Pathways to Success Program: Frequently Asked Questions (FAQ)

Updated: September 7, 2021
Additional questions received after August 17, 2120, begin on page 19

General

1. **What is the Pathways to Success program?**

   A. Pathways to Success is a program for Medicaid enrolled children under the age of 21 in Illinois who have complex behavioral health needs and require intensive services and support. The program provides access to an evidence-informed model of intensive care coordination and additional home and community-based services. Pathways is targeted to launch on March 1, 2022. Please check out the Pathways to Success Program Overview and Family Experience webinar to learn more about the program.

2. **What is the total number of youth estimated to be eligible for Pathways?**

   A. HFS is estimating that in the first year of implementation approximately 10,000 children will be served through Pathways to Success. However, this number is just an estimate and does not represent a cap or a minimum. HFS anticipates this number will increase in subsequent years.

3. **Are the services only for Pathways participants?**

   A. To receive the Pathways to Success services, children must meet all the eligibility criteria and be enrolled in the Pathways to Success program. Medicaid eligible children who are not enrolled in Pathways will have access to existing Medicaid covered behavioral health services, including services covered under 89 Ill. Admin. Code 140.453.

4. **I am concerned with the current lack of resources/professional supports in some of these service areas.**

   A. HFS is aware of the workforce shortages in many sectors across the state and is working to support staff recruitment and retention efforts.

5. **When evaluating the qualifications of staff, what counts as years of experience? Does work completed during an undergraduate degree count toward this?**

   A. Any supervised and documented clinical experience in a behavioral health setting may count toward experience requirements for staff. This would include clinical internships/practicum experiences completed during an undergraduate or graduate degree program.

6. **Will trainings provided by the Provider Assistance and Training Hub (PATH) be offered virtually?**

   A. Trainings will be virtual throughout the duration of the COVID-19 Public Health Emergency. A determination regarding moving trainings to in-person will be made after the COVID-19 Public Health Emergency has ended.

7. **Are providers expected to be trained in the Illinois Medicaid - Comprehensive Assessment of Needs and Strengths (IM+CANS) before becoming a provider of these services?**

    A. Any staff who participates in the gathering of information, clinical interview and assessment, or review and authorization of the IM+CANS must be trained and certified in the tool prior to delivering services.

8. **What is the benefit of being a Care Coordination and Support Organization (CCSO) vs. providing the other Pathways support services?**

    A. Care Coordination and Support Organizations will provide Care Coordination and Support Services as well as Mobile Crisis Response for their Designated Service Area. Providers of other Pathways services will focus on the provision of Intensive Home-Based, Family Peer Support, Therapeutic Mentoring, and Respite services. Providers should carefully review requirements for becoming a CCSO as well as requirements for providing other Pathways to Success services and determine if either option fits with the provider's mission, service goals, and business plan.

9. **How do you suggest current Screening Assessment and Support Services (SASS) providers prepare for this change? How should we continue in the meantime?**

    A. SASS providers should carefully review all information available about Pathways to Success, including the requirements for becoming a CCSO or for providing other Pathways services, to determine what role they are interested filling and which services they may want to provide under the Pathways program. All current Mobile Crisis Response (MCR) Designated Service Area providers should continue normal SASS/MCR operations until crisis accountability is transitioned on 02/01/2022. HFS will work closely with SASS providers in the coming months to provide technical assistance, guidance, and to collaborate in the transition of responsibilities to CCSOs, as needed.

10. **Can you be a MCR provider and not a provider of Pathways?**

    A. Any provider who has been approved to offer MCR may provide that service to individuals that they serve. Only CCSOs will receive calls from CARES as the Designated Service Area Mobile Crisis Response providers.

11. **What does a Family Support Program (FSP) community youth get that's different or additional to the care coordination here? Is FSP community still necessary?**

    A. The Family Support Program (FSP) is a state-funded program that offers both community and residential services to youth regardless of their eligibility for Medicaid. While FSP and Pathways offer similar services, FSP will remain a separate program to serve youth who require intensive services, but either may not be Medicaid eligible or may prefer participation in the FSP rather than Pathways.

12. **Should FSP residential just be one of the listed services within the 1915i, rather than a separate thing?**

    A. The 1915(i) State Plan Amendment is a Home and Community-Based Services (HCBS) benefit. Residential services are not home and community-based services.

13. **Will there be any guidance for differentiating between when to refer to FSP vs. Pathways?**

    A. Children with complex behavioral health needs may benefit from the additional services and supports under FSP or Pathways. Providers should familiarize themselves with the eligibility criteria, services, and requirements of each program, so they can help educate families who may benefit from additional behavioral health supports on their options, and can help families make informed decisions about which programs or services they want to pursue. Providers will still continue to assist families in completing and submitting the FSP Application, while eligibility for the Pathways to Success program will be determined after the IM+CANS is completed and uploaded into the HFS Provider Portal. HFS will continue to provide technical assistance to providers on these programs and will monitor feedback to determine if additional written guidance is needed.

<u>**Interagency Coordination**</u>

14. **To apply to be a CCSO, does a provider have to have been awarded a Division of Mental Health (DMH) 590 grant? If we do not apply to be a CCSO will we lose our 590 status?**

    A. No, CCSOs are not required to be recipients of a DMH 590 grant. Similarly, 590 grantees are not required to become CCSOs.

15. **Do providers have to have separate crisis teams with 24/7 coverage to respond to child and adult crisis referrals as a CCSO and to meet 590 grant requirements?**

    A. Separate crisis teams will not be required for CCSOs who also are 590 grantees. Providers will have the flexibility to structure their crisis response teams to meet requirements and expectations of both CCSOs and the 590 grant, so long as the provider ensures they are not supplementing Medicaid reimbursement.

16. **We have the 590 grant which requires us to cover our county for team based MCR. If we do not enroll as a CCSO and another organization is the CCSO for our geographical area, won't there be duplicative coverage for MCR in our county? If so, how will this be triaged through the CARES line?**

    A. CCSOs will be the designated Mobile Crisis Response provider for their Designated Service Area (DSA). Crisis referrals from the CARES line will only be directed to the CCSO for the DSA. Other CMHC providers in the area that have a 590 grant or are approved to provide Mobile Crisis Response as a Medicaid service under 89 Ill. Admin. Code 140.453 and Table N may continue to provide that service to individuals that their agency serves.

17. **How will CCSOs work with young people in the Department of Children and Family Services (DCFS) who are getting a whole other level of case management and other services? Who is the lead coordinator and how does it link together?**

    A. HFS is working closely with DCFS to establish process flows and training curriculum for DCFS staff and providers to fully understand how Pathways to Success will assist DCFS Youth in Care who also have complex behavioral health needs.

18. **Will CCSOs get specific training related to the DCFS population? Will DCFS Case Managers receive training on how to best collaborate with the CCSOs?**

    A. Yes. HFS will be working with DCFS and PATH to establish the appropriate training and coaching to CCSO and DCFS staff on Pathways and cross-system collaboration.

<u>**Eligibility Requirements and Determination Process**</u>

19. **What are the eligibility requirements for the Pathways to Success Program?**

    A. In order for a child to be enrolled in the Pathways to Success program, they must:
       i. Be eligible for Medicaid;
       ii. Be under the age of 21;
       iii. Have been diagnosed with a Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI); and
       iv. Demonstrate a need for intensive services pursuant to HFS' Decision Support Criteria.

20. **Are youth automatically enrolled in Pathways if they qualify or does a provider have to request this service?**

    A. HFS will automatically apply the Pathways eligibility criteria, including the IM+CANS Decision Support Criteria, to all completed IM+CANS that have been entered into the IM+CANS Provider Portal. Children who meet eligibility criteria for Pathways will be automatically enrolled in the program and will be contacted by the CCSO to determine if they want to engage in Pathways to Success services. Families will also have the option to submit a request for eligibility determination independent of the automated eligibility determination process.

21. **You estimate that 70-80% of youth will be Medicaid eligible. Is HFS providing eligibility/funding for the remaining youth or will CCSO's need to work with TPL insurance as well?**

    A. HFS anticipates that 70-80% of Pathways eligible children will be enrolled in an MCO, while the remaining 20-30% will be covered under the Medicaid fee-for-service system. All children served in the Pathways program must be Medicaid eligible.

22. **Why is HFS managing eligibility determination instead of allowing providers to apply the criteria? Does HFS have the capacity to manage the volume?**

    A. Federal regulations require that HFS or a delegated government entity conduct all eligibility determinations for Medicaid benefits. HFS is confident it has sufficient resources to ensure all eligibility determinations are completed in a timely fashion either through the automated process or a family's request for eligibility determination.

23. **Will there be an opportunity for clinical judgement to overrule the outcome of the Decision Support Criteria?**

    A. Children and families dissatisfied with the outcome of the IM+CANS Decision Support Criteria will be provided with information on their rights and the processes for appealing the determination.

24. **Can a client/family decline Pathways? And is there specific paperwork for participating in Pathways?**

    A. Yes, children and families may decline participation in the Pathways to Success program. Additional information regarding intake processes and any required forms will be provided closer to CCSO implementation.

25. **Will there be a transition period once a youth is determined to no longer be eligible or will services end upon that determination?**

    A. Redeterminations of a child's ongoing eligibility for Pathways will be begin approximately 45 days prior to the end of the child's 6-month eligibility period. This timeframe was established to provide time for the CCSO, child, and family to prepare for transition, if the child is determined to be no longer eligible for the program.

26. **Why don't the Pathways to Success program, Family Support Program (FSP), and Specialized Family Support Program (SFSP) all use the same eligibility criteria and determination process?**

    A. Pathways, FSP, and SFSP were each designed for specific purposes and populations of youth with behavioral health needs. These programs are managed consistent with the applicable Federal and State laws and administrative rules governing their operations. While HFS has taken steps to align the administration, infrastructure, and operations of these programs where possible, the eligibility criteria and determination processes must remain unique to each program at this time.

Provider Enrollment

27. **What are Provider Enrollment requirements for the Pathways program?**

    A. To provide any Pathways services, a provider must be certified as a CMHC, or as a BHC, and enrolled in HFS' provider enrollment system, known as IMPACT. For further details regarding the Provider Enrollment process and requirements, please refer to the webinar slides, which are posted on the HFS website at: pathways.illinois.gov.

28. **When can providers enroll to provide Pathways services?**

    A. IMPACT Provider Enrollment will be open in December 2021 for providers who have been selected as CCSOs and for providers who wish to be approved to offer other Pathways to Success services.

29. **Is there a limit of how many providers the state is accepting?**

    A. HFS will be determining providers qualified to serve as a CCSO for each DSA through a Request for Qualifications (RFQ) process. Providers of other Pathways to Success services will have their qualifications reviewed as part of the IMPACT provider enrollment process. Only one CCSO will be chosen per DSA but there are no limits on the number of providers that may be enrolled to deliver other Pathways services. HFS will be working in collaboration with its MCOs to ensure that there is statewide access for all children enrolled in the Pathways program.

30. **How long do you anticipate the IMPACT approval process to take?**

    A. IMPACT applications and modifications are reviewed in the order in which they are submitted. There are many factors that may affect how long the IMPACT review process takes, although the Department works to review all provider enrollment requests as quickly as possible to avoid service delays. Intensive Home-Based services also require a specific Program Approval process. The Program Approval component of the enrollment process is anticipated to take no longer than 90 days.

31. **Does an agency have to enroll and provide all the new services, or can they choose which ones they would want to be trained to provide?**

    A. Providers may choose which of the new services they wish to enroll to provide. However, providers of Intensive Home-Based services must also be enrolled and trained to provide Family Peer Support, Respite, and Therapeutic Mentoring services.

32. **Can a provider register in IMPACT for both subspecialties - that is both Child Services and Intensive Home Based? Or must providers select only one?**

    A. Yes, providers may enroll for both the subspecialties of Child Services and Intensive Home-Based. To be a provider of IHB, the provider must enroll to provide both the Child Services and Intensive Home-Based subspecialties.

<u>**Designated Service Areas (DSAs)**</u>

33. **What information was used to determine new DSAs as mentioned to determine viability? Will this information be available for applicants?**

    A. HFS examined historical crisis service and inpatient psychiatric hospitalization utilization data to inform its estimate of the number of children who may be determined eligible for the Pathways program during the first year of implementation. HFS is targeting an average minimum monthly enrollment of 250 Pathways enrolled children within each DSA to ensure financial viability of the program. The geographic boundaries of the DSA were established using these estimates as a guide. Information regarding utilization estimates for each DSA are anticipated to be released along with the RFQ.

34. **Does the new DSA keep zip code areas whole**?

    A. DSAs outside of Cook County are county based. DSAs within Cook County will be zip code based.

35. **Will you be sharing a map that contrasts current and new map? The Cook County map needs to have more specific information please.**

    A. HFS will be posting maps of the updated DSAs along with a description of the counties or zip codes (for Cook County) that each DSA will be responsible for covering to the Pathways website.

36. **How will this change in DSA impact current FSP and SFSP youth?**

    A. The CCSO in the DSA will be responsible for care coordination and other activities that are required under FSP and SFSP. HFS will work with current SASS providers to transition FSP and SFSP youth to the selected CCSOs, as necessary.

Care Coordination and Support Organizations (CCSOs)

37. **There will be a time period where selected CCSO agencies will be hiring and training staff prior to the assignment of Pathways youth. What support will the state be providing to providers to cover these otherwise unfunded costs?**

    A. The State has requested funding through the American Rescue Plan Act of 2021 (ARPA) to help off-set costs associated with establishing a CCSO and time associated with staff training. HFS will notify providers once a final response has been received from federal CMS.

38. **Will HFS be providing any numbers on the expected number of youth who would qualify for Pathways and CCSO care management per DSA?**

    A. Yes. HFS anticipates releasing these estimates as part of the CCSO RFQ release on September 1, 2021.

39. **Will Cook County have a CCSO?**

    A. Cook County has been divided into 11 Designated Service Areas. Each DSA will be covered by at least one CCSO.

40. **If you are not a CCSO in Cook County do you need to contract with CountyCare?**

    A. It is not uncommon that a CountyCare member may need services from a CCSO, particularly Mobile Crisis Response services, while located or residing outside of Cook County (e.g. an older youth attending college). The Department will encourage all CCSOs and CountyCare to establish a contract with one another to ensure coverage and reduce confusion for customers in these situations. HFS will establish policies with CCSOs and all MCOs to ensure there are no gaps in coverage of necessary services for Pathways enrollees.

41. **Am I correct in understanding that Rule 140 services are not under the conflict of interest separation for CCSOs and that those services can continue to be provided while a youth in Pathways?**

    A. It is correct that CCSOs may also provide the services under Rule 140 (89 Ill. Admin. Code 140.453). Please note that for children enrolled in Pathways, the CCSO must take additional precautions to establish sufficient separation between Care Coordination and Support (CCS) services and the other Rule 140 services to further reduce the potential for a conflict of interest. This includes documenting that children and families made affirmative choices of the services, settings, and providers from which services will be delivered, establishing a grievance process, and prohibiting CCS Care Coordinators from delivering other Rule 140 services, with the exception of Mobile Crisis Response team services.

42. **If a provider is selected as a CCSO, will that provider be ruled out as a prospective Intensive Home-Based provider, or will the provider still have the opportunity to provide those services?**

    A. CCSOs may not provide the other HCBS services covered under Pathways (Family Peer Support, Therapeutic Mentoring, Respite, or Intensive Home-Based), unless that provider is the only qualified provider within their geographic area and has received written approval from HFS to provide additional Pathways services.

43. **Does the LPHA that CCSOs are required to have to be 100% dedicated to the Pathways program?**

    A. Yes.

44. **Can the dedicated clinical manager (LPHA) of a CCSO also be the Care Coordination Supervisor if the anticipated numbers are low enough to not warrant 2 separate individuals?**

    A. No, the CCSO's Clinical Manager is to be separate from the Care Coordination Supervisor. HFS is anticipating a minimum monthly Pathways enrollment of 250 youth per DSA. Given these estimates, Pathways enrollment should be sufficient to support a separate Clinical Manager position; HFS will continue to monitor enrollment numbers and work with CCSOs to address any staffing challenges that arise during implementation.

45. **If a provider is approved to cover multiple DSAs, can the Clinical Manager over the Pathways program cover Pathways programming in multiple DSAs?**

    A. Each DSA must maintain a unique, full-time, 100% dedicated Clinical Manager that meets the qualifications of an LPHA. The Clinical Manager may not cover multiple DSAs.

46. **Since the Care Coordinators are dedicated to Pathways clients-how are the required FSP and SFSP services paid for?**

    A. FSP and SFSP youth who are not also enrolled in the Pathways program will continue to be provided the services outlined in the CBS Handbook, consistent with programmatic requirements, and reimbursed according to the existing community mental health fee schedule.

47. **Are Pathways Care Coordinators able to provide services to FSP or SFSP youth who aren't Pathways eligible?**

    A. HFS will allow CCSOs to use CCS Care Coordinators to provide Case Management services to FSP and SFSP youth, so long as the Care Coordinators do not exceed the caseload thresholds established for CCS (1:10 for High Fidelity Wraparound Care Coordinators, 1:25 for Intensive Care Coordination Care Coordinators).

48. **Is it my understanding that if you do not become a CCSOs then you will no longer be a provider of MCR/SASS services?**

    A. CCSOs will act as the MCR Designated Service Area provider responsible for receiving all crisis referrals from the CARES line for that DSA. However, any provider in the DSA that is approved to provide MCR may provide that service if a customer they serve is experiencing a crisis and requires that level of intervention.

49. **While any agency interested to provide CCSO must be an approved MCR provider, if the MCR provider is not interested in the CCSO, there is a possibility that the MCR services are moved over to an agency who is willing to provide the MCR and CCSO, yes?**

    A. A provider who wishes to become a CCSO will also be required to be the Designated Service Area Mobile Crisis Response provider. Other providers in the DSA may continue to provide MCR services but will not be the MCR Designated Service Area provider contacted by CARES.

50. **Is it correct that CCSOs can enter into agreements to provide MCR services for part of their designated area they might not currently cover?**

    A. Yes. CCSOs may enter into partnerships with other provider organizations qualified to deliver Medicaid crisis services in order to meet the CCSO's MCR responsibilities. All partnerships are subject to the approval of HFS.

51. **We are the MCR provider for two separate regions with the map you have shared today. Does this mean we would be MCR provider for adults in our existing counties but would be MCR provider for children only in the counties laid out in these new regions?**

    A. The revised Designated Service Areas applies to both adults and children. While the CCSO will be providing Care Coordination and Support Services only to children under the age of 21, they will be the Designated Service Area Mobile Crisis Response provider and must serve both children and adults who are referred for crisis services by the CARES line.

52. **Will CCSO's receive CARES calls for all children in the new DSA regardless of enrollment in Pathways?**

    A. Yes. The CCSO will be the MCR Designated Service Area provider and will receive all CARES referrals for eligible children and adults.

53. **If we apply to be a CCSO then must we cover all hospitals within that region? There are some regions with more than 8 hospitals.**

    A. CCSOs must accept all Mobile Crisis Response referrals from the CARES line on a no-decline basis for eligible customers presenting in crisis within the CCSO's DSA. This includes responding to referrals for customers presenting in crisis in a hospital.

54. **How is 'short-term follow-up post crisis' for non-Pathways youth/adults defined? Will there be further discussion, definition for this requirement?**

    A. Additional information regarding post-crisis follow-up responsibilities for CCSOs will be provided in the Request for Qualification (RFQ).

55. **Does a "telephonic infrastructure" for crisis calls include the ability to have an answering service?**

    A. Yes, the usage of an answering service would be allowable so long as all crisis referrals from CARES are able to be received within 30 minutes, and the answering service is able to receive all information from CARES upon first live contact.

56. **Please confirm - the CCS team is not the team providing MCR services, as they cannot possibly adhere to the 1:10, 1:25 ratio and do MCR, correct? Does this mean CCS staff cannot be a part of an overall MCR on call rotation?**

    A. CCS Care Coordinators should be included in a Mobile Crisis Response whenever possible for a Pathways child on their caseload but should not be considered Mobile Crisis Response staff and should not be placed on the CCSO's MCR on-call rotation. The MCR and CCS teams are to consist of separate staff.

<u>CCSO Request for Qualifications (RFQ) Process</u>

57. **What is timeline for CCSO selection?**

    A. The Request for Qualifications (RFQ) will be released on 9/01/2021. A provider notice will be distributed when the RFQ is posted. Interested parties will have until close of business 10/01/2021 to submit their proposals. HFS will announce which providers were determined to be qualified as CCSOs on 11/15/2021.

58. **In the RFQ process, will benefit be given to those CMHC's already in a DSA?**

    A. Providers interested in applying to serve as a CCSO within a DSA must already have a site operating within the DSA that is certified and enrolled with HFS as a Community Mental Health Center or Behavioral Health Clinic.

59. **If you must be a CMHC/BHC and be providing MCR - it seems that they are the targeted entities to apply for CCSO?**

    A. To apply to be a CCSO, a provider must already have a site operating within the DSA that is certified and enrolled with HFS as a Community Mental Health Center or Behavioral Health Clinic. Additionally, the site must have or be able to obtain a Crisis Services Program Approval within 60 days of selection as a CCSO.

60. **Can we find out how many other providers have applied to be a CCSO in our DSA? This may help us to decide whether we will move forward in that application?**

    A. All applications for providers who wish to be considered qualified as a CCSO will be due on 10/01/2021. Public notification regarding which providers applied will not be available prior to that date.

61. **Can two or more agencies be awarded CCSO status within one DSA?**

    A. It is possible for there to be more than one CCSO in a DSA.

62. **As the new DSA geographic areas are different from existing LANS and designated MCR areas, are providers in the RFQ process able to designate a specific area within a DSA to provide these services to?**

    A. Selected CCSOs will be responsible for meeting all CCSO service delivery requirements for eligible customers within the entire DSA, as outlined in the RFQ. Providers may not submit to cover only part of a DSA. CCSOs may partner with other provider agencies to meet the Mobile Crisis Response requirements but must maintain oversight responsibilities to ensure their partner's performance is in line with HFS' policies, procedures, and expectations.

63. **Will anticipated numbers of youth expected for each tier be shared with the CCSO RFQs so that providers can determine what revenue and staffing numbers to expect?**

    A. Estimated utilization data will be provided for each DSA as part of the RFQ.

64. **Does the RFQ process only apply to becoming a CCSO? Or does it also apply to providers interested in delivering IHBS?**

    A. The RFQ process will only be used to select qualified CCSOs. Providers interested in delivering Intensive Home-Based services will add the appropriate Specialty/Subspecialty to their IMPACT provider enrollment and must complete a Program Approval process.

<u>**Care Coordination and Support (CCS) Services**</u>

65. **What are Care Coordination and Support Services?**

    A. Care Coordination and Support is the foundational service that CCSOs will be responsible for providing. It is an evidence-informed, structured approach to care coordination that is based upon the values, principles, and processes of Wraparound. CCS includes a broad set of activities designed to assess, plan, and monitor the service needs of the child and family and includes:

    i. Engagement and outreach to children and families, including education on Systems of Care and Wraparound processes; Organization and facilitation of a Child and Family Team, or CFT, that meets on a regular basis;
    ii. Reviewing and updating the child's IM+CANS on a regular basis, which includes the identification of needs and strengths and the development of a service plan;
    iii. Crisis Assessment, Safety and Prevention Planning, and Response activities;
    iv. Coordinating and consulting with providers and other formal and informal supports involved with the child's care. This includes working to help transition children from an institutional setting to a community-based living arrangement; and,
    v. Referring, linking, and following-up with service providers and social service agencies for services recommended by the CFT on the service plan.

    CCS services are provided at two intensity levels or tiers. Children in Tier 1 will receive CCS services consistent with High Fidelity Wraparound. In this tier, Care Coordinators will maintain an average caseload of no more than 1 care coordinator to 10 Pathways clients. Child and Family Teams will meet once every 30 days and will review and update, as needed, the IM+CANS and the Crisis Prevention and Safety Plans. Care Coordinators will be required to maintain weekly contact with children and families. At least 2 contacts per month must be in-person, while the other 2 monthly contacts may be done telephonically.

    Children in Tier 2 will receive CCS services consistent with the requirements for Intensive Care Coordination. In this tier, Care Coordinators will maintain an average caseload of no more than 1 care coordinator to 25 Pathways clients. Child and Family Teams will meet once every 60 days and will review and update, as needed, the IM+CANS and the Crisis Prevention and Safety Plans. Care Coordinators are also required to maintain weekly contact with children and families, however, only one of those monthly contacts must be in-person.

    Across both tiers, care coordination supervisors will maintain an average of no more than one supervisor to every eight (8) care coordinators.

66. **Why the two-tier system? Wouldn't we want all eligible children to receive evidence-based high-fidelity wraparound?**

    A. Intensive Care Coordination is based upon the same processes and procedures of Wraparound, but the core activities are delivered on a less frequent basis. This tiered approach to Care

Coordination and Support allows additional children to receive intensive care coordination services who would not otherwise be eligible to receive High-Fidelity Wraparound, while also providing a step-down for children and families who no longer require the intensity of High-Fidelity Wraparound. Several states have implemented similar tiered approaches and have achieved positive outcomes for a larger number of children.

67. **Are there different or adjusted approaches for older youth? We know from the literature and practice that older youth don't benefit as well from a traditional wraparound approach to services and need some adjusted approaches.**

    A. HFS is not aware of any literature demonstrating High-Fidelity Wraparound is less effective for older youth. However, HFS does understand that CCSOs should adapt their approach to CCS services to meet the individual, developmental, and cultural needs of the youth they are serving. CCSOs will receive guidance on working specifically with older youth through the ongoing coaching and training provided by PATH.

68. **Has HFS considered the workforce shortage of MHPs when limiting the ability of CCSO Care Coordinators only to response to MCR referrals concerning Pathways Clients. In some geographies, this will result in needing to recruit multiple new staff to add to on call rotations.**

    A. Care Coordinators should participate whenever possible in Mobile Crisis Response Team services to respond to a crisis for a Pathways enrolled youth on their caseload. However, care Coordinators may not be the sole crisis responder and should not be used as on-call staff for MCR. This separation between MCR staff and Care Coordinators is required to ensure that Care Coordinators are able to maintain appropriate maximum caseloads and fidelity to the care coordination model.

69. **Do staff providing these services have to be dedicated to this program or can they have a mixed caseload and work in other programs at the agency?**

    A. Care Coordinators, Care Coordinator Supervisors, and the Clinical Manager must all be dedicated to Pathways. HFS has made an allowance for Care Coordinators to also provide case management to FSP or SFSP youth, so long as the maximum caseloads required for CCS are not exceeded.

70. **This will require significant staffing resources on an already strained system. What is the plan if a selected CCSO is not able to reach the required staffing levels?**

    A. HFS and the MCOs will have frequent communication with CCSOs, particularly during the implementation phase, regarding staffing and capacity and will collaborate closely with CCSOs to address any staff shortages.

<u>Intensive Home-Based Services</u>

71. **What is Intensive Home-Based services?**

    A. Intensive Home-Based (IHB) services are strengths-based, family-driven services that are provided directly to children and families in their home and other community settings. IHB is designed to be a short-term service, focused on preventing the child from experiencing a psychiatric hospitalization or other out of home treatment episode. Interventions delivered by IHB staff are grounded in the evidence-informed clinical approaches of PracticeWise's Managing

and Adapting Practice (MAP), and solution-focused therapy. IHB services are delivered by a team responsible for providing two distinct components – Intensive Home Based Clinical, or IHBC, and Intensive Home Based Support, or IHBS. These two components work together in tandem to develop, implement, and monitor a clinical intervention plan that works to improve child and family functioning, improve the family's ability to effectively support the child at home, and promote overall healthy family functioning.

72. **How is IHB different from CST?**

    A. Although the target population to receive IHB and Community Support Team (CST) services may be similar, the services themselves are distinct. CST is a team-based service that focuses on increasing an individual's ability to function in the community through the facilitation of illness self-management, skill-building, and the use of natural supports and community resources. IHB uses an evidence-informed approach to clinical services and focuses on enhancing the family's overall functioning and capacity to maintain a child with significant behavioral health challenges in their home and community.

73. **Can the IHB team partner with MCOs (health plans) to remind recipients of the service of well-child visits with PCPs and report back to the recipient's health plan?**

    A. HFS encourages providers and MCOs to develop strong partnerships in support of the customers they serve. Providers need to work directly with MCOs in the development of this partnership, particularly to define any parameters or agreements about the scope of work a provider is willing and able to offer for MCO customers.

74. **Will there be a specific clinical tool required to conduct the Functional Behavioral Assessment?**

    A. Yes. A Functional Behavioral Analysis tool/format will be provided during training for agencies that are approved to provide Intensive Home-Based services.

75. **How will the Functional Behavioral Assessment and IM+CANS be coordinated?**

    A. The IM+CANS is designed to serve as the comprehensive, single integrated assessment and plan of care. Similar to any other additional assessment completed for a customer (i.e., psychological, psychiatric, diagnostic assessments), the information from the Functional Behavioral Assessment (FBA) should inform the completion of the IM+CANS as well as a child's Crisis Prevention Plan. The IHB staff should be sharing information about the FBA with the child's Care Coordinator and should be included as a member of the Child and Family Team for Pathways enrollees.

76. **Can the IHBC and IHBS be the same person or does it need to be a team approach?**

    A. No, IHB is a team-based approach. The two components (IHBC and IHBS) must be provided by distinct staff with appropriate credentials.

77. **Does the IHB Team Lead (an LPHA) have to be 100% dedicated to this program?**

    A. No. The IHB Team Lead must be a full-time employee of the provider, but their time does not have to dedicated 100% to oversight of IHB services. Additionally, IHB Team Leads may also serve as IHB clinicians, and are permitted to deliver IHB Clinical services.

78. **Will providers need to have staff certified in MAP before they can deliver IHB services? Or will they be able to deliver IHB services as long as they have staff enrolled in the MAP training?**

    A. IHB Clinical and Support staff may begin delivering IHB services once they are certified in the IM+CANS and have completed the two-day IHB training through PATH. IHB Clinical staff will work with PATH to be added to a waitlist to join a MAP Therapist cohort following their initial 2-day training.

79. **If you have staff that have already gone through this formal MAP therapist certification process, will that be accepted? We have done the formal MAP certification with a certified MAP Trainer.**

    A. Yes. Staff that are currently certified and recognized by PracticeWise as a MAP Therapist will only need to complete the two-day IHB training through PATH and attend ongoing training boosters and coaching sessions.

80. **Will the MAP training/certification through PATH follow the same procedures/expectations as the PracticeWise training? Will this training/certification also be free to providers and offered on an ongoing basis to account for staffing changes?**

    A. Yes. PATH will be utilizing MAP Trainers who have been certified by PracticeWise to deliver the five-day training and subsequent coaching to clinicians working to achieve certified MAP Therapist status. The MAP training will be free of charge to providers and will be offered on a rolling basis, based upon trainer availability, to cohorts of clinician in need of the training.

81. **Do you anticipate sufficient MAP trainers to meet the provider demand/need?**

    A. The MAP Therapist training process is most effective when it is rolled out to smaller cohorts of clinicians working closely with MAP certified trainers. Because of this, HFS anticipates there may be a greater demand for MAP Therapist training than trainer capacity is initially able to accommodate. While strategies are being developed to expand the State's number of MAP certified trainers, HFS and PATH have collaborated with PracticeWise to develop a phased approach to training related to the MAP system and tools. This phased approach ensures that the initial two-day IHB training contains the information necessary to demonstrate appropriate usage of the MAP system and tools while therapists are waiting to join a cohort to obtain full MAP Therapist certification.

82. **If individuals engaged in the five-day MAP training but not certified, will they need to redo the entire training process?**

    A. PracticeWise standards require that individuals obtain certification within 12 months after attending the initial five-day MAP training. If any individual fails to obtain certification within that timeframe, they must retake the five-day MAP training and start the certification process over.

<u>Respite Services</u>

83. **What are Respite Services?**

    A. Respite provides a planned, short break to parents and caregivers. A trusted professional can come to the home and stay with the child or take the child to a community activity to give everyone a chance to rest and relax. Respite is primarily delivered on an individual basis but may

be provided to sibling groups of up to three children. Respite services require a prior authorization, and is time limited to seven (7) hours per event, 21 hours per month, or 200 hours per state fiscal year without additional review and authorization.

84. **For Respite Services, can this be subcontracted with another agency or must these services be provided directly by the CCSO agency/employees?**

    A. Respite services must be provided by a Community Mental Health Center (CMHC) or Behavioral Health Clinic (BHC). Respite services may not be provided by a CCSO, unless that CCSO is the only provider within their geographic area and has received approval from HFS to provide other Pathways to Success services, such as Respite.

85. **Concerning Respite, would this service preclude a person from allowing a child to stay overnight if it was less than seven (7) hours or is the intent this is an in-home service?**

    A. Respite services covered under Pathways to Success are not intended to be overnight services.

86. **Could Respite be provided at a site with more than one youth (not siblings)?**

    A. Respite services are not intended to be provided at locations where multiple youth requiring staff supervision are congregated. If services are provided at a site with more than one youth, there must be a Respite staff providing services to each of the children at that site. Group Respite is only allowed for up to three siblings in one group.

87. **For group Respite with siblings - must all the siblings be enrolled/eligible for this program? or just one identified youth and their siblings?**

    A. Each child for whom the provider is seeking reimbursement for Respite services must be enrolled in Pathways and have the service authorized on the child's IM+CANS.

88. **Does siblings include only biological siblings, or could it be foster siblings? Households may have unrelated youth in their homes.**

    A. Group Respite services may be provided to foster siblings, so long as each child is enrolled in Pathways.

89. **Could the Therapeutic Mentoring and Respite services be provided by the same staff? These services seem very connected on what they aim to provide.**

    A. Yes, so long as the staff qualifications for each service is met.

<u>Therapeutic and Individual Support Services</u>

90. **What are Therapeutic and Individual Support Services?**

    A. Therapeutic and Individual Supports are designed to offer additional services and supports that complement the other services included in Pathways to Success. Therapeutic Supports including non-traditional therapies such as art therapy, dance therapy, equine therapy, and music therapy. Youth can receive up to $3,000 for these supports on an annual basis. Individual Supports include activities, services and goods such as: summer camps, special recreation, wellness activities, sensory items (e.g., weighted blankets). Youth can receive up to $1,500 for these supports on an annual basis.

91. **For Therapeutic and Individual Support services, is the cumulative per CCSO eligible client $4,500 per calendar year?**

    A. Therapeutic Support Services are limited to $3,000 and Individual Support Services are limited to $1,500. The services are not interchangeable, so a total of $4,500 should be broken out into the two categories, not treated as a global number for each child each fiscal year.

<u>**Billing and Reimbursement**</u>

92. **When will we know about the reimbursement rates?**

    A. Rates for each of the new services covered for Pathways enrolled children are included in the posted webinar slides, which can be found on the HFS website at: pathways.illinois.gov.

93. **Will MCOs be required to reimburse the CCSOs at the HFS rates?**

    A. MCOs are not required to reimburse CCSOs according to the HFS fee schedule, however MCOs generally do not reimburse providers at rates lower than fee-for-service.

94. **Will HFS be developing a reimbursement structure to pay for staff time in training and coaching? What support will the state be providing to providers to cover these otherwise unfunded costs?**

    A. The State has requested funding through the American Rescue Plan Act of 2021 (ARPA) to provide financial support to providers in the development and implementation of new community behavioral health services, including CCSOs and other providers of Pathways covered services. HFS will keep providers informed of the final approved usage of ARPA funds from federal CMS.

95. **If a CCSO refers to another local provider to provide services, how is that local provider reimbursed, is it through the CCSO?**

    A. Providers who are offering services that are covered under Medicaid will be reimbursed either by the child's MCO, if the child is enrolled in managed care, or by HFS, if the child is covered under fee-for-service. If the local provider is offering Therapeutic Support Services or Individual Support Services for the child who is enrolled in Pathways, then the CCSO will act as the fiscal agent for those services and will reimburse the provider for those services consistent with the prior authorization for services from HFS.

96. **Will there be rate differentials if we hire someone that meets QMHP standards for Therapeutic Mentoring or Family Peer Support?**

    A. Please refer to the rate information provided in the Pathways CCSO and HCBS webinar slides, which can be found on the HFS website at: pathways.illinois.gov.

97. **Why is there a difference between the IATP: Child and Family Team Participation rate and the other IATP service rates on the current HFS fee schedule?**

    A. The IATP: Child and Family Team Participation is designed to reimburse community-based behavioral health providers for the time spent consulting on the IM+CANS review and update during Child and Family Team meetings. HFS set the rate for this service consistent with similar services.

98. **Can multiple providers bill IATP: Child and Family Team Participation at the same time? For each person present?**

    A. Multiple providers can offer IATP: Child and Family Team Participation on the same day at the same time. Additional guidance will be published regarding when it would be appropriate for multiple staff from an agency to bill for the same time participating in a CFT meeting.

99. **Will IATP: CFT Participation code only be available in the formal CFTM or also available if having any contact with Care Coordinator?**

    A. The IATP: CFT Participation is only reimbursable for CMHCs and BHCs consulting on the IM+CANS review and update during Child and Family Team meetings.

100. **Does IHB allow observations in the school setting to inform an FBA to see if the youth presents differently in different environments?**

    A. Yes, this would be appropriate under IHB Clinical services for the purposes of informing the Functional Behavioral Assessment.

101. **Would providers be able to attend IEP meetings or any other treatment team meetings to ensure all providers are in line with the CCSO's plan?**

    A. Providers may attend any meetings regarding a youth's care; however, Targeted Case Management Services of any kind are not be reimbursable for children receiving Care Coordination and Support (CCS) services.

102. **If a therapist is providing Rule 140 services to a youth, submits the IM+CANS, and the youth becomes eligible for Pathways, can the therapist still work with them?**

    A. Yes, if the family wishes to continue receiving therapy services from that provider and therapy continues to be a recommended service on the child's IM+CANS. The therapist should be included in the Child and Family Team and coordinate ongoing updates to the IM+CANS through the CFT process.

103. **Can you please clarify services that would be considered duplicative and therefore not eligible for Pathways Home and Community Based Services?**

    A. In general, HFS is required to ensure that services are not provided to customers at the same time as another service that is the same in nature and scope, regardless of funding source. The requirement to ensure non-duplication of services must be considered for each service individually. Additional guidance regarding non-duplication of services will be provided in policy and billing guidance issued for Pathways services.

104. **If a Pathways enrolled child is receiving any of these identified services on a particular day (mentoring, respite, etc.) does that mean that a separate Community Mental Health Center cannot provide that child therapy?**

    A. Non-duplication of services is a requirement of the Medicaid program and is not limited to Pathways enrollees or services. Services that are the same in nature and scope may not be provided to the same child on the same day. A few examples to illustrate this – Respite and Therapeutic Mentoring are not the same in nature and scope as Therapy/Counseling; therefore,

there would be no issue if a child were to receive those services on the same day. However, IHB and Therapy/Counseling services would be considered of the same nature and scope and are not permitted to be delivered on the same day as one another.

105. **Can two different agencies get reimbursed for IHB and therapies in the same day? And if so, how would therapy agency know IHB was called in earlier that day?**

    A. No. Medicaid cannot pay twice for the same service for the same beneficiary. As such, IHB services may not delivered on the same day as Community Support, Therapy/Counseling, Community Support – Team (CST), or Assertive Community Treatment (ACT), as this would be a duplication of services. Coordination of IHB and other services will be conducted during the Child and Family Team meetings and in between meetings by the care coordinator. This process will ensure that all providers who are offering services to the child and family are communicating and coordinating effectively to prevent the duplication of services.

106. **If a young person is in or necessitates specific lines of services that includes case management how does that work? I'm thinking of a young person that needs something like First Episode Psychosis services which inherently has a strong and integrated case management piece to the work.**

    A. Receiving Case Management services from multiple entities is considered a duplication of services and is not allowed under Medicaid. Care Coordinators and providers should ensure that families have all the information necessary to make informed decisions about which services they would like to receive from which providers. If a particular evidence-based practice/approach, such as First Episode Psychosis programming, is more appropriate to meet the needs of a young adult and their family, the family may decline Care Coordination and Support services and receive Case Management from a First Episode Psychosis program.

107. **There are circumstances where direct Case Management - Client Centered Consultation is necessary and should be paid for outside the Care Coordinator. An example would be therapist consulting with psychiatrist. Will this be allowed and billable by Rule 140 providers?**

    A. No. Targeted Case Management Services of any kind are not reimbursable for children receiving Care Coordination and Support (CCS) services. Consultation between providers should occur as much as possible during the Child and Family Team meetings.

108. **There are case management services that are needed at time of crisis – will those services be billable?**

    A. No. Targeted Case Management Services of any kind are not be reimbursable for children receiving Care Coordination and Support (CCS) services.

109. **Are providers for any of these Pathways enrolled children allowed to bill for IATP services?**

    A. CCSOs may not separately bill for IATP services for Pathways enrolled children receiving Care Coordination and Support (CCS) services, as the review and update of the IATP is an included activity of the CCS service. Other CMHC/BHC providers may not bill for IATP and IATP: Review and Update services for Pathways enrolled children. CMHC/BHC providers may provide and bill for IATP: Clinical Assessment Tool, IATP: Psychological Assessment, IATP: LOCUS Assessment, and IATP: Child and Family Team Participation, when such services are deemed medically necessary.

Questions and Answers received after August 17, 2021

<u>**Timelines**</u>

110. **During the webinars it was mentioned that HFS is working on initiatives focused on increasing children's mental health workforce. Can you provide more detail? What is the expected timeline?**

    A. In addition to requesting funding through ARPA to support community behavioral health, HFS considers many of the other initiatives it has undertaken to be workforce development initiatives. In particular, HFS' partnership with the University of Illinois's Provider Assistance and Training Hub (PATH), which represents a significant investment in workforce development and training that is free of charge to all Medicaid providers. In addition, during the spring legislative session, a new law (Public Act 102-0004) created the Medicaid Technical Assistance Center (MTAC) that is intended to provide training and technical assistance for organizations once the provider enrolls as a Medicaid provider and contracts with Medicaid managed care organizations. MTAC will be housed within the Office of Medicaid Innovation (OMI) at the University of Illinois, which offers support services to the Medicaid program. HFS will continue to monitor workforce challenges and consider other ways it can support the development and retention of staff within the community behavioral health workforce.

111. **There is great concern that the proposed timeline to rollout out both CCSO and new Homebased services will present hiring and workforce challenges. In addition, the anticipated 11/15/21 award announcement with January training is an unrealistic timeline given the need to have those staff dedicated to the CCSO. Hiring has historically been a challenge over the December holidays. With the new DSA map with significant changes to existing geographies, there would be too much uncertainty to begin hiring prior to award notification.**

    A. HFS is committed to working closely with selected CCSOs to understand staffing challenges and capacity in preparation for implementation. HFS is intending to approach Pathways enrollment using a phased approach – staggering the go-live date across three months for different DSAs and limiting new Pathways enrollments for the first three months of each DSA's implementation to provide agencies time to staff to needed capacity.

<u>**IM+CANS / Eligibility determination**</u>

112. **Will there be transparency around the eligibility determination criteria? It will be helpful for providers to have a sense of potential eligibility metrics to provide some anticipatory guidance to families on the potential to receive contact from a CCSO organization.**

    A. HFS intends to make the Decision Support Criteria publicly available.

113. **Who were the provider stakeholders who participated in the workgroup to determine decision support criteria? Will the recommendations shared be made publicly available?**

    A. Dr. John Lyons, the developer of TCOM tools which includes the CANS and ANSA, and his team at the University of Kentucky developed the initial Decision Support Criteria. Decision models using CANS have been implemented in many programs and states across the nation. Dr. Lyons utilized learnings, data, and his team's vast experience with these models to inform the development of Illinois' Decision Support Criteria. This Decision Support Criteria was presented to a workgroup of licensed clinicians representing each of the contracted MCOs, DHS-DMH,

DCFS, Centerstone, Jewish Child and Family Services, Kenneth Young Center, and Will County Health Department. The Workgroup reviewed the Decision Support Criteria developed by the University of Kentucky utilizing a case review methodology. The Workgroup process was facilitated by the University of Kentucky and supported by HFS. This initial process was not conducted with the understanding that participating independent clinician's recommendations would be made public, but this is something HFS may consider in future reviews of the Decision Support Criteria.

114. **What is the reasoning behind the provider who completes initial IMCANS not being a part of the notification process? In our experience, the process of notification for FSP is often delayed/confusing. Since the provider completing the IM+CANS has had the most recent contact it would help in ensuring expedient contact is made. In addition, this would involve a "cold call" from unknown parties and families who haven't had the best experiences might not answer.**

    A. HFS will continue to explore ways to streamline notification and communication to the initial provider who completes the IM+CANS, if possible.

115. **In the flowchart, the initial IMCANS in the portal will determine eligibility and will be used for the first 6 months until there is a review, there is concern that the originating LPHA will be "responsible" for recommended services that may not be provided within their agency.**

    A. HFS understands and appreciates there are concerns from the provider community on how to realize the concept of a single IM+CANS for a child involved with multiple service providers. HFS is currently considering the best approach to providing guidance on this topic and hopes to establish a forum with providers to discuss this in greater detail in the near future.

116. **Where/when will the appeals process be documented?**

    A. The appeals process for Pathways Youth will be outlined in administrative rule. Similar to other adverse determinations for Medicaid customers, the process for filing an appeal will be outlined for families in the letter that they receive notifying them of an adverse decision or determination.

CCSO Roles and Responsibilities

117. **Is the CCSO case rate a per month/per person rate? At what point would the youth be deemed eligible for the PMPM rate? How will that occur, who will need to approve it, when will payments begin, will MCOs have the capacity to argue eligibility, particularly after the first review period?**

    A. Only HFS will be determining a youth's eligibility for Pathways to Success. The CCS service will be reimbursed as a monthly case rate for each Pathways Youth. The RFQ will outline the service expectations that must be met to receive reimbursement for CCS each month.

118. **There are many providers across the state who have provided High Fidelity Wraparound services. Feedback from those agency staff is that providing services to a caseload of all high acuity youth and families causes burnout and staff turnover. It is recommended that a CC be able to serve a mixed population of youth.**

    A. Based upon feedback and recommendations from national experts, HFS will not be allowing CCS Care Coordinators to serve a mixed tier caseload of Pathways Youth, with some minor

exceptions made for sibling groups. Experience from other states who have implemented multiple tiers of care coordination for children with complex behavioral health needs indicates there are significant challenges in maintaining fidelity to the Wraparound model, particularly for High-Fidelity Wraparound, when caseloads were mixed.

119. **High Fidelity Wrap and Intensive Care Coordination-will virtual service be allowed for monthly contacts if families have concerns about in person contact?**

    A. The completion of care coordination activities through telehealth will be allowed for all required contacts through the duration of the COVID-19 Public Health Emergency with signed documentation of this preference from the family.

120. **How will the changes to DSAs where it changes the provider for existing FSP\SFSP clients be managed?**

    A. HFS will be working with current FSP/SFSP providers, new CCSO providers and families to ensure a smooth transition in services.

121. **If a CMHC or BHC applies to be a CCSO in multiple DSA's, does that mean that each DSA would need to have a separate CCSO Team?**

    A. Each DSA must have a dedicated Clinical Manager to oversee CCS services. The CCS Care Coordinators and Supervisors may span DSAs as long as they do not exceed their caseload maximums.

MCR

122. **It was noted in the webinar that "partnerships can be developed for MCR services only." What are the parameters of this partnership? Who would be responsible for billing MCR services?**

    A. Partnerships are allowed for MCR so that CCSOs may ensure all of their designated responsibilities related to MCR, inclusive of the initial screening and any follow-up activities, are covered for the entirety of their DSA. HFS requires that the CCSO provide oversight in the partnership to ensure that all responsibilities are met and are in line with HFS expectations. Any agency a CCSO partners with for the delivery of MCR must be enrolled with HFS for MCR services. The provider delivering MCR services must bill HFS or the appropriate MCO directly for any services delivered.

123. **Who will CARES be dispatching if a CCSO youth presents in crisis outside of his home geography?**

    A. The CCSO responsible for covering the DSA where the youth presents in crisis.

124. **Are CCSO's expected to provide crisis services outside of DSA?**

    A. HFS only requires that CCSOs provide crisis services within their DSA, as well as responding to a CARES referral for a customer presenting in crisis in one of the contiguous counties the CCSO is responsible for (please see the RFQ for details on contiguous county responsibilities and Appendix D of the RFQ for a list of contiguous counties and the responsible DSA).

Interface with 590

125. **As a recipient of the 590 grant, we built many of the program deliverables upon our existing mobile crisis response structure from the SASS program; however, with the change in the designated service areas, we don't believe we could adequately coverage the geographic catchment area indicated for our area. Why did HFS realign the geographic designated services areas? Is there any consideration for reverting to the current designated service areas?**

    A. HFS determined it was necessary to update the geographic boundaries of the state's Designated Service Areas in consideration of multiple factors: ensuring a statewide infrastructure for both CCS and MCR services, ensuring the financial viability of CCSOs, streamlining the administrative oversight of CCSOs, and to create a stronger connection between care coordination and crisis services in line with the Department's goals of reduced recidivism in crisis services and reduced instances of psychiatric inpatient hospitalization. HFS is not considering reverting to the previous LAN designations.

DCFS

126. **What is the process for youth in RTC to be identified and stepdown into Pathways to Success?**

    A. Youth receiving residential treatment services are not prohibited from enrollment in Pathways. Youth may be found eligible for the program while residing in a community setting or potentially while receiving residential treatment.

127. **Since there are so many intricacies involved in DCFS youth in care including CANS tool used, has there been consideration made in staggering DCFS timeframe until after all geographies have gone live.**

    A. HFS is working with the DCFS Guardian regarding the enrollment of DCFS Youth in Care into Pathways. HFS believes Pathways offers access to critical services for N.B. Class Members and would not want to prevent DCFS Youth in Care exclusively from being able to access these services. HFS is continuing to work with DCFS on the delivery of Pathways services to Youth in Care.

Respite

128. **In the presentation, it was noted that all sibs must be open Pathways to Success clients, was this a mistake? It seems unlikely that all sibs would meet eligibility criteria for Pathways to Success.**

    A. To clarify, in order to receive the group reimbursement rate for Respite, each child the provider is delivering Respite to must be Pathways eligible.

129. **The rate for Respite doesn't cover the cost of staff hourly rate, transportation expenses, activity fees.**

    A. The rate for respite is consistent with the rate used for similar services covered under the State' HCBS Waivers.

130. **The group rate is a disincentive to provide services for all sibs at the same time. As an example, if there are only 2 siblings, the hourly rate would only be $14.56.**

    A. The Respite group rate was established similar to how other group rates are set. It is meant to provide additional options for service delivery when siblings are involved rather than limiting the service to a 1:1 staff to youth ratio. Providers do not have to deliver group services.

IHB

131. **What are the direct clinical responsibilities of the IHB team lead?**

    A. The IHB Team is responsible for overseeing the team delivering IHB services. They will be responsible for reviewing the treatment progress of youth receiving IHB services weekly with the IHB team and making sure there is ongoing necessity for service delivery by reviewing the youth's clinical intervention plan monthly.

132. **Is it expected that the IHB team lead will be responsible for carrying cases to "submit a portfolio"?**

    A. This will be necessary during the time the IHB Team Lead is working through the MAP Therapist certification process. Outside of that, there is no requirement that the IHB Team Lead carry a caseload.

133. **We acknowledge/appreciate the higher rate for IHB services-when will more specifics as to what is allowable billing be available?**

    A. Billing guidance will be provided in the Provider Handbook covering these new services.

134. **There is a requirement for IHB providers to also be certified in IMPACT to provide the new additional home and community-based services (Family Peer Support, Therapeutic Mentoring, Respite) can any of those additional services be subcontracted out?**

    A. No. The provider organization must be enrolled and delivering all the other three services (Family Peer Support, Therapeutic Mentoring, Respite).

Training

135. **What is the training requirement for therapeutic mentoring?**

    A. HFS and PATH are in the process of finalizing the training material for Therapeutic Mentoring in consultation with national experts. HFS will provide an update on what the training time commitment for Therapeutic Mentoring will be as soon as this is finalized.

136. **What is the anticipated time commitment for quarterly boosters, ongoing training and coaching for all of the proposed training?**

    A. Some of this will vary based upon the individual provider's needs for coaching. Quarterly boosters may vary in time commitment, depending on the topic being covered, but many are intended to only be 1-2 hours of training material. HFS will include more information regarding the training plan and include this in its training crosswalk for providers.

137. **It would be helpful to have a comprehensive information page on all required trainings, expected length of training, expected timeframe of when it will be offered, if there is an expected sequence?**

    A. Thank you for this suggestion. HFS will work with PATH to develop such a crosswalk and make this information available to all interested providers.

138. **Will you be developing a train-the-trainer model?**

    A. Trainings required for the provision of certain community behavioral health services will continue to be provided by PATH.

<u>**Additional Questions**</u>

139. **Youth and Family Leadership-will each MCO be developing separate leadership councils? We are recommending this be a collaborative process, so youth and family voice isn't lost or siloed.**

    A. Each MCO has had a Family Leadership Council in place for several years. This is designed to ensure that each MCO is eliciting feedback specific to the experience of families enrolled with their MCO. HFS will be convening a joint statewide Family Leadership Council (FLC) that will include representation from each of the individual MCO FLCs to ensure system wide feedback and knowledge sharing is happening in a joint space.

140. **There are many examples of where direct case management/client centered consultation that is needed outside of care coordination. Therapist interfacing with a school or psychiatrist, finding hospital beds, ongoing contact with CC outside of CTM. There is concern without a rate to support these services, they will not occur or there will be a negative impact on agencies providing services but not getting paid.**

    A. The prohibition on the duplication of services, particularly as it relates a customer having one case manager, is a federal requirement of the Medicaid program. HFS has sought to provide flexibility to providers in seeking reimbursement for necessary activities. For example, a therapist could be reimbursed for time discussing a customer with their psychiatrist under the service of IATP, so long as the consultation is for the purposes of completing, reviewing, and/or updating the IATP. This also includes the addition of new billing codes for the purposes of participating in CFTs and clearer guidance on billing related to MCR and Crisis Intervention services.

141. **While this is great opportunity to provide increased services, there are larger system changes, how does HFS plan to inform families and stakeholders of these changes?**

    A. HFS will be working with the Family Leadership Councils, its MCO partners, providers, and other stakeholders to inform and educate families in particular on the upcoming systems changes. HFS anticipates this will take a multi-faceted, continuous communication approach to provide the necessary education. Materials including a Family Guide to Pathways, brochures, updates to MCO Member Handbooks, the use of a Family Journey Map, ongoing presentations and meetings with key stakeholder groups, and other information available publicly on the HFS website are all anticipated to be developed and implemented at this time as part of the Pathways communication strategy.