – Division of Specialized Care for Children for expanded staff to provide care coordination for Class Members under the Interim Relief process. The Department will work with the University to continue to oversee the Interim Relief process and care coordination for Interim Relief participants. The Interim Relief Care Coordinators will work closely with Class Members, their families and relevant service providers to ensure the Interim Relief process is implemented consistent with the requirements of the Consent Decree.

Class Members participating in the Interim Relief process may continue to receive coordination services through the Interim Relief Care Coordinator for a period of up to 180 days after the Class Member is discharged from a PRTF. The Department reviews participating Class Member eligibility on a monthly basis to verify ongoing eligibility for services. The Interim Relief Application, instructions and process information is available here: https://www.illinois.gov/hfs/MedicalProviders/behavioral/sass/Pages/NBConsentDecree.aspx.

G. IMPLEMENTATION TRAINING AND TECHNICAL ASSISTANCE

The Department recognizes that implementation of the Model through the development of CCSOs, implementation of High-Fidelity Wraparound and Intensive Care Coordination, building upon the standardized assessment to establish stratification through decision support criteria, development of new services and enhanced oversight from MCOs will take a good deal of time and very close partnership with Class Members, families, providers and other stakeholders. To ensure that the necessary training and technical assistance supports and resources are available, the Department has developed the Provider Assistance and Training Hub (PATH) through the University of Illinois Urbana-Champaign School of Social Work to act as the Department's approved Children's Behavioral Health - Technical Assistance and Training resource.

The Department, in collaboration with Dr. John Lyons and PATH, has implemented a training and certification process for staff utilizing the IATP instrument as well as a registration system to track practitioners' completion of the certification in the IATP. Since the certification process was launched, PATH has trained over 16,000 practitioners, with over 13,000 obtaining certification. The Department, in collaboration with PATH, also has launched additional trainings related to treatment planning, clinical interviewing and engagement of customers who are accessing mental health treatment.

The Department, in collaboration with the N.B. Expert and PATH, has also launched a new series of trainings related to Mobile Crisis Response, Crisis Stabilization, Crisis Safety Planning and Crisis De-escalation. Additional training and certification programs developed for Wraparound facilitators and supervisors, Intensive Care Coordination care coordinators and supervisors, as well as trainings for all new services that will be implemented in calendar year 2022.

As the HFS-required certification processes are implemented through PATH, the Department will receive regular reports from PATH regarding providers who have attended training and meet certification standards for provision of specific services. The Department will share these reports with

MCOs notifying them of new providers who are certified to provide these services. The Department will also monitor service access reports from MCOs that specifically address CCSOs and other

behavioral health service providers.

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

The Department also has utilized PATH as a resource for data analysis, research into best and evidence-based practices and other areas as needed to support the Department in implementation of the Model. For example, PATH worked in collaboration with the Department to analyze utilization of Mobile Crisis Response / Screening Assessment and Support Services along with psychiatric hospitalization to project potential service needs of class members. PATH has also worked with the Department to design the evidence-based component of Intensive-Home Based Services, known as PracticeWise. PATH also regularly reports on the number of IATP trained and certified practitioners across the state to assist the Department in determining if there is adequate statewide access for Class Members to receive an IATP from a properly certified practitioner. The Department will engage PATH in additional research and analysis initiatives as additional services are implemented.

H. CROSS-AGENCY COLLABORATION ON MODEL DEVELOPMENT AND IMPLEMENTATION

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

The Department has established regular meetings with representatives from each of these child-serving agencies to ensure ongoing communication and engagement with other agencies as the Model is being implemented. The Department has received feedback from sister agencies on policies, procedures and implementation matters that affect Class Members they serve and will continue to gather additional feedback as the services are being implemented. The Department will work to develop cross-agency communication and training materials that sister agencies can use with their field staff to ensure that they understand Class Member services and are able to collaborate effectively with CCSOs and Child and Family Teams at the local level.

In particular, the Department is collaborating with DCFS regarding processes to appropriately address the needs of Class Members who are also under the guardianship or custody of DCFS. Discussions are ongoing with DCFS to ensure that the Model and child welfare processes are coordinated, in support of both programs’ goals of serving Class Members.

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

CCSO staff will also communicate regularly with DCFS caseworkers regarding the involvement of the foster parents, and biological parents, of a youth who is under the guardianship or custody of DCFS, as

applicable and appropriate to the child's needs. Child serving agency partners including, but not limited to, DCFS caseworkers, probation officers, school personnel, etc., will be oriented through PATH and through their local CCSOs to the High-Fidelity Wraparound and Intensive Care Coordination process so that they understand what to expect and how they are to collaborate with the CCSO staff.

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

I. IMPLEMENTATION STEPS AND TIMELINES

The implementation of the Model involves multiple steps with timelines that began upon the finalization of the initial Implementation Plan in December of 2019 and are updated in this First Revised Implementation Plan to reflect the progress and new developments in implementation. Key steps and timelines were sequenced from the effective date of the Implementation Plan with many requiring federal and state approvals of variable timelines. While several of the timelines included in the initial Implementation Plan dated December 2, 2019, have already been met, the diversion of resources related to the COVID-19 public health emergency and efforts to realign federal authority for care coordination and services have impacted several timelines.

Therefore, Table 2 below outlines key timelines that have been met along with updated key timelines for implementation. The anticipated timelines in Table 2 below are contingent upon federal and state approvals and rulemaking processes. These timelines represent the Department's best estimation of anticipated completion as of the date of this First Revised Implementation Plan but may be subject to change depending on those processes or other unanticipated major events such as further public health emergencies or other issues outside of the Department's control. It should be noted that the Department continues to work with Class Members, their families, the N.B. Consent Decree Expert, MCOs, providers, and stakeholders while completing the activities listed below.

Table 2: Key Implementation Steps and Timelines

Timeline	Activity
Completed Key Implementation Steps	
December 2019	Finalized Initial Implementation Plan
January 2020	Established regular meeting schedule for N.B. Subcommittee for ongoing input into implementation of the Model
April 2020	Established PATH at UIUC-SSW
July 2020	Implemented IATP Provider Portal
December 2020	Drafted and submitted the 1915(i) authority application to CMS that included High-Fidelity Wraparound, Intensive Care Coordination, Intensive Home-Based Services, Family Peer Support, Therapeutic Mentoring, Respite, Therapeutic Support Services, and Individual Support Services
July 2021	Established selection process for CCSOs

Timeline	Activity
September 2021	Began process of promulgating administrative rule to include Care Coordination and New Services (to be completed after CMS approval of the 1915(i) State Plan Amendment)
September 2021	Began the CCSO selection process
December 2021	Identified initially selected CCSOs
June 2022	Revised MCO contracts according to requirements in the First Revised Implementation Plan and begin regular meetings with MCOs regarding implementation of new contract requirements
July 2022	Notified initially selected CCSOs
August 2022	Finalized adoption of Pathways to Success Administrative Rule 141
October 2022	Finalized First Revised Implementation Plan
Upcoming Key Implementation Steps	
October 2022	Begin initial CCSO enrollment into HFS' Provider Enrollment system
October 2022	Require MCOs and CCSOs to begin establishing provider network agreements
October 2022	Begin training CCSO staff on High Fidelity Wraparound and Intensive Care Coordination
October 2022	Begin training and certifying providers on other new Pathways to Success services
November 2022 and ongoing	Monitor provider network development and adequacy for CCSOs and other services
December 2022	Begin identifying Class Members and assign to identified level of care coordination
January 2023	Complete CCSO readiness reviews and begin enrollment of Class Members

J. BENCHMARKS

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

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

Benchmark No. 2: Within two (2) years after the successful certification of Benchmark No. 1, Defendant shall accurately certify to Class Counsel, the Expert and the Court that the Model is at a capacity to

substantially serve the Class's needs for intensive home- and community-based services on a systemic level statewide. After successful certification of Benchmark No. 1, the Implementation Plan shall be amended to establish the standard for sufficient capacity that is necessary to substantially serve the Class's needs for intensive home- and community-based services on a systemic level statewide. Nothing in this Consent Decree shall be interpreted to require that the standard for Benchmark No. 2 guarantees that each Class Member will receive care or services precisely tailored to his or her particular needs.

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

K. PERSONNEL NECESSARY TO IMPLEMENT CONSENT DECREE

As required in Paragraph 21(b), HFS has hired and will continue to hire as necessary, personnel who will be responsible for implementing, overseeing and monitoring the implementation of the Consent Decree. HFS established the Bureau of Behavioral Health in August 2016 to oversee the implementation of the anticipated Consent Decree as well as assist in the overall behavioral health transformation. The Bureau Chief is responsible for overseeing the execution of the Implementation Plan and has two sections within the bureau to support this task, one for Federal Compliance and Client Relations and the other specifically related to Program and Policy. Staff within this bureau has experience in designing, developing and implementing behavioral health services, particularly emphasizing children's services. The bureau has 16 staff members, and the Department will be working with additional DSCC staff for coordination of care for current N.B. Class Members who are receiving services through the Interim Relief process. Staff members from the Bureau of Behavioral Health work to administer several areas of programming related to behavioral health services and focus much of the Bureau's resources on implementation of N.B. and its coordination with other Medical Assistance and behavioral health programs.

The Bureau Chief of Behavioral Health will collaborate with the Bureau of Managed Care to oversee services for Class Members who are enrolled in MCOs. The Bureau of Managed Care has a designated N.B. Liaison who will work directly with the Bureau Chief of Behavioral Health related to the implementation of the managed care requirements for Class Members. The Behavioral Health Bureau Chief and N.B. Liaison also meet regularly with the Children's Behavioral Health Program Managers from each of the MCOs.

In addition, the Bureau of Managed Care has Account Managers who have responsibilities for the comprehensive oversight of assigned MCOs to ensure the long-term success of HealthChoice Illinois and the Class Members served in that program. Account Managers are tasked with three primary duties: performance management, programmatic improvement and relationship governance. Performance management requires Account Mangers to hold the MCO accountable to contractual performance requirements. Programmatic improvement utilizes outcomes and Class Member-related performance data to help develop MCO capabilities, and to encourage MCOs to implement innovative ideas. Relationship governance aligns MCO management strategies with HFS internal resources, assigns internal roles and responsibilities and establishes effective MCO review governance.

In addition, Account Managers have frequent Account Management meetings where the Account Managers discuss contract compliance issues, day-to-day operations, and a variety of agenda items from

the MCOs or HFS. Monthly Operational Review meetings include discussion of issues such as network development, transitions of care, day-to-day operational issues, reporting, and care coordination efforts. Quarterly Business Reviews focus on the opportunity for MCOs to highlight strengths, weaknesses, opportunities and threats, provide pertinent program updates for both the MCOs and HFS, and identify and assign actions, owners and due dates. In Annual Relationship Reviews, the annual performance scorecard, unsolved and critical escalations, and important MCO updates are reviewed and discussed. Annual Relationship Governance Review confirms HFS roles and participants, reviews MCO relationship strategy, trends and issues, and ensures alignment of MCO management strategy within HFS Bureaus and Divisions. The Bureau of Behavioral Health works closely with the Bureau of Managed Care in all of these meeting and processes to monitor quality and performance expectations specifically related to the N.B. Class.