

Appendix A

List and Summary of Recommendations Directors Declined to Implement

All recommendations are being considered at this time.

Appendix B

Compiled Public Comments Submitted to HFS as of 12/23/2019

Thank you for the opportunity to ask questions and provide feedback as part of the Child Welfare Medicaid Managed Care Implementation Workgroup. I re-read Public Act 100-0646 to be sure I was clear of the intent of the law and this group, and the responsibilities I was accepting by agreeing to be a member. To me the overarching goal is one shared by DCFS and HFS -- ensuring each child's enrollment in Medicaid Managed Care and the transition supports continuity of treatment and does not hinder service delivery. Below are some initial questions/observations.

General

1. Regarding the committee's process so far --- I think you probably realize that for most members -- the process is experienced as rushed. We had not heard anything (even that we were still being considered for membership) for quite some time, then we were notified of meeting dates with only 2-days notice before the first meeting and no more than two-weeks' notice before meeting #3. Also the revised plan was not available for review until the morning of the first meeting --- not ideal for ensuring full informed participation. I know I did not have the opportunity to review it before the meeting.
2. Obviously, the Nov. 1 implementation date is driving the timeline. It would be helpful if you would explain to the members why that date is so important/what is driving it?
3. Also, could you also explain if a phase in of any kind has been considered and why was it decided against? (for example, why not transition physical health then behavioral health, or why not start with children in Trad/REL foster care then move higher levels of care and more intensity, or why not start with the most intense (smaller numbers) like medically complex and then move to full roll out, or start with geographies where provider enrollment is highest?) Just the idea of starting a little smaller and working out any transition issues that were not anticipated before a full roll out seems prudent -- so help us understand why that isn't the way you want to go.

Transition Plan

Initiative 1

4. During meeting one, it was mentioned that 70% of the current 1700 identified providers were enrolled. Is this 70% consistent across geographies? Or is it different for different regions? Do you have a threshold you want to meet ideally before your start date? Are there geographies you are worried about more than others?
5. The info in the transition plan about who to have providers contact and where to do a search is good and critical --- I know you are sharing it widely. But a Dnet announcement couldn't hurt in ensuring that everyone sees the info now.

Initiative 2

6. I asked about the plan for communicating with foster caregivers during the meeting. If POS agencies are going to be tasked with communication to foster parents -- I recommend providing the materials and key messages so they are consistent and cover all bases - have a specific website for foster parents to go to for more info and provide training materials to be used.

Initiative 3

7. Regarding changes to administrative processes – recommend using CWAC workgroups to get input/feedback on these from POS perspective. Both Foster Care and Residential Committee can serve in this capacity. But you would need to reach out soon to schedule special meetings in October. Bill Franklin at LSSI is foster Care co-chair Bill.Franklin@lssi.org and Judy Griffith is Residential JGriffeth@allendale4kids.org

Initiative 4

8. From my perspective, the biggest place for potential role confusion with POS case workers, supervisors, etc. will be in the area of coordinating behavioral health services. POS agencies responsibilities in that area is currently very different and more involved than medical, dental, or vision care. Specific targeted discussions with provider community on this will be critical.
9. The Transition plan mentions using CWAC sub-committees for work in this area as well. That is certainly a good plan. To date – this has been limited. Just in the last couple of weeks – the System of Care (SOC) committee finally met and had a more thorough discussion. To my knowledge, the Foster Care and Residential CWAC committees have not be utilized for input yet. But they would be very appropriate for more detailed discussion regarding ensuring role definition, responsibilities and lines of authority. They will also be good at identifying obstacles/challenges and solutions before roll out if given the opportunity. I would recommend contacting those co-chairs and scheduling meetings sooner than later. We all know placement stability is critical to the well-being of all children in foster care. For kids with more complex needs (behavioral or medical) if those around them (caseworker, foster parents, providers etc. are confused, or cannot confidently and in a timely manner get their needs met – that can lead to placement disruption – particularly for teens. So anything we can do to help everyone get on the same page as much as possible before roll out is warranted.

Initiative 7

10. Not so much dispute resolution – but can the transition plan also address the continued roll of DCFS as guardian? DCFS is the ultimate decision maker for our youth – and that is not changing. For some of the youth with the greatest high end needs (think medically complex foster care) – and those most likely in the current system to have needs that Medicaid doesn't meet -- the DCFS Guardian office can be a resource and is ultimately a decision maker – and is a valued partner.

Again thanks for the opportunity to provide feedback and ask questions.

How will IlliniCare review utilization of psychiatric hospitalization for foster children?

Since Medicaid-eligible non-foster children moved to managed Medicaid, utilization review for psychiatrically hospitalized children and adolescents has been inappropriately aggressive. Youths' hospital stays are approved for 1 – 3 days. Hospital stays are denied if a youngster goes 24 hours without expressing suicidal ideation. Doctors and hospitals are placed in the untenable position of either discharging a youngster they know to be unstable or keeping an unstable youth in the hospital for whom they will not be reimbursed.

Despite having similar psychiatric diagnoses as non-foster care, Medicaid-eligible youth, children involved in the child welfare program, by virtue of the numerous risk factors they present, have much more severe, non-responsive, life-limiting and chronic behavioral and psychiatric symptoms. These risk factors make them harder to diagnose and harder to treat. These risk factors may include, but are not limited to:

- high levels of maternal stress during pregnancy due to poverty, due to multiple factors, including:
 - housing insecurity
 - food insecurity
- poor prenatal care
- poor prenatal nutrition
- in utero exposure to drugs and alcohol
- parental mental illness
- impaired early caregiving experience resulting in pathological attachment patterns resulting in:
 - poor self-concept
 - impaired impulse control
 - increased baseline levels of arousal
 - poor impulse control
- exposure to domestic violence
- exposure to physical, sexual and emotional abuse
- neglect
- poverty
- cognitive deficits
- precipitous removal from the child's family of origin
- multiple placement disruptions affecting continuity of friendships, caregiving relationships, neighborhoods and schools
- impaired socialization in congregate care settings due to exposure to transient caregivers and caregiving and to youth with severe emotional and behavioral problems

Children may also become involved with the child welfare system as a result of severe emotional and behavioral problems that cannot be managed in the home setting. Unable to access appropriate mental health services, these youth often enter the system as dependency through lockouts. Some youth involved with the juvenile justice system are mandated to the custody of DCFS for treatment.

Regardless of whether children and adolescents involved in the foster care system enter due to abuse and/or neglect, dependency or as the result of a court mandate for delinquency, these youth are very high utilizers of mental health services, including inpatient psychiatric services. Inappropriate utilization review for psychiatric hospitalization for children in care will have numerous foreseeable negative outcomes:

- discharge of youth that are not psychiatrically stable will result in repeated psychiatric hospitalization which will result in a negative cascade:
 - lack of behavioral/psychiatric stabilization despite multiple psychiatric hospitalizations will result in caregiver frustration and hopelessness, ultimately resulting in placement instability and increased utilization of high-end congregate care settings
 - disruption of school resulting in poor academic outcome and poor achievement in adult life
 - decreased age-appropriate social interactions
 - decreased involvement in normative community-based activities
- access to high end services will be adversely affected for this population:
 - physicians, overburdened by administrative demands, such as frequent consultations with utilization review personnel, will cease to provide care to Medicaid-eligible children

- hospitals will foot larger and larger portions of the costs for a youth's psychiatric hospitalization resulting in operational losses and closure of psychiatric hospital services, especially in general acute care hospitals and academic or teaching hospitals. Indeed, Rush Medical Center recently closed its inpatient child and adolescent psychiatric unit
- there may be a massive transfer of money from DCFS and Psychiatric facilities to Illinicare and its stockholders:
 - in order to understand this, it is important to understand what is meant by Beyond Medical Necessity (BMN). There are essentially three definitions:”
 - as defined by Medicaid utilization review, BMN means that Medicaid will no longer pay for a youth's inpatient care. There are several justifications for this determination:
 - the youth's psychiatric symptoms have improved enough that (s)he no longer meets criteria for inpatient care
 - the youth continues to be unstable, but due to the structure of the hospital milieu or to the youth's knowledge that if (s)he behaves well and presents as being asymptomatic for a short period of time (s)he would be discharged (the so-called honeymoon period). Clinicians have FAR greater insight into the youth's clinical stability in this instance than the utilization reviewers
 - the youth's symptoms are slow to respond resulting in the reviewer determining that the patient is, “chronic” and will not benefit from continued hospitalization
 - as defined by clinicians, BMN refers to a youth whose psychiatric symptoms have resolved sufficiently that the patient can be treated safely as an outpatient
 - as defined by DCFS, BMN refers to a youth no longer meeting criteria for continued inpatient hospitalization as defined by either Medicaid or clinician or both and who does not have a placement that is able to care for the youth
 - once Medicaid determines that a patient is BMN, they stop payment for the remainder of the hospital stay. If the youth truly is BMN by Medicaid and clinician definition and has a placement, there is no problem; the patient is discharged. If the youth continues to be unstable despite Medicaid's determination that (s)he is BMN, or if the patient does not have a placement once (s)he is BMN by Medicaid and clinician definition, DCFS pays for the remainder of the hospital stay at a markedly reduced rate compared to negotiated Medicaid rates. Typical rates are \$400.00+/day for the first 30 days after Medicaid determines the patient to be BMN and \$600.00+/day for the subsequent days. The \$600.00/d rate factors out to about 33 – 50% of Medicaid reimbursement for hospitals.
 - inappropriate utilization review will result in DCFS paying for hospital days that should be covered and in hospitals supplementing the state's costs of providing care for these youth
 - hospital cannot afford to lose that kind of money for DCFS youth and will refuse to treat these youth. This is not theoretical. Presently, if hospitals suspect that a foster child referred for inpatient care does not have a placement, they will refuse to take him or her in transfer from emergency rooms. The number of foster children waiting in emergency rooms and being housed on general pediatric units in lieu of psychiatric hospitalization have skyrocketed over the past year.

Question: How will IlliniCare review utilization of psychiatric hospitalization for foster children?

- How many days will a hospital be given initially to evaluate, stabilize, treat and discharge plan for foster children requiring acute psychiatric hospital?
- Will the utilization review process be clinically driven by the child's best interests or by the expenses incurred by a youth's hospital treatment?
- What criteria will be used to determine that a youth is beyond medical necessity?
- What are IlliniCare's criteria for determining when a patient's symptoms are 'chronic' and the hospital stay is no longer reimbursable?
- What is the appeal process if the clinician and Medicaid disagree on whether a child or adolescent is BMN?

Please note, I asked how Illinicare plans to review the appropriateness of a youth's hospital stay in the Child Welfare Medicaid Managed Care Advisory Workgroup Meeting on Friday, September 20. The answer completely missed the point, addressing IlliniCare's plans to provide services to prevent hospitalization and services to ensure continuity of care after discharge to shorten lengths of stay.

What will the role of the CATU be the MCO?

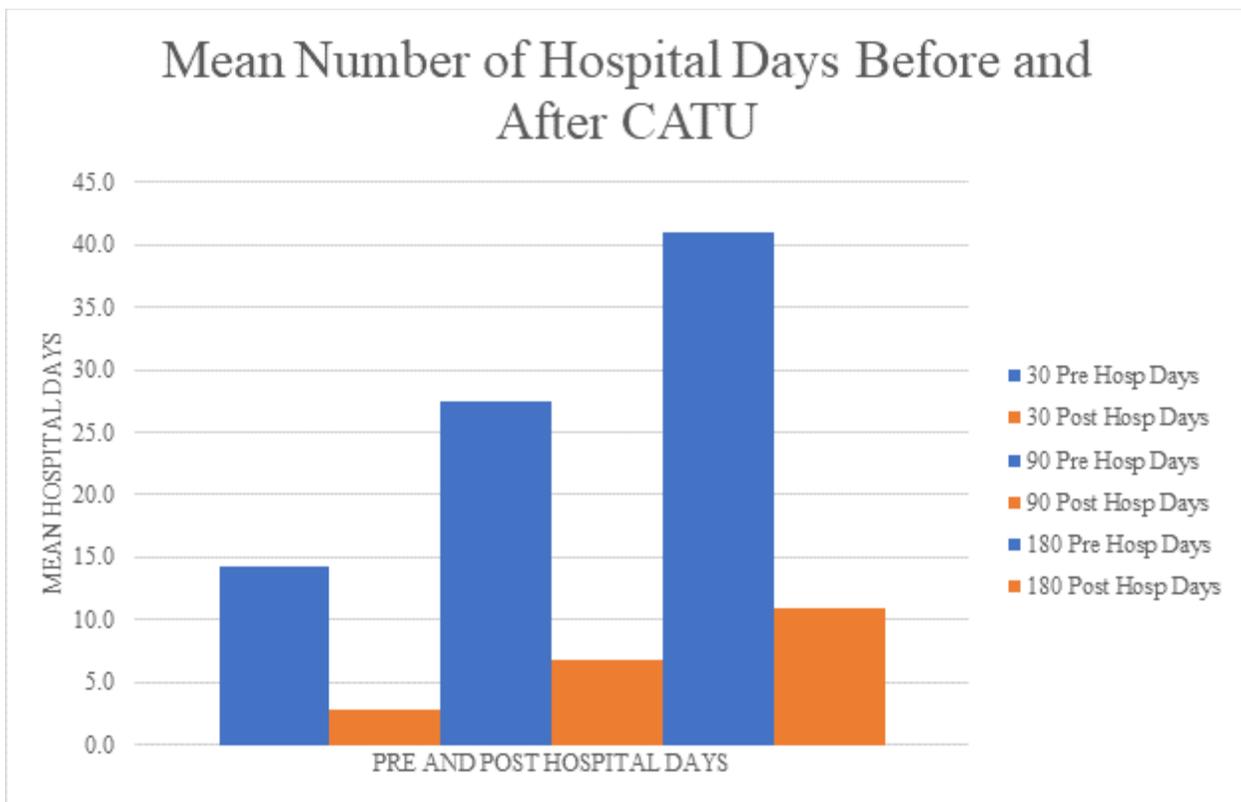
The Comprehensive Assessment and Response Training System (CARTS), established by contract between the University of Illinois at Chicago (UIC) and the Department of Children and Family Services (DCFS) in response to the B.H. vs. McDonald consent decree, is a multidisciplinary program consisting of an acute psychiatric inpatient unit, the Comprehensive Assessment and Treatment Unit (CATU), and the Response Training System (RTS), a mobile consultation and technical assistance team that functions to support DCFS care providers caring for youth hospitalized on the CATU.

The CATU is a 9-bed unit established specifically to treat foster children between the ages of 11 and 17 years with the most severe behavioral and psychiatric symptoms. Children referred to the CATU have been hospitalized multiple times, have disrupted from multiple placements (residential, group home and foster care), are in danger of losing yet another placement due to their behavioral/psychiatric symptoms and cannot be managed in other settings (often, even other psychiatric hospitals). In contrast to other psychiatric units, the main goal of the CATU is to enhance a youth's placement stability and prevent future psychiatric hospitalizations. The initial phase of the hospitalization focuses on stabilization and crisis intervention. The bulk of the hospitalization consists of assessment and treatment planning. The multidisciplinary assessment includes psychiatric, medical, social work and occupational therapy and milieu, functional and educational evaluations. Neuropsychological, psychological, psychoeducational and speech pathology evaluations are obtained when indicated. The data are synthesized in the Integrated Psychiatric Assessment (IPA). Perhaps the most critical component of the IPA is the biopsychosocial case formulation which forms a common understanding among all members of the youth's treatment team.

Based on the IPA and on the treatment interventions piloted on the inpatient unit, a second component of the CARTS program, the Response Training System (RTS) consultant compiles a set of highly specific discharge recommendations written specifically for use by foster care agencies and childcare staff. They are designed to be "user friendly," "hands-on" recommendations that address the everyday issues facing care providers in their day to day work. These recommendations are reviewed with provider staff at the time of discharge from the hospital and 'exported' to the youth's placement via weekly on-site consultation and weekly telephone consultations. These consultations are designed to

assist program staff in implementing the treatment recommendations, to provide opportunities to incorporate additional observations/data in order to modify the recommendations as appropriate, to support the program staff as they continue to work with these highly challenging youth, to head off potential problems in a timely fashion, and to identify critical resource needs. The frequency and nature of the RTS consultations are reviewed regularly and modified as necessary. Typically, cases remain active for three to four months, although the range has been as short as six weeks and as long as 48 months. Cases are not closed, but "deactivated" when the youth demonstrates greater stability within the treatment setting and both agency staff and the RTS consultant concur that the provider staff have incorporated the issues addressed during the consultations into their treatment approach. Cases can be reactivated upon request of the provider, DCFS, or other involved agency if further consultation is desired. Frequently, cases are reactivated at times of transition, such as changes in level of care or when the patient is about to age out of DCFS.

The CARTS Program has been remarkably successful in decreasing the utilization of psychiatric hospitalizations in this highly select patient population. We regularly evaluate the utilization of Psychiatric hospitals for the 30, 90 and 180 days before the patient's first CATU hospitalization and the 30, 90 and 180 days following the patient's discharge. Our most recent evaluation looked at youth discharged from the CATU between November 16, 2016 and November 15, 2018. We documented a 69.2% decrease in psychiatric hospitalizations and a 73.5% decrease in total hospital days comparing the 180-day pre- and 180-day post- CATU hospital days.



It should be noted that the lengths of stay for these youth hospitalized on the CATU is quite high (60.4 days). This reflects the high number of children who do not have a placement when the youth is ready for discharge. Prior to systemic problems with placement for high end youth, the average length of stay varied between 35 and 40 days. These numbers, while high compared to the length of stay for non-

CARTS children in the child welfare system and for non-foster care Medicaid eligible youth, are comparable to the average length of stay for youth who eventually become CARTS clients in other psychiatric hospitals. This reflects the severity and treatment refractoriness of his most challenging patient population.

Questions.

1. What is the role of the CARTS program, and more specifically, the CATU in the MCO?
 2. If there is a role for the CATU in the MCO, will allowances will be made in the utilization review process to recognize the clinical challenges presented by this most difficult to treat patient population?
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Reggie Stambaugh from the Schuyler County Mental Health Department contacted me yesterday. He stated that they had turned a contract in two years ago. He has been on the phone several times attempting to rectify the situation and to no avail. They have not been paid by Illini Care. Their phone number is 217-322-4373.

I understand that some letters may have already been sent to current Youth in Care (is that correct?) but it sounded like another letter would be sent. How will the state choose what address to send these letters to? 906 placement? I'm just curious if I need to share with my staff at Cunningham that case managers or other 'authorized agents' who are not as aware of this roll out may receive letters-or that the kids themselves may receive letters and have a lot of questions.

This memorandum shares IHA's questions on the transition of Youth in Care and Former Youth in Care to Medicaid managed care in response to the Department of Healthcare and Family Services' (HFS) and the Department of Children and Family Services' (DCFS) request for feedback from members of the Child Welfare Medicaid Managed Care Advisory Workgroup.

Enrollment

1. When will sample enrollment letters and other enrollment-related educational materials sent to the Special Needs Children (SNC) population, including Youth in Care of DCFS and Former Youth in Care, be published on the HFS website?
2. In which program will a child be enrolled if he/she is (1) a Youth in Care and medically complex/other special needs; or (2) a Former Youth in Care and medically complex/other special needs?
3. Please confirm that Former Youth in Care will be automatically enrolled in *YouthCare*, effective Feb. 1, 2020, with the option of switching to one of the current HealthChoice Illinois (HealthChoice) Managed Care Organizations (MCOs) during the 90-day switch period, with the exception of IlliniCare Health (ICH) (i.e., ICH's HealthChoice plan will not be an option for Former Youth in Care).
4. Please confirm that the children of current Youth in Care will automatically be enrolled in *YouthCare*, effective Feb. 1, 2020, but will have the option to switch to another to another HealthChoice MCO (except ICH) during the 90-day switch period.
5. Are the children of Former Youth in Care included in the transition? If so, will they be automatically enrolled in *YouthCare* and given the option to switch to a HealthChoice plan?

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6. How is information on the procedures for enrolling the distinct populations described above being shared with patients, families, and providers in enrollment and/or other educational materials?
7. If not outlined in mandatory enrollment/educational materials, how do DCFS and HFS plan to ensure patients, families, and providers are aware of enrollment distinctions prior to the full rollout on Feb. 1, 2020?

Provider Network

8. Can you please provide an updated list of hospitals contracted with ICH to care for DCFS Youth and Former Youth in Care as of Dec. 20, 2019?
9. The Oct. 24 Q&A (#11) states that providers who are already in-network for ICH's HealthChoice plan and also plan to participate in *YouthCare* do not need to enter into a separate contract or make any changes to their existing ICH contracts. How will CVS Health's acquisition of Centene's Illinois Medicaid line of business affect the contracting process since *YouthCare* is specifically excluded from the acquisition and will remain under the Centene umbrella?
10. The Oct. 24 Q&A (#58) states there will be no changes to the Medical Electronic Data Interchange (MEDI) for Youth in Care and Former Youth in Care (i.e., "IlliniCare Health MMP" will be listed in the MCO eligibility segment). How will a provider know if the patient is enrolled in *YouthCare* or ICH's HealthChoice plan? Hospitals must have access to this information to determine whether the patient needs to be referred to an in-network provider (non-emergent) or transferred to an in-network provider post stabilization.

Continuity of Care

11. ICH's health care coordinators must obtain authorized consent from a patient's assigned DCFS case worker prior to speaking with his/her clinician. Please describe how this process works and how providers will know if consent has been obtained?
12. According to the Oct. 24 Q&A (#11), Medicaid providers need a contract with ICH to submit claims. Does this requirement apply during the 180-day continuity of care period? In other words, do out-of-network (OON) providers have to enter into a single case agreement to bill and be paid for services during the continuity of care period? If a provider does not have a single case agreement, will the claim be denied during this 180-day period?
13. If an OON provider agrees to a single case agreement, is ICH required to reimburse, at a minimum, the provider at the state's fee-for-service (FFS) rate?

Prior Authorization

14. Will *YouthCare* have the same defined prior authorization requirements as ICH's existing HealthChoice plan for prescriptions, goods, and services in emergency and non-emergency situations?

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- a. If the prior authorization requirements differ, how specifically will they change from existing requirements?
- b. Where can providers find a detailed list of *YouthCare's* authorization requirements?
- 15. Will ICH waive prior approval for 24-hour Initial Health Screenings and 21-day Comprehensive Health Evaluations, deeming them pre-approved?
 - a. Will ICH send these screening and evaluation results to the member's clinician(s), DCFS case worker, and other approved caregivers?
- 16. How will ICH identify and prevent improper denials of psychotropic medication to members who are entitled to consent to their own medication and for whom further authorization is not required? This inquiry focuses solely on the front-end prevention of serious adverse health consequences due to an administrative error, as Former Youth in Care over 18 do not require consent as set out in Procedure 325.40 and presently administered by the University of Illinois at Chicago.
- 17. How will ICH broaden its medical necessity criteria for the *YouthCare* population from the existing rigid/standardized limits in place for its HealthChoice product to account for trauma-informed judgement in the context of these children's particularized experiences, specifically abuse and neglect?
- 18. Please describe the provider dispute process for service authorizations (not the member appeal process) for *YouthCare*, including peer-to-peer review procedures.
 - a. How will this process differ from the existing service authorization provider dispute process in place for the HealthChoice plan?

Stays Beyond Medical Necessity

For inpatient psychiatric stays Beyond Medical Necessity (BMN):

- 19. Will ICH's reimbursement to freestanding psychiatric hospitals established by Public Act (PA) 100-0646 (codified at 305 ILCS 5/5-5.07) align with the DCFS per diem rate, limitations, and end date (Jul. 1, 2020) set by Senate Bill (SB) 1321/PA 101-0209?
- 20. Will ICH continue to adhere to the definition of BMN at 305 ILCS 5/5-5.07 after Jul. 1, 2020? BMN is currently defined as an "inpatient psychiatric stay at a free-standing psychiatric hospital effective the 11th day when a child is in the hospital beyond medical necessity, and the parent or caregiver has denied the child access to the home and has refused or failed to make provisions for another living arrangement for the child or the child's discharge is being delayed due to a pending inquiry or investigation by the Department of Children and Family Services."
- 21. Will ICH add General Acute Care Hospital Distinct Part Units (DPUs) to this definition for dates of service on or after Feb. 1, 2020 to ensure care coordination across hospital settings?
- 22. According to the Children and Young Adult Mental Health Crisis Act (House Bill 2154/PA 101-0461) and its Veto Session trailer bill SB 0391, in the absence of abuse or neglect, a psychiatric lockout or custody relinquishment to DCFS must only be considered as the option of last resort. Will ICH work with DCFS and HFS to create new care coordination

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protocols specified under the aforementioned law for the first 11 days BMN prior to a patient's transition to the DCFS Youth population to actively engage the patient and family around available supports, such as the Family Support Program, Specialized Family Support Program, post-acute long-term care and residential care coverage, if clinically indicated as medically necessary by hospital clinicians caring for the patient?

23. Will hospital stays BMN that do not qualify for reimbursement under 305 ILCS 5/5-5.07 including inpatient stays in hospital DPUs, be reimbursed by ICH in accordance with 305 ILCS 5/14-13 established by PA 101-0209?

24. ICH notes in the Transition Plan (p.6) that for DCFS Youth hospitalized BMN, specialized care conferences with the DCFS caseworker will be convened within 20 days BMN. Is there an opportunity to adjust this policy to within 10 days BMN? As this situation can disrupt access to school, social connections, and may cause deterioration following medical stabilization, the goal is to ensure timely coordination and transfer to the least restrictive setting as soon as possible.

Other Questions

25. Will ICH create and publically post a separate Provider Manual for *YouthCare*?

26. When will the *YouthCare* addendum to the HFS-MCO Model Contract be made publically available and where will it be posted?

27. The Oct. 24 Q&A (#60) states that ICH requires submission of the CMS-1500/837P, which is used to submit claims for services rendered by physicians and other practitioners. With limited exceptions specific to Illinois Medicaid, hospitals bill institutional services on the UB-04/837I, in accordance with national standards. Please clarify *YouthCare's* billing requirements.

28. Please describe the provider dispute process for claim denials, which is separate and distinct from the member appeals process described in the Q&A (#43). Will it mirror the process in place for ICH's HealthChoice plan?

29. Which providers will have access to ICH's 'individual plan of care' for the patient and how will this information be made available?

IHA appreciates the significant steps, DCFS, HFS, and ICH are taking to ensure a smooth transition to managed care for this vulnerable population. We also appreciate the opportunity to comment on the transition plan. Should you have any questions, please reach out to Helena Lefkow at hlefkow@team-ih.org, 312-906-6008 or Lia Daniels at ldaniels@team-ih.org, 630-276-5461.

Thank you for the opportunity to provide feedback on the Transition of DCFS Youth to YouthCare Questions and Answers Document (Q&A). ICOY submits the following comments on the Q&A, as well as what is missing from the Q&A, with the understanding that our comments will be used to update the draft *Transition Plan for Illinois Child Welfare Medicaid Managed Care Implementation Workgroup: HealthChoice Illinois YouthCare (transition plan)* dated September 20, 2019. The following comments are organized into two sections: (1) comments and questions and (2) recommendations for additional questions. We look forward to providing comments on the revised transition plan.

Comments and Questions:

- Question 2 - All letters to foster care parents and youth should be reviewed by their peers for clarity.

- Questions 3,6 & 12 - Will the continuity of care period apply for providers who are: (1) registered in IMPACT without an IlliniCare contract, (2) registered in IMPACT with an IlliniCare contract and (3) providers who are not registered in IMPACT at all? If so, how will providers who are not registered in IMPACT get paid by IlliniCare in the continuity of care period? The Q&A must provide clear guidance for both providers who are currently registered in IMPACT and those who are not.
- Question 7 - How will the coordination be handled between with the N.B. Implementation Plan and the Families First Prevention Services Act? Will there be a written coordination plan?
- Question 8 - There are two questions numbered "8".
- Questions 11, 29 & 33 - When are providers required to submit or update their universal roster in order to receive payment from IlliniCare? The Q&A must provide clear guidance for both providers who are currently enrolled in IMPACT and for providers who are not.
- Question 30 - Providers need guidance on how they are required to track and administer the \$75 per month funding for counseling. Can a provider refer a child or youth in care to their own certified counseling services? If so, guidance is needed on how the provider should document the \$75 per month counseling funding.
- Questions 49 & 50 – Is the process and timeline for contracting with IlliniCare the same for providers who are registered in IMPACT and for those who are NOT registered IMPACT? The Q&A must provide clear guidance for both providers who are currently enrolled in IMPACT and for providers who are not.
- Question 68 - Will there be a written plan on how IlliniCare will ensure that its care coordinators will reflect the cultural diversity of the DCFS children and youth they serve? What will be in place to ensure and promote the provision of culturally competent services for DCFS children and youth?
- Question 77 - Will the Health Care Coordinator remain in-place when a youth transitions out of care?
- Question 78 - How will IlliniCare work with community organizations, providers and community members to locate former youth in care? Will IlliniCare provide trainings to staff at such organizations and hospitals? Will there be a state-wide communications strategy to educate former youth in care about their health benefits?
- Question 81 - What will be the responsibilities for the Infant Parent Institute after February 1, 2020?

Recommended Additional Questions:

- How will IlliniCare initiate temporary identification cards?
- How will IlliniCare coordinate with the Early Intervention program?
- What trainings are required of providers from IlliniCare?
- How will IlliniCare know when a child or youth (1) changes placement, (2) changes case manager or (3) changes service provider?

- How will IlliniCare and DCFS streamline their incident reporting systems to reduce the burden of reporting duplication placed on case workers?
- Will FY20 DCFS contracts cease on 2/1/2020 or on 7/1/2020? If these contracts cease on 2/1/2020, providers may not have a mechanism to be paid.
- In what circumstances are providers who are already contracted with IlliniCare required to obtain a new IlliniCare contract in order to provide services to the YouthCare population?

Compiled Public Comments to Workgroup 9/20/19-12/18/19

For answers to questions, please see consolidated Questions and Answers document.

9/20/19

1. Question about LGBTQ, particularly services for trans youth. Are we making sure Illinicare is covering services that LGBTQ youth are statutorily permitted to have?

Encourage both departments to “pump the brakes”, take a breath and calm down, not throw 1000s of medically vulnerable children into an unknown abyss. Stated this will end terribly if we do not do this the right way.

2. Concerns about dental care, currently have to drive a distance to obtain services, sometimes up to four hours. Question about DCFS continuing to pay for non-covered services, specifically ABA (Applied Behavioral Analysis) coverage.
3. Illinicare mentioned interacting with caseworkers to determine placement post hospitalization. What are you doing to stabilize placement pre-hospitalization - unnecessary hospitalizations due to lack of access to psychiatrists to get medication, etc.? Encourage to look at in the transition plan to ensure psychiatrists available before hospitalization is needed. Question about committee – is it appointed or not? Work in advocacy and this is first I heard of it, found out at 8:22 today.
4. Alongside managed care transition, there are significant systemic changes (Family First Prevention Services Act and NB Consent Decree). These are three big changes especially affecting youth, congregate care and alumni. How much work is going to align managed care to these NB and FFPSA and mapping so it's consistent since happening at same time?
5. Question about merger potential and network adequacy, do not understand appeals and advocacy process for youth in care if there is a denial. Wondering about Beyond Medical Necessity and not having enough residential beds. What is the plan for when youth are ready to move out, and is there a long term plan for them? Would like to see path to permanency, whether in therapeutic foster home and not in any sort of “weigh station”. What we have been asking DCFS for, now that HFS is involved we must ask of both agencies.
6. In this hold harmless period, how long does it last and does it impact all providers even if their contracts not finalized with Illinicare yet?

9/25/19

- 1.** Providers (including psychiatrists and therapists) are not aware of changes and are anxious about having info. Illinicare and/or state agencies should reach out to professional societies – Illinois Council of Child and Adolescent Psychistrists, Illinois Psychiatric Society, Illinois Psychological Association, National Association of Social Workers (IL), etc.
- 2.** Regarding high-end youth, the doctors who work with this population have valuable information to share with Illinicare. This includes youth who are beyond medical necessity.
- 3.** There is a need to improve and expedite information sharing with providers.
- 4.** What happens when a provider does not wish to contract with Illinicare, but the child has an established relationship with that provider?
- 5.** What portions of the Illinicare contract will be changed?
- 6.** Network adequacy was assessed for the existing Medicaid population, but has a similar study of comparable quality been done for the DCFS population? Same question regarding capitation rates.
- 7.** Concerned that training of Illinicare staff is happening when process flows have not yet been developed.
- 8.** To what extent are staff representative of the population they are serving?
- 9.** The communication plan with foster parents needs to be strengthened.

10/1/19

- 1.** Will there be risk stratification?
- 2.** Regarding predictive analytics, since Centene has worked with this population in other states, are they using that data to inform what happens in Illinois?
- 3.** How will caseworkers and providers be able to access information that Illinicare has about the youth's medical services?
- 4.** Practitioners (therapists, psychiatrists) do not have enough information about this transition, for example, the roles of stakeholders, models being used, etc. The links on the web do not work.
- 5.** Can you speak to the support planned for hospital discharge planning and for youth who are in hospitals beyond medical necessity?
- 6.** How will information be distributed going forward?
- 7.** A recent individual provider reported a concern that they had been interested in working with Illinicare and had submitted the contract, but it had been two years and the contract was still not complete.
- 8.** Regarding staffing for care coordinators, will all children be assigned to a care coordinator? What will care coordinators' caseload sizes be?

January 3, 2020

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9. Who is the audience for the Illinicare town halls? If it includes doctors, the professional associations should be engaged.

10. Will Centene (Illinicare) engage these professional organizations before developing a model?

11. Families received a letter three weeks prior to roll-out, and there is a concern regarding provider availability in-network. Will the contracting process be escalated?

10/15/19

1. Can we access the Illinicare slide show?

2. Is it the intention to create workflows between primary care physicians (PCPs), purchase of service (POS) and Illinicare, etc.? These workflows do not really exist on the POS side, and they would help with the transition.

3. In my program, there is high demand for oral health services due to the challenges faced by population both before and after coming into care. I also suggest tele-dentistry to be evaluated.

4. There is a concern about how all the various assessments will work together on DCFS Caseload (IM-CANS, Integrated Assessment, etc.)? Has thought been given to the burden of paperwork? How will electronic portals ensure that all this information is stored in one spot (HFS/IM CANS, CCWIS, Illinicare, etc.)?

5. We know that care coordination in IL has been 'touch and go'. Does DCFS have a plan to inform the field that this is coming? The more information that case management has and support that the Administration provides, the better chance this has of succeeding.

6. Will Illinicare have someone physically placed in the DCFS Advocacy Office?

7. There are lots of members of the clinical care team with complex tasks they are performing. How do they work together (communication, etc.)?

8. These children, by definition, have been exposed to trauma. If you put them next to the general population, you would call them high risk. What assumptions did you make involving trauma and risk when coming up with the staffing and stratification plan?

9. Some of these children will be NB class members and will have integrated health homes (IHH) providing intensive care coordination. This is example of youth with additional support but they may be classified as low as a result.

10. What is the raw number breakdown of contracted providers now compared to the report provided at the subject matter hearing last month?

10/29/19

1. Will YouthCare be involved in placement/level of care decision-making?

2. YouthCare has talked about getting primary care physicians (PCPs) on contract, and you have a long timeline. I recommend moving them to get on contract sooner than later, so as to not delay payment.
3. When we talk about the enrollment of former youth in care, is this in addition to the 17,000 number?
4. At what point do you start to see the intersection between primary care and mental health. What does the interaction look like between the PCP and psychiatrist/therapist?
5. How does DocAssist fit in?
6. Will you all do initial screening or will Healthworks do that?
7. How will the Clinical Intervention for Placement Preservation (CIPP) process be folded into the care coordination?
8. Will CIPP change at all?
9. For many youth in hospitals beyond medical necessity, there isn't a home that is comfortable taking care of that child, or an available residential center. How do you envision the care coordinator assisting with this?
10. Have Purchase of Service agencies received letters about what is going to happen on Friday (soft launch), so we can notify caseworkers about it?
11. For children and youth in hospitals beyond medical necessity, are the hospitals being notified of upcoming contact from YouthCare?
12. If notification is not going out until October 31 for a soft launch starting November 1, we will have glitches. It may be a rough week or so before everyone gets the information.
13. I recommend that in communications to providers, you include the consent process for releasing information to Youth Care— providers are hesitant to provide information before the actual rollout.
14. Please make sure the letter is also distributed in Spanish.

11/5/19

1. Are there individuals other than the caseworker that can be contacted to complete the Health Risk Screening, since some caseworkers do not have much history with the Youth in Care that they are assigned?
2. Do private agencies all know about the transition to DCFS Youth in Care into the YouthCare program?
3. How was the prioritizing of the seven populations done, and could the agencies serving these populations of DCFS Youth in Care be notified regarding which children are under their care?
4. How will the Illinicare appeals process differ from or be coordinated with the DCFS Service Appeal process?
5. This will result in multiple appeals going to Illinicare and to DCFS. How will this be addressed?

11/12/19

1. Are YouthCare staff meeting in-person with youth initially?
2. Are the Health Risk Screenings (HRS) able to determine behavioral health needs?
3. How does the authorized representative designation work, particularly for youth in residential settings when staff change?
4. For youth in medically complex foster care, nurses are an important part of the service team. Is there a way to better coordinate the process with YouthCare, including them?
5. Staff have reported having a hard time getting a hold of a live person when calling Health Care Coordinators back. They state there are long waits, and that it is difficult to reach the original person who called when returning messages.
6. POS providers request that agency CEOs be notified which youth are identified for outreach, so that they can identify assigned caseworkers and help facilitate getting information needed by YouthCare.
7. Can POS be provided with an outline of questions staff will be expected to answer as part of the HRS, so agency staff can prepare to answer them for their youth. It could also be sent out over the Residential list-serv.
8. Traditionally, there have been some cases where DCFS will pay for services. If an issue goes through the YouthCare Appeal and Grievance process, then the DCFS Service Appeal process, could there then be a General Revenue spend to pay for the service?
9. Who is authorized to file appeals and/or grievances on behalf of youth in care?
10. For appeals, will responses be sent to the actual person who filed them?
11. Who will receive the notice of denial and result of appeals?
12. If there is an appeal and continuation of benefits is approved, is there a delay in payment? Also, if the appeal is denied, does the provider have to pay YouthCare back?
13. DCFS and YouthCare should examine trends related to appeals and grievances.
14. Where will YouthCare's Grievance and Appeal policy be posted for constituents?

11/19/19

1. In your research and fact finding, are you surprised with what you are finding?
2. With regard to hospital providers who are not in the network and do not want to contract with YouthCare, will you be going to individual providers to establish contact for a rate for services they intend to provide?

3. With various providers being contacted, will contracts and rates potentially be different for the same services provided, and will they be able to bill YouthCare for each unit at their particular agreed upon rate?
4. Who will ultimately pay the providers for the services they render to the DCFS and their youth in care?
5. Will caseworkers have to make a double entry – one into the Significant Event Screen and another into Illinicare?
6. Are we responding to and using the current transition plan guidelines?
7. The Infant-Parent Institute has a wealth of knowledge and expertise in certifying/approving and billing for services. Will YouthCare continue using them or work with them to allay the fears of many residential providers that there will be mass confusion when they stop using the MBS billing system?
8. How will the provider rates work?
9. Why are youth being discharged without adequate meds? Why can't the patient contact the hospital for the prescription?
10. Will out-of-state Tele-psychiatrists be brought in?
11. Is there a contact person in the Peoria area?
12. There are several issues POS agencies are concerned with. How are POS agencies going to transition from MBS to Illinicare?
13. Will the new system support foster parents who have developmentally challenged and disabled youth? What if the providers now being used are not in the network? What about other medically fragile youth? What services are available to them? These cases can wait several months to be seen.

12/3/19

1. The news reported that CVS acquired Illinicare. How will this affect YouthCare?
2. Has the issue with the call back number, mentioned in previous meetings, been addressed?
3. Who will receive this letter?
4. Do adopted children qualify if their parents opt for Medicaid?
5. Doesn't the Affordable Care Act provide Medicaid coverage of former youth in care up to age 26?
6. Has the letter to former youth in care been peer reviewed by foster parents or foster care alumni?
7. Have Purchase of Service (POS) providers been told this letter is going out?
8. How will care plans be shared with the primary care provider (PCP)?
9. Under the current system, providers will need to submit the same information to SACWIS and Illinicare – is there a plan to deal with double entry?

10. There is some confusion regarding the enrollment letter going out to former youth in care. I thought former youth in care would be enrolled in Illinicare, not YouthCare.

11. So, the rest of special needs children who are not in YouthCare can opt into another plan as well?

12. Please clarify the language in the letter that mentions youth in care having children; what does this mean? The letter should make this language clearer.

13. Is there a benefit to teen parents who select YouthCare for their children? Can we encourage teen parents to select YouthCare and include the advantages? Can TPSN communicate that if the broker cannot?

14. Is there a way to send enrollment letters to the DCFS Advocacy Office so they have copies?

12/10/19

1. Do you know, out of the 800 psychiatrists identified, who serve children and adolescents vs adult patients?

2. Are you still working on the 3,737 priority children and youth identified? So the number seen thus far is about 75% of that?

3. How many children/youth have been stratified into high or moderate levels to trigger a comprehensive assessment and care plan?

4. Can providers get a list of unreachable people to assist in connecting YouthCare to youth and caregivers?

5. Are the 3,737 in the priority group still 3,737? Has anyone been added to or taken out of that population since November 1 as individual needs have changed?

6. After February 1, when YouthCare is launched, will there be real-time ways for YouthCare to know when children are in the hospital BMN?

7. There seems to be a lot of process improvement that is happening along the way before getting to February 1. The alternative is that the 2,700 children who have had HRS would be sitting there without it if we had not started this soft launch.

8. I am an adoptive parent who enrolled in the Meridian plan in November. I called the 877 number and was told that my children are no longer enrolled in any program.

9. DCFS should consider putting a YouthCare staff member in the DCFS Advocacy office.

10. When will staff of YouthCare be housed in DCFS offices?

11. How long from when an enrollee receives a denial can a service be appealed?