ILLINOIS DEPARTMENT OF Healthcare and Family Services

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REQUEST FOR QUALIFICATIONS (RFQ)

Care Coordination and Support Organizations (CCSOs)

RFQ Title:	CCSO Proposals
Geographic Areas:	DSA 3: Jefferson, Franklin, Hamilton, White, Saline, Gallatin, Pope, and Hardin Counties DSA 7: Scott, Morgan, Cass, Mason, Menard, Logan, Sangamon, and Christian Counties DSA 9: Champaign, Vermilion, Douglas, Edgar, Coles, Cumberland, and Clark Counties DSA 10: Kankakee, Ford, and Iroquois Counties DSA 14: Rock Island, Mercer, Henderson, Warren, and Knox Counties DSA 16: Jo Daviess, Carroll, Stephenson, Winnebago, and Ogle Counties DSA 17: Boone and McHenry Counties DSA 23: Evanston and all or parts of Northfield, Maine, New Trier, and Niles Townships (see Appendix C for zip code breakdowns) DSA 28: West Central Chicago (see Appendix C for zip code breakdowns) DSA 29: East Central Chicago (see Appendix C for zip code breakdowns) DSA 31: Southeast Chicago (see Appendix C for zip code breakdowns)
Target Implementation Date:	May 1, 2022
Application Due Date:	5:00 PM Friday, November 5, 2021
Deliver Applications via Email to:	HFS.Pathways@illinois.gov

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SECTION 1 – DEFINITIONS

Administrative Case Review (ACR): A review conducted by a designated DCFS Administrator pursuant to 89 Ill. Admin. Code 316 and open to the participation of the parent.

Admission, Discharge, and Transfer (ADT) System: A statewide data exchange platform that holds customer information and shares it with connected Illinois Medical Assistance Program providers and MCOs in a timely and secure manner. The first phase of the platform allowed for admission, discharge, and transfer alerts to be shared with providers whose patients visit a hospital or emergency department.

Background Check: As defined by DCFS, this includes, but is not limited to, a check of the Child Abuse and Neglect Tracking System (CANTS), the Illinois Sex Offender Registry (ISOR), and a fingerprint check by the Illinois State Police and the Federal Bureau of Investigation. All checks shall be done in accordance with DCFS requirements and shall adhere to all standards as set forth in DCFS rules, regulations, procedures, and protocols.

Care Coordination and Support (CCS): An evidence-informed, structured approach to care coordination that adheres to required procedures for child and family engagement, individualized care planning, identifying and utilizing strengths and natural supports while monitoring progress and fidelity to the required process.

Care Coordination and Support Organization (CCSO): Provider-based organizations qualified by the Department to serve as localized, accountable hubs with responsibilities for delivering Mobile Crisis Response and care coordination to eligible customers within a Designated Service Area.

Children's Mental Health Act of 2003: An Illinois statute that required HFS to implement the screening and assessment of children prior to any Medicaid-funded admission to an inpatient hospital for psychiatric services, pursuant to subsection (a) of Section 5-5.23 of the Illinois Public Aid Code [405 ILCS 49/1 et seq. and 305 ILCS 5/5-5.23].

Community-Based Behavioral Services (CBS) Handbook: A manual for providers of community-based behavioral health services that defines the policies, procedures, and service guidelines providers must adhere to in order to receive reimbursement from the Department. The CBS Handbook can be found on the HFS website: https://www2.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter200.aspx.

Comprehensive Community-Based Youth Services (CCBYS): A program authorized by the Children and Family Services Act (20 ILCS 505/17) administered by DHS to provide services and support to help children ages 11-17 years old who are at risk for involvement in the child welfare or juvenile justice system.

Contact Attempt: A minimum of three (3) documented and varied, either by contact method, time, or day, attempts to contact or coordinate contact with the child and family. This may include outreach to the family by telephone (including leaving a voicemail when possible), email, text messaging, in-person, or any other form of communication based upon the needs and preferences of the family.

Contiguous Counties: Counties in neighboring states immediately adjacent to Illinois.

Continuous Quality Improvement (CQI): A process whereby the goal is to design, develop and implement a system of services that is effective and efficient and continues to improve the quality of the overall system.

Crisis and Referral Entry Service (CARES): The single point of entry to the statewide Mobile Crisis Response system that provides intake, screening, eligibility, and referral services for individuals in mental health crisis requiring referral to the most appropriate program or resource.

Crisis Prevention Plan: A proactive plan prepared with individuals who are at high risk of experiencing a behavioral health crisis. The Crisis Prevention Plan focuses on helping prevent future crises from occurring by identifying triggers, warning signs, and strategies and steps to take to de-escalate potential crisis situations.

Crisis Safety Plan: An individualized plan prepared with individuals who have experienced or are at high risk of experiencing a behavioral health crisis. The Crisis Safety Plan includes components that help the individual, family, and all others involved with the individual to know what to do and whom to contact if a crisis situation occurs.

Caregiver: An individual age 18 and older who has significant responsibility for the direct care, protection, and supervision of a minor or an adult with a diagnosed disability or other chronic condition.

Child and Family Team (CFT): A group of individuals responsible for the development, implementation, and monitoring of a unified strengths-based service plan that engages and involves the child and family.

Cultural Humility: A lifelong process of self-reflection and self-critique whereby individuals learn about others' cultures as well as examining their own beliefs and cultural identities (National Institutes of Health). Training on Cultural Humility is available through PATH.

Customer: An individual eligible for the services outlined within this RFQ.

Days: Refers to calendar days unless otherwise stated.

DCFS: The Illinois Department of Children and Family Services.

DCFS Intensive Placement Stabilization (IPS) program: A statewide network of DCFS-funded, community-based providers responsible for placement stabilization services to a targeted group of children under DCFS custody or guardianship and in foster care.

DCFS Youth in Care: A child for whom DCFS has temporary protective custody, custody, or guardianship via court order, or a child whose parent(s) signed a surrender of parental rights to or voluntary placement agreement with DCFS.

DCFS Case Manager: The Case Manager assigned by DCFS to oversee child welfare services for the Youth in Care. The DCFS Case Manager may be an employee of DCFS or an employee of a Purchase of Service agency under contract with DCFS.

Designated Service Area (DSA): The geographic region of the State in which a provider is designated as the entity accountable for delivering services as outlined in this RFQ, including responding to all crisis referrals for eligible customers.

DHS-DMH: The Illinois Department of Human Services, Division of Mental Health.

DJJ: The Illinois Department of Juvenile Justice.

DPH: The Illinois Department of Public Health.

Family Driven Care: A set of values and principles for providing services and supports to individuals and their families involved with child-serving systems. The driving philosophy of Family Driven Care is the idea that families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. Refer to: www.ffcmh.org/family-driven-definition.

Formal Supports: Paid professionals who work with children and families, such as service providers or teachers.

Family Support Program (FSP): A program administered by HFS that provides funding for intensive community-based mental health services or residential treatment for children and youth who meet specific eligibility criteria as defined in 89 Ill. Admin. Code 139.

FSP Alternative Community Services: Refers to FSP Therapeutic Support Services and FSP Family Support Services as defined in 89 Ill. Admin. Code 139.

FSP Coordinator: An individual employed by a CCSO who has primary responsibility for providing case management and service coordination to an individual enrolled in the FSP or SFSP programs.

FSP Youth: A youth enrolled in the FSP Program.

Guardian: Any of the following: the court-appointed guardian of the person under the Probate Act of 1975 [755 ILCS 5/1-1 et seq.]; a temporary custodian or guardian of a child appointed by an Illinois juvenile court or pursuant to the Juvenile Court Act of 1987 [705 ILCS 405/1-1 et seq.]; or a legally appointed guardian or custodian or other party granted legal responsibility for an individual.

Grievance: An expression of dissatisfaction by a customer, including complaints and requests for disenrollment or service discharge, about any matter other than a matter that is properly the subject of an appeal.

HFS or the Department: The Illinois Department of Healthcare and Family Services.

HFS Social Services: The eligibility segment of the Illinois Recipient Database that is used to record the enrollment status of all SASS enrolled children.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Federal Public Law 104-191 and the Federal Regulations codified at 45 CFR Parts 160, 162, and 164, including all amendments thereto.

High-Fidelity Wraparound (HFW): The evidence-based, nationally recognized model of Wraparound that adheres to the fidelity standards maintained by National Wraparound Initiative.

Home MCR Agency: The CCSO, or its approved MCR partner, that is accountable for serving customers in behavioral health crisis who reside in or whose home address falls within the provider's DSA.

Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS): A comprehensive, multi-purpose tool that provides a standardized, modular framework for assessing the global needs and strengths of individuals who require mental health treatment in Illinois.

Illinois Medicaid Crisis Assessment Tool (IM-CAT): A screening tool approved by the Department for use in the delivery of Mobile Crisis Response services. The IM-CAT is composed of a subset of items from the IM+CANS tool and is used as part of the crisis assessment to recommend whether a customer can be stabilized in the community or a higher level of care may be needed.

Individual Support Services (ISS): Habilitative activities, services and goods not otherwise covered under the Illinois Medical Assistance Program that serve as adjunct supports to the therapeutic interventions and supports for customers. ISS are intended to promote health, wellness and behavioral health stability through community stabilization and family stability. ISS are covered services for Pathways Youth.

Interagency Clinical Team (ICT): The interagency clinical team established by intergovernmental agreement between the various state agencies responsible for the Specialized Family Support Program (SFSP), as required by the Custody Relinquishment Prevention Act (20 ILCS 540/1 et seq.).

ISBE: The Illinois State Board of Education.

Licensed Practitioner of the Healing Arts (LPHA): An individual who meets the qualifications outlined at 89 Ill. Admin. Code 140.453(b)(3).

Managed Care Organization (MCO): A term used to describe an entity that meets the definition of a Managed Care Organization, as defined in 42 CFR 438.2, or a Managed Care Community Network, as defined in 89 Ill. Admin. Code 143, and that is contracted by the Department to provide care management to customers enrolled in HFS administered healthcare programs.

Medicaid: For the purposes of this RFQ, describes the fully array of Medical Assistance Programs administered by the Department pursuant to the Public Aid Code [305 ILCS 5/1-1 et seq.].

Mental Health Professional (MHP): An individual who meets the qualifications outlined at 89 Ill. Admin. Code 140.453(b)(5).

Mobile Crisis Response: An intervention available to respond urgently to a customer who is experiencing a behavioral health crisis, consistent with 89 Ill. Admin. Code 140.453 and the CBS Handbook.

Natural Supports: Individuals or organizations in the child and family's own community, kinship, social, or spiritual networks, such as extended family members, neighbors, friends, coaches, religious leaders, and so forth.

Pathways to Success: A program for Medicaid enrolled children under the age of 21 in Illinois who have complex behavioral health needs requiring intensive services that provides access to an evidence-informed model of intensive care coordination and additional home and community-based services.

Pathways Youth: A child enrolled in the Pathways to Success program.

Provider Assistance and Training Hub (PATH): A Medicaid-based training and technical assistance center funded by HFS and administered by the University of Illinois' Office of Medicaid Innovation (OMI), with content provided by various parts of the University system, including community-based behavioral services content from the University of Illinois at Urbana Champaign's School of Social Work.

Psychiatric Lockout: A situation that occurs when a parent or guardian refuses to accept a youth back home, or find suitable other habilitation arrangements following the youth's inpatient psychiatric hospitalization stay, resulting in the youth remaining at the inpatient facility beyond medical necessity with no clear path for the provider of inpatient psychiatric hospitalization services to achieve a successful discharge.

Qualified Mental Health Professional (QMHP): An individual who meets the qualifications outlined at 89 Ill. Admin. Code 140.453(b)(4).

Rehabilitative Services Associate (RSA): An individual who meets the qualifications outlined at 89 Ill. Admin. Code 140.453(b)(6).

Residential Admissions Packet (RAP): The standardized set of clinical documentation, as defined by the Department, utilized for FSP Youth seeking admission into a residential facility. The RAP is prepared by FSP Coordinators and submitted to HFS-contracted FSP network residential facilities for review to determine if the FSP Youth is clinically appropriate for admission to the facility.

Responding MCR Agency: The CCSO, or its approved MCR partner, that is accountable for providing crisis response services for or within a particular DSA based upon where the customer is physically located, as determined by CARES.

Screening, Assessment, and Support Services (SASS): A multi-agency crisis response and intervention program administered pursuant to 59 Ill. Admin. Code 131. SASS screens and assesses eligible children in psychiatric crisis and provides short-term follow-up services and linkage to ongoing community mental health services. In the instance that children require inpatient psychiatric care, SASS provides transitional support back into the community.

SFSP Assessment Report: A written document developed as the primary output of an SFSP Youth's enrollment in the SFSP that is submitted for review by the Interagency Clinical Team (ICT) prior to the SFSP Youth's completion of the SFSP. The SFSP Assessment Report is reviewed and approved by an LPHA and contains the administrative and clinical information necessary to make a recommendation to the ICT regarding ongoing treatment for the SFSP Youth.

SFSP Youth: A Youth at Risk of Custody Relinquishment, referred to CARES, and determined eligible for the Specialized Family Support Program, established pursuant to the Custody Relinquishment Prevention Act [20 ILCS 540/1 et seq.].

Specialized Family Support Program (SFSP): A multi-departmental, 90-day assessment program, established through intergovernmental agreement pursuant to the Custody Relinquishment Prevention Act [20 ILCS 540/1 et seq.], which requires HFS, DCFS, DHS, DJJ, DPH, and ISBE to establish protocols for Youth at Risk of Custody Relinquishment to receive services through the appropriate State child-serving agency.

Strengths, Needs, and Cultural Discovery (SNCD): A component of the Wraparound process in which a Care Coordinator engages in conversation with a child and family to learn about the strengths, assets, and resources the child and family possess, as well as the family's culture and needs as seen from the family's perspective. The SNCD results in a written narrative, also commonly referred to as the family story, and is used to help inform CFT members about the family's journey and goals.

Successful Contact: An oral communication (telephonic, video, or in-person) between the CCSO and a Pathways Youth and/or their parent/guardian for purposes of conducting CCS activities. Written communication (emails, texting) is not considered a Successful Contact.

System of Care (SOC): A philosophy that provides an organizing framework and set of values for providing services and supports to children and families. A System of Care is a broad flexible array of effective services and supports for a defined multi-system involved population, which is organized into a coordinated network; integrates care planning and care management across multiple levels; is culturally and linguistically competent; builds meaningful partnerships with families and with youth at service delivery, management and policy levels; has supportive management and policy infrastructure; and, is data-driven. (Pires, Building Systems of Care: A Primer, 2010).

Therapeutic Support Services (TSS): Adjunct therapeutic modalities not otherwise covered under the Illinois Medical Assistance Program that support individualized goals as part of the customer's service plan. TSS are designed to help participants find a form of expression beyond words or traditional therapies to reduce anxiety, aggression, and other clinical issues while enhancing service engagement through direct activity and stimulation. TSS are covered services for Pathways Youth.

Trauma-Informed: A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in children, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization (SAMHSA, 2014).

Wraparound: A strengths-based, individualized care planning process for children, youth, and families that occurs in a team setting and that proceeds through four phases. The Wraparound process adheres to a philosophical set of principles, as outlined by the National Wraparound Initiative.

WrapStat: A data management system used to facilitate and help monitor fidelity to Wraparound.

Youth at Risk of Custody Relinquishment: A youth whose parents or guardians refuse to take the youth home from a hospital or similar treatment facility because the parents or guardians have a reasonable belief that the youth will harm himself or herself or other family members upon the youth's return home, and there is no evidence of abuse or neglect.

Youth-Guided Care: Youth Guided means that young people have the right to be empowered, educated, and given a decision making role in the care of their own lives as well as the policies and procedures governing care for all youth in the community, state, tribe, territory and nation. (This definition of youth guided was developed originally by Youth M.O.V.E National and the Substance Abuse and Mental Health Services Administration (2011).

SECTION 2 – PURPOSE AND BACKGROUND

Purpose

The Illinois Department of Healthcare and Family Services (HFS), in collaboration with its partners at the Department of Children and Family Services (DCFS), the Department of Human Services – Division of Mental Health (DHS-DMH) and the HealthChoice Illinois Managed Care Organizations (MCOs), is issuing a Request for Qualifications (RFQ) to solicit proposed plans from interested providers to be qualified as Care Coordination and Support Organizations (CCSOs) for the following identified Designated Service Areas (DSAs): DSA 3, DSA 7, DSA 9, DSA 10, DSA 14, DSA 16, DSA 17, DSA 23, DSA 28, DSA 29, and DSA 31.

CCSOs play a critical role in the community behavioral health service delivery system. CCSOs will serve as local hubs of accountability, responsible for delivering care coordination, Mobile Crisis Response, and facilitating access to other support services to eligible customers across a range of HFS-administered programs within a Designated Service Area (DSA). CCSOs operate consistent with the core values and guiding principles of Systems of Care, ensuring that services are delivered in a manner that is family-driven, youth-guided, individualized, community-based, trauma-informed, culturally and linguistically responsive, and data driven.

Providers selected through this application process will be deemed qualified, and subsequently enrolled in the HFS IMPACT Provider Enrollment system, as a CCSO for a specific DSA. CCSOs will be responsible for providing:

- Care consistent with Systems of Care and Family Driven Care principles;
- Customer and family engagement;
- Service planning and treatment focused on service delivery in the home and other community-based settings;
- Coordination across the systems in which customers are involved;
- Care Coordination and Support (CCS) services consistent with the values, principles, and processes of Wraparound and HFS' CCS fidelity model for children and families enrolled in the Pathways to Success program;
- For SASS eligible children and Medicaid enrolled children and adults:
    - Mobile Crisis Response (MCR) services, inclusive of rapid response pre-admission psychiatric hospitalization screenings;
    - Crisis intervention and stabilization services;
    - Discharge planning during a psychiatric hospitalization to ensure continuity of care following the customer's return to the community;
    - Short-term post-crisis care coordination;
    - Referral and linkage to post-crisis services.
- Case management and support to children and families enrolled in the Family Support Program (FSP) and the Specialized Family Support Program (SFSP); and
- Administration and oversight of the usage of alternative community services for specialized services under the Pathways, FSP, and SFSP; and,
- Transition planning and coordination to other service systems and programs.

Providers selected to serve as a CCSO will be held responsible and accountable for delivering the program and service requirements outlined within this RFQ, as well as for complying with all subsequent Provider Handbooks, policies, or procedures, to all eligible customers within their DSA. This includes MCR coverage of those counties contiguous to Illinois for which the CCSO is responsible (see Attachment D).

Background
The Children's Mental Health Act of 2003 required HFS to develop protocols for implementing the screening and assessment of children prior to any admission to an inpatient hospital for publicly funded psychiatric services. In July 2004, HFS, DCFS, and DHS-DMH established the Screening, Assessment, and Support Services (SASS) program, creating a single, statewide infrastructure to serve children experiencing a mental health crisis whose care requires public funding from one of the three agencies. The three Departments simultaneously established the Crisis and Referral Entry Service (CARES) hotline, which serves as a single point of entry into the statewide crisis system, adjudicating crisis referrals and dispatching local crisis workers, when appropriate.

With the expansion of mandatory managed care to children and families in July 2014, HFS took steps to ensure the maintenance of the statewide crisis infrastructure for children by establishing specific children's behavioral health requirements within the MCO contracts, essentially mimicking core SASS program requirements for MCO enrolled children experiencing a behavioral health crisis. This is commonly referred to as the MCO Mobile Crisis Response system.

In August 2018, HFS introduced the standalone service of Mobile Crisis Response to the Illinois Medicaid State Plan and with that, expanded access to the statewide crisis infrastructure first established through CARES and the SASS agencies to Medicaid-eligible adults over the age of 21.

Illinois' statewide crisis system was built upon the core values and principles of Systems of Care. For nearly three decades, the System of Care approach has served as the major federally supported framework for serving children with behavioral health needs. This approach, particularly when combined with evidence-informed intensive care coordination models such as Wraparound, has been shown repeatedly to improve outcomes and reduce per capita costs.

Building upon these lessons learned and the statewide infrastructure established through the crisis system, HFS has established a new program, Pathways to Success (Pathways). Pathways introduces an enhanced care coordination model and additional home and community-based services for Medicaid enrolled children with complex behavioral health needs that require intensive services. The goals of Pathways to Success, supported by strong implementation from CCSOs, are to: improve access to crisis supports and to appropriate home and community-based services and supports for children with complex behavioral health challenges; closely coordinate care across programs and systems; reduce unnecessary use of inpatient psychiatric hospitalization, residential treatment and emergency rooms; and improve clinical and functional outcomes for children and quality and cost outcomes for the system.

SECTION 3 – ELIGIBLE APPLICANTS

To be considered an eligible applicant pursuant to this RFQ, providers must commit to meeting all the following criteria prior to delivering CCSO services:

1. Establish a physical site within one of the Illinois counties within the DSA the applicant is applying to serve;

2. Enroll as a provider in the Illinois Medical Assistance Program pursuant to 89 Ill. Admin. Code 140 Subpart B, as either:

    a. A certified Community Mental Health Center (CMHC) pursuant to 59 Ill. Admin. Code 132; or

    b. A certified Behavioral Health Clinic (BHC) pursuant to 89 Ill. Admin. Code 140.499 and 89 Ill. Admin. Code 140.Table O.

3. Obtain a Program Approval for Crisis Services pursuant to 89 Ill. Admin. Code 140.Table N.

Any partner organizations the applicant proposes utilizing for the delivery of MCR services and responsibilities (consistent with Section 4, item 1.9) must also commit to meeting these requirements.

SECTION 4 – SERVICE REQUIREMENTS

1. **General Infrastructure and Service Requirements.**

1.1. CCSOs shall operate consistent with System of Care values and principles as well as the principles of Family Driven Care: https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

1.2. CCSOs shall ensure compliance with: the Children's Mental Health Act; 59 Ill. Admin. Code 131; 89 Ill. Admin. Code 139; 89 Ill. Admin Code 140.453; and, all applicable local, state, and federal laws, rules, and regulations as well as all HFS policies and handbooks governing the administration of any services provided.

1.3. The CCSO shall have the capacity to serve, on a no-decline basis, all customers who present or reside in the CCSO's DSA and who are determined by HFS as eligible for Pathways to Success, the SASS program, FSP, SFSP, or Mobile Crisis Response services, including responding to all eligible Illinois customers presenting in crisis in a contiguous county to Illinois for which the CCSO is responsible.

1.4. CCSOs shall negotiate in good faith and enter into an agreement with all HealthChoice Illinois MCOs operating within the CCSO's DSA for the provision of CCS and MCR services and responsibilities, as outlined in this RFQ.

1.5. The CCSO shall enroll with HFS as an All Kids Application Agent. The CCSO must provide assistance to families, whose child is not covered by one of the full benefit medical assistance programs administered by HFS, in the completion and submission of applications for medical benefits.

1.6. CCSOs shall ensure that services are provided in a culturally humble manner and shall ensure that staff are trained annually in topics that enhance their cultural proficiency.

1.7. CCSOs shall have a mechanism for interpreting sign and other languages, including offering translation services, to communicate with customers, when needed.

1.8. CCSOs must establish and maintain the following operational plans. Operational plans must be available for review and approval by the Department or its designee upon request.

1.8.1. Disaster Recovery Plan: The Disaster Recovery Plan shall detail the steps the CCSO will take in the event of an outage or failure of HFS' or CCSO's data, communications system(s), or technical support system(s), and the steps the CCSO shall take to notify and continue to serve customers in the event the CCSO's place of business experiences a significant event (e.g., pandemic, fire, flood, electrical systems, act of God) that forces the CCSO to relocate on a temporary or permanent basis. The Disaster Recovery Plan should note any particular changes to operations the CCSO has implemented or intends to monitor and implement related to the COVID-19 public health emergency.

1.8.2. Program Plan: The Program Plan shall establish and maintain the policies and procedures to be used by staff in the administration of the programs and services required pursuant to this RFQ.

1.8.3. Continuous Quality Improvement (CQI) Plan: The CQI Plan shall demonstrate the ability to internally assess the operation's strengths and weaknesses, and implement required corrections, with the ability to track responsiveness to referrals, particularly the timeliness of response to crisis referrals from CARES. The CCSOs shall establish mechanisms to involve families and customers directly in the CQI process and shall integrate their feedback into the CCSO's Plan.

1.8.4. Community Outreach and Engagement Plan: The Community Outreach and Engagement Plan shall detail how the CCSO will establish and maintain collaborative working relationships with key stakeholders from across the child-serving systems located in the CCSO's DSA. Key stakeholders include, but are not limited to: schools, law enforcement, jails, local courts, hospitals, 708 boards, social service organizations, service providers, local DCFS offices, and the local CCBYS provider. The Community Outreach and Engagement Plan shall also outline the CCSO's planned efforts to educate stakeholders in the DSA about the services and programs offered by the CCSO.

1.8.5. Staffing and Training Plan: The Staffing and Training Plan shall outline the CCSO's plans for recruiting, hiring, and maintaining appropriately credentialed staff who are reflective and representative of the diversity of the communities served by the CCSO. The Staffing and Training Plan shall also outline the CCSO's plan for appropriately training staff consistent with their role and in line with the Department's training requirements.

1.9. CCSOs shall be available 365 days per year, 24 hours per day to accept all crisis referrals from CARES on a no-decline basis within 30 minutes. CCSOs may enter into partnerships with other qualified provider organizations for the delivery and coverage of Mobile Crisis Response services and responsibilities. Any such partnerships must be proposed to HFS in writing a minimum of 30 days prior to the proposed effective date and approved by HFS prior to the partnership taking effect.

1.10. Health Information Technology (HIT) Requirements. CCSOs shall:

1.10.1. Ensure access to a computer with High Speed/Broadband Internet and email access for program staff.

1.10.2. Complete all data collection, entry, and reporting as required by HFS or the MCOs, including interfacing with all HFS required systems, including but not limited to: CRS, the IM+CANS Provider Portal, ADT, and WrapStat.

1.10.3. Establish a communications system capable of receiving incoming crisis referrals 24 hours a day within 30 minutes of CARES initiating the referral. The CCSO shall provide CARES with a number for its Administrative or Executive Staff that will be answered 24 hours a day, seven days a week, every day of the year.

1.10.4. Within three (3) years after qualification as a CCSO, have an Electronic Health Record (EHR) capable of tracking referrals and care coordination activities across the various programs and service lines delivered by the CCSO.

1.10.5. Negotiate in good faith with HFS and its designee(s) and enter into any contracts or other agreements necessary to facilitate access to data systems or for the sharing of data across organizations.

1.11. Conflict of Interest Requirements.

1.11.1. CCSOs may not enroll to provide other home and community-based services covered under a 1915(i) state plan benefit, unless HFS has determined and given written approval indicating the CCSO is the sole provider willing and qualified to provide such services within the CCSO's DSA and that the CCSO has established sufficient separations and independence between its direct service delivery and CCS services to ensure that conflict of interest standards are met.

1.11.2. CCSOs are expected to maintain sufficient separation between their CCSO duties and any other Medicaid activities that the provider may operate or engage in to ensure that access to CCS and other Medicaid services are independent.

1.11.3. If the CCSO has a legal relationship with a hospital, the CCSO must demonstrate and maintain sufficient separation in governance, clinical functions, and staff duties between the hospital and CCSO.

1.11.3.1. Applicants must disclose any existing legal relationships with a hospital as part of the applicant's response to this RFQ (see Section 9 – Application Content and Requirements).

1.11.3.2. CCSOs must provide written notice to HFS a minimum of 30 days prior to entering any new legal relationship with a hospital. The written notice must include documentation that demonstrates how the CCSO will maintain separation between the hospital and CCSO lines of business.

1.11.4. CCSOs must develop policies and procedures to ensure that CCS services are not delivered by staff who are:

1.11.4.1. Related by blood or marriage to the customer, or any paid caregiver of the customer;

1.11.4.2. Financially responsible for the customer;

1.11.4.3. Empowered to make financial or health-related decisions on behalf of the customer; or

1.11.4.4. Responsible for providing other Medicaid community behavioral health or home and community-based services, except that CCS staff may participate in the delivery of Mobile Crisis Response services.

1.11.5. CCSOs must establish and communicate processes that clearly outline how customers can request a different Care Coordinator or Case Manager at any time.

1.11.6. CCSOs must establish and maintain an internal grievance process specific to customers enrolled in Pathways to Success for tracking and resolving customer complaints related to the CCSO, its staff, or any service providers or supports involved in the customer's care.

1.12. CCSOs shall establish a Community Stakeholder Council within the first six months of operation, comprised of customers served and community stakeholders from across the DSA, whose purpose is to advise and provide feedback to the CCSO on the implementation of its services. CCSOs shall provide information on the meeting schedule and location/call-in information to HFS and all MCOs at least 14 days in advance of the scheduled council meeting. The Community Stakeholder Council shall:

1.12.1. Be open to participation from all stakeholders;

1.12.2. Include customer and family representation;

1.12.3. Have a customer or family representative serving as a co-chair of the council;

1.12.4. Be reflective and representative of the cultural, ethnic, and geographic composition of the DSA; and,

1.12.5. Meet on a standardized meeting schedule that meets no less frequently than once every quarter.

1.13. CCSOs shall establish a Community Resource Directory within the first six months of operation that is accessible on-line and minimally reviewed and updated every six months. With approval from HFS, CCSOs may partner with other community organizations in the establishment and maintenance of the Community Resource Directory to prevent duplication of effort within the local community.

1.14. Prior to receiving referrals for CCS or MCR services, CCSOs must pass a Readiness Review, conducted by HFS, its MCOs, and/or its designee(s), indicating to HFS' satisfaction the CCSO is ready to provide services to customers in a safe and efficient manner.

1.15. CCSOs must provide HFS and all MCOs with a minimum of 90 days written notice in the instance that the provider is unable or unwilling to continue serving as a CCSO within the DSA.

1.15.1. No later than thirty (30) days after the date of notice of the need to transition CCSO duties, CCSOs must submit to HFS and all MCOs for review and approval a plan for transitioning all services and responsibilities, including the CCSO's plan for how it will continue uninterrupted services throughout the transition period.

1.16. CCSOs must agree to work in a collaborative manner with HFS, other CCSOs, and other service providers to ensure the seamless transition of services, crisis accountability, and other responsibilities outlined in this RFQ during CCSO implementation and upon notice of any programmatic or provider changes impacting coverage within the DSA.

2. **Care Coordination and Support (CCS) Service Requirements.**

2.1. CCSOs shall use a multifaceted approach to locate, engage, and educate Pathways Youth and their families. This includes employing various methods of contact (phone, text, email, letters, in-person) as appropriate based upon the child and family's needs and preferences, and, when possible, collaborating with other service providers, MCOs, and HFS to gather up-to-date contact information. CCSOs shall minimally verify and update, as needed, the contact information and preferences for each Pathways Youth and their family once every six (6) calendar months.

2.2. <u>Initial Outreach and Engagement.</u>

2.2.1. CCSOs shall complete a Successful Contact or a Contact Attempt with each referred Pathways Youth and their family within seven (7) calendar days of receiving the referral from HFS.

2.2.2. CCSOs shall educate Pathways Youth and their families about the Pathways to Success program and CCS services, including providing information on Systems of Care and the Wraparound approach to care planning.

2.2.3. CCSOs shall provide Pathways Youth and their families with a copy of the HFS-issued Pathways to Success Program Consent Form. CCSOs shall ensure that Pathways Youth and their families are informed of their right to decline enrollment in Pathways or to decline any of the recommended services available under Pathways, including CCS services. CCSOs shall inform families who decline Pathways enrollment or any of the Pathways services on the process to re-engage in the program or those services, consistent with HFS guidance.

2.2.4. During initial outreach and engagement, CCSOs must minimally make one Contact Attempt each week to facilitate the Pathways Youth's enrollment into CCS services.

2.2.5. CCSOs shall have a period of 60 days from the day of referral to engage and successfully enroll Pathways Youth into CCS services.

2.2.5.1. CCSOs shall notify HFS within five (5) business days of any referred Pathways Youth that 1) requests disenrollment from Pathways or 2) declines CCS services.

2.2.5.2. CCSOs shall notify HFS if they are unsuccessful in engaging, making contact, or otherwise completing the CCS enrollment process for any Pathways Youth 60 days after receipt of the referral from HFS.

2.2.6. A Pathways Youth's CCS effective date of enrollment shall be the latter of the day the child and their parent/guardian(s), as applicable, sign the Pathways to Success Program Consent form or the day a Successful Contact has been made.

2.3. Care Coordination Model.

2.3.1. CCSOs shall deliver CCS services at two intensity levels, consistent with the tier assigned to the Pathways Youth by HFS.

2.3.1.1. Tier 1 is known as CCS: High Fidelity Wraparound (CCSW).

2.3.1.2. Tier 2 is known as CCS: Intensive Care Coordination (CCSI).

2.3.2. CCS services shall be delivered by dedicated Care Coordinators who are designated to one tier. Care Coordinators may not have mixed tier caseloads and must be designated to serve children either in CCSW or CCSI, with the following exception:

2.3.2.1. If a sibling of a Pathways Youth assigned to CCSW is also enrolled with the CCSO, but assigned to CCSI, the sibling may be assigned to the same CCSW Care Coordinator as the sibling but be served at the CCSI tier.

2.3.3. CCSOs shall provide CCS services on a no-decline basis to all Pathways Youth residing within the CCSO's DSA and who are referred to the CCSO by HFS.

2.3.4. CCSOs may not disenroll or discharge a Pathways Youth from CCS services unless the family has declined CCS services, declined Pathways program enrollment, or unless the CCSO has received express written verification from HFS that the child has been disenrolled from the Pathways program.

2.3.5. CCS services shall be delivered consistent with the values, principles, and processes of Wraparound and in line with the frequency and intensity of activities as defined in HFS' fidelity model for each CCS tier.

2.4. CCS Caseloads.

2.4.1. CCSW Care Coordinators shall not exceed an average Care Coordinator to Pathways Youth caseload of 1:10 with no more than 12 youth on any CCSW Care Coordinator's caseload at one time.

2.4.2. CCSI Care Coordinators shall not exceed an average Care Coordinator to Pathways Youth caseload of 1:25 with no more than 30 youth on their caseload at one time.

2.4.3. Supervisors of Care Coordinators shall not exceed an average Supervisor to Care Coordinator caseload of 1:8. with no more than 10 Care Coordinators on their caseload at one time.

2.4.4. CCSOs shall monitor Care Coordinator caseloads monthly to ensure caseloads are balanced consistent with the caseload ratios for their assigned tier.

2.5. Crisis Prevention and Safety Planning. Care Coordinators shall develop an initial, or review and update as needed an existing, Crisis Prevention Plan and Crisis Safety Plan for all children receiving CCS within ten (10) days of enrollment. Crisis Prevention Plans and Crisis Safety Plans shall be reviewed and updated, as needed, minimally at each Child and Family Team (CFT) meeting.

2.6. Strengths, Needs, and Cultural Discovery (SNCD). Care Coordinators shall complete the initial SNCD process for all children receiving CCS within 21 days of enrollment. The SNCD shall be updated, as needed, throughout a Pathways Youth's enrollment in CCS services to reflect additional information learned about the family.

2.7. Child and Family Teams. Care Coordinators shall convene a unique CFT for each child receiving CCS services for the purposes of identifying the needs and strengths of the child and family, service planning, coordination of care, and regular review of the child and family's progress toward meeting their goals.

2.7.1. The CFT shall include the child, the family, the Care Coordinator, and other formal and natural supports involved in the child and family's lives. The child and family shall have full choice in determining the members of their CFT. CCSOs shall work with the child and family to identify the most appropriate participants to join the CFT.

2.7.1.1. For DCFS Youth in Care, the CFT shall include the child's DCFS Case Manager and any other DCFS staff or foster parents, as approved by the DCFS Guardian. DCFS and assigned DCFS Case Manager retain decision making authority in the CFT process as the guardian of DCFS Youth in Care.

2.7.1.2. For children enrolled in Managed Care, the CFT shall include the designated MCO Care Manager.

2.7.1.3. The CFT shall include a member of the MCR team for children enrolled in SASS or receiving MCO MCR services.

2.7.2. CCSOs shall be solely responsible for facilitating the CFT process.

2.7.3. CCSOs shall conduct CFT meetings according to the following timeframes:

2.7.3.1. An initial CFT meeting shall be held within 30 days of the child's enrollment in CCS services.

2.7.3.2. An emergency CFT meeting shall be held within 48 hours of a Mobile Crisis Response event occurring, regardless of the disposition of the MCR event.

2.7.3.3. CFT meetings shall minimally be held every 30 days for children receiving CCSW.

2.7.3.4. CFT meetings shall minimally be held every 60 days for children receiving CCSI.

2.8. Strengths Based Service Planning.

2.8.1. CCSOs will work with children, their parent/guardian, and CFT members, as appropriate, to develop an individualized, strengths-based service plan using the IM+CANS.

2.8.2. CCSOs will serve as the lead entity responsible for ensuring the IM+CANS for Pathways Youth is reviewed and updated consistent with HFS requirements, including collaborating and coordinating with all other service providers to ensure the appropriate documentation and authorization by an LPHA of recommended services.

2.8.3. The IM+CANS shall be reviewed and updated, as needed, at each CFT meeting.

2.8.4. CCSOs will ensure that children and their parent/guardian have full, informed choice of the services, providers, and settings from which they can receive recommended services. CCSOs shall maintain documentation of the affirmative choices made by children and families regarding service delivery.

2.8.5. CCSOs will work in collaboration with the Pathways Youth's MCO Care Manager, as applicable, to identify in-network providers of recommended services.

2.8.6. CCSOs will obtain signatures on the IM+CANS from the child, their parent/guardian, and all individuals and providers responsible for service implementation following each significant update to the IM+CANS. CCSOs shall provide a copy of the IM+CANS to the family and all service providers identified on the IM+CANS.

2.8.7. CCSOs will be responsible for completing and maintaining the IM+CANS for each Pathways Youth residing within their DSA, regardless of whether the child and parent/guardian are engaged in CCS services. The IM+CANS for Pathways Youth not engaged in CCS services shall be reviewed and updated no less frequently than every 180 days.

2.8.8. CCSOs will be responsible for uploading data for Pathways Youth into the HFS IM+CANS Provider Portal.

2.9. CCSOs will minimally complete one Successful Contact per week with each Pathways Youth and parent/guardian receiving CCS services. For children receiving CCSW, a minimum of two (2) Successful Contacts per month must be conducted in-person. For children receiving CCSI, a minimum of one (1) Successful Contact per month must be conducted in-person. CFT meetings will count as one of the Successful Contacts.

2.10. CCSOs shall notify HFS anytime the CCSO has been unable to make Successful Contact with a Pathways Youth or their parent/guardian for a period of more than 90 days.

3. **MCR Requirements.**

3.1. CARES Interface.

3.1.1. CCSOs shall accept all referrals on a no-decline basis from CARES within 30 minutes of CARES engaging the CCSO's communication system to complete a referral for crisis services.

3.1.2. CCSOs shall establish protocols and procedures for accepting all information from CARES necessary to complete the crisis screening event on the first live contact.

3.1.3. CCSOs shall supply CARES with the necessary primary, secondary, and tertiary contact numbers for facilitating crisis referrals. The tertiary contact shall be a member of the CCSO's Administrative or Executive Staff with responsibility for oversight or management of MCR services. The CCSO shall notify CARES of any changes to its contact numbers prospective to any known changes or updates or as soon as possible in the event of an emergency.

3.2. MCR Crisis Screening Event.

3.2.1. The CCSO shall conduct a face-to-face assessment and screening for every customer who has been referred by CARES within 90 minutes of receiving the referral from CARES. Whenever possible, the screening shall be conducted where the crisis is occurring. In the instance the screening occurs at a location other than the location of crisis as reported by CARES, the CCSO must document the reason for the change in location.

3.2.2. The MCR crisis disposition shall be completed within four (4) hours after the CARES referral to the CCSO.

3.2.3. The MCR crisis screening and assessment shall minimally include the following:

3.2.3.1. Evaluation using the Illinois Medicaid Crisis Assessment Tool (IM-CAT) decision support tool;

3.2.3.2. A determination of the viability of less restrictive resources available in the community to meet the treatment needs of the customer; and,

3.2.3.3. Initiation of a Crisis Safety Plan for the customer and their family.

3.2.4. CCSOs shall include the designated Care Coordinator in the delivery of MCR services for any child receiving Care Coordination and Support (CCS) services, whenever possible.

3.2.5. In the event that the customer is identified by CARES to not be enrolled in one of the full benefit Medical Assistance Programs administered by HFS, the CCSO shall notify the customer and parent/guardian, as part of the crisis event, of the potential healthcare costs associated with receiving medical services, including the availability of funding for children under the age of 18 to purchase a limited package of medical and mental health services throughout a child's HFS Social Services special eligibility period.

3.2.6. The CCSO shall report the IM-CAT results within five (5) calendar days after completion of the screening event into the Department's web-based Crisis Reporting System (CRS).

3.2.7. If community stabilization is a clinically appropriate option, the CCSO shall deliver Crisis Intervention and provide or ensure access to Crisis Stabilization services, as defined in 89 Ill. Admin. Code 140.453, in response to the crisis as an alternative to inpatient care.

3.2.7.1. The CCSO may establish partnerships with other provider organizations within their local communities for the provision of Crisis Stabilization services.

3.2.7.2. The CCSO shall ensure access to Crisis Stabilization services as an alternative to inpatient care for all customers receiving MCR services, whenever it is deemed clinically appropriate.

3.2.8. If community stabilization is not a clinically appropriate option, the CCSOs shall facilitate the customer's admission to a psychiatric hospital or other inpatient level of care, including facilitating necessary transportation services. The CCSO shall inform the customer or, as applicable, their parent, guardian, caregiver, or residential staff about all of the available service providers and pertinent policies needed to understand and allow the involved parties to select an inpatient provider and setting that is clinically appropriate.

3.2.9. The CCSO shall give customers and their parent/guardian contact information that may be used any time during the day, evening, or night to contact the CCSO's MCR team in moments of crisis in lieu of utilizing CARES. CCSOs should educate customers and their parent/guardian regarding when to contact their Care Coordinator for help or when to utilize their CPP instead of engaging the crisis system.

3.2.10. Regardless of crisis disposition, the CCSO must follow-up with the customer and their parent/guardian, as appropriate, within 48 hours after the completion of the MCR screening event to offer support and follow-up.

3.3. Services During Inpatient Hospitalization.

3.3.1. If a customer is admitted to an inpatient psychiatric hospital, the CCSO shall maintain written documentation of its participation in the admission, initial staffing, subsequent staffing(s), discharge planning sessions, discharge staffing, and weekly contacts with the customer, their parent/guardian, DCFS Case Manager, and hospital social worker (for all weeks when a hospital staffing does not occur).

3.3.2. The CCSO shall coordinate the provision of mental health and other supportive services to the customer's parent/guardian during the course of hospitalization for the purpose of preparing the parent/guardian to support the customer following discharge.

3.3.3. Prior to the customer's discharge, the CCSO shall work with the psychiatric inpatient treatment team and the customer's MCO, as applicable, attend treatment and discharge planning meetings to ensure that specific and scheduled mental health services are in place to support the customer and their parent/guardian immediately following discharge from the hospital.

3.4. The CCSO shall complete the development or update of a Crisis Safety Plan for all customers receiving MCR services within 48 hours after the crisis screening event in the case of a customer who is community stabilized, or prior to discharge for a customer who is admitted to an inpatient level of care. The CCSO shall provide the customer and parent/guardian, as applicable, with a physical copy of the Crisis Safety Plan.

3.5. Linkage, Referral, and Service Coordination.

3.5.1. The CCSO shall determine if the customer being served is currently receiving behavioral health services from an existing service provider and link the customer back to this provider for follow-up services, as appropriate.

3.5.2. As appropriate, the CCSO shall include the customer, their parent/guardian, in all aspects of the customer's crisis intervention and mental health treatment planning.

3.5.3. The CCSOs shall provide linkages and referrals to other providers, as appropriate, and as requested by the customer or their family and shall work collaboratively with the customer's MCO Care Manager, as applicable, to identify in-network providers capable of providing necessary follow-up mental health services.

3.6. Responsibilities for Children Enrolled in the SASS Program.

3.6.1. The CCSO shall manage and maintain the HFS Social Services eligibility segment for SASS enrolled children residing in its DSA and shall request extensions from CARES when clinically appropriate.

3.6.2. The CCSO shall provide care coordination to children enrolled in the SASS program for the extent of their HFS Social Services eligibility period, either through the delivery of CCS services for Pathways Youth or through the delivery of case management services.

3.6.3. The CCSO shall coordinate the delivery of the necessary short-term intensive mental health services for community stabilization, either as an alternative to psychiatric hospitalization or following discharge from a psychiatric hospitalization, to children enrolled in the SASS program, providing referrals and linkages to local providers as necessary.

3.6.4. The CCSOs shall ensure children are linked with ongoing traditional, transitional, child, young adult, or adult mental health services prior to the exhaustion of the child's 90-day SASS eligibility period.

4. **FSP Requirements.**

4.1. The CCSO shall act as the FSP Coordination Agency for its DSA, complying with all program requirements as detailed in the 89 Ill. Admin. Code 139 and HFS-issued provider handbooks.

4.2. The CCSO shall help all families within the DSA who request assistance with preparing, submitting, and tracking applications for FSP.

4.3. The CCSO shall complete and maintain the IM+CANS for all FSP Youth whose home address is within the provider's DSA, incorporating the youth, family, and other treatment providers, as applicable, in the service planning process.

4.4. If the FSP Youth is enrolled with one of the HFS contracted MCOs, the CCSO shall connect with the MCO and request the FSP Youth be enrolled in the MCO's Care Management program if they are not already. The CCSO shall collaborate and coordinate with the MCO Care Manager in the completion of care coordination activities.

4.5. The CCSO shall provide linkages and referrals to other providers, as appropriate, for delivery of the recommended services on the FSP Youth's IM+CANS. The CCSO shall work collaboratively with the FSP Youth's MCO, as applicable, to identify in-network providers capable of providing necessary services.

4.6. The CCSO shall be responsible for coordinating and arranging the delivery of FSP Alternative Community Services, consistent with Department policies and procedures.

4.7. The CCSOs shall make direct contact (telephonic or in-person) on a weekly basis with the FSP Youth, the youth's guardian, and the youth's residential treatment provider, when applicable.

4.8. When medically necessary, the CCSO shall assist the FSP Youth and their family with accessing residential treatment, including assisting the family in completing and submitting the Residential Admissions Packet (RAP) to in-network FSP residential providers for an admissions determination.

4.9. For FSP Youth receiving residential treatment, the CCSO shall actively participate in any residential staffing and discharge planning regarding the FSP Youth. The CCSO shall coordinate the provision of mental health and other supportive services to the FSP Youth's family while the youth is receiving residential treatment to prepare the family to support the youth following discharge from residential treatment.

5. **Specialized Family Support Program Requirements.**

5.1. The CCSO shall act as the SFSP provider for its DSA, complying with all program requirements as detailed in the SFSP Provider Guide and any administrative rules, policies, or procedures issued by the Department regarding SFSP.

5.2. The CCSO shall complete an in-person crisis screening and assessment for all SFSP Youth referred to the CCSO by the CARES line within 24 hours of receiving the referral from CARES.

5.3. If the SFSP Youth is enrolled with one of the HFS contracted MCOs, the CCSO shall notify the MCO of the youth's psychiatric lockout status within one (1) business day of receiving the referral from CARES. The CCSO shall involve the MCO in the SFSP Youth's service and treatment planning, including the hospital discharge planning process.

5.4. If the CCSO serving as the Responding MCR Agency is not the SFSP Youth's Home MCR Agency, the Responding MCR Agency shall notify the Home MCR Agency of the SFSP Referral. The two CCSOs shall work collaboratively to plan for service coordination to the SFSP Youth, consistent with the requirements of the SFSP Provider Guide.

5.5. Within 72 hours of a SFSP Youth's enrollment into SFSP, the CCSO shall facilitate the completion of the standardized SFSP Multi-Agency Consent to Disclose Information and the SFSP Parent Agreement.

5.6. The CCSO shall complete, or arrange for the completion of, the IM+CANS for all SFSP Youth within 5 days of receiving the referral from CARES.

5.7. Following the completion of the SFSP screening and intake process, the CCSO shall work urgently to coordinate, and deliver as necessary, the crisis stabilization and support services necessary to stabilize the SFSP Youth in the community and resolve the immediate presenting problem(s), including developing a hospital discharge plan in collaboration with the guardian and hospital, in order to transition the SFSP Youth safely from the inpatient hospital setting to the community.

5.8. The CCSO shall coordinate the delivery of the medically necessary community mental health services, including FSP Alternative Community Services, to all SFSP Youth for whom the CCSO is the Home MCR Agency.

5.9. The CCSO shall maintain weekly contact with the SFSP Youth, guardian, and any out-of-home service provider, as applicable, throughout an SFSP Youth's eligibility period.

5.10. Within 75 days from the referral of an SFSP Youth from CARES, the CCSO shall complete and submit to the Department the SFSP Assessment Report for each SFSP Youth for whom the CCSOs is the Home MCR Agency.

5.11. In the event that the guardian of an SFSP Youth declines to participate in SFSP at the point of intake, refuses to continue to participate in the SFSP after intake, or is unwilling to accept the SFSP Youth back into the home or find a suitable alternative living arrangement for the youth, the CCSO shall take steps to discharge the SFSP Youth from SFSP and make the appropriate notifications to the DCFS Child Abuse Hotline and the Department, as outlined in the SFSP Provider Guide.

6. **Other Responsibilities Related to DCFS.**

6.1. The CCSO shall participate in case staffings as requested by DCFS staff, including Administrative Case Reviews (ACRs) and court hearings. Additionally, CCSO staff will provide written reports, upon request, for any case staffing, including an ACR or court hearing.

6.2. CCSOs shall assist DCFS Case Managers and coordinate closely with them in planning and decisions regarding services and supports for Pathways Youth who are DCFS Youth in Care.

6.3. CCSOs shall communicate regularly with DCFS Case Managers regarding the involvement of foster parents and biological parents of Pathways Youth who are DCFS Youth in Care, as applicable and appropriate to the child's needs.

6.4. For DCFS Youth in Care who experience a MCR screening event, the CCSO shall notify the child's DCFS Case Manager of the circumstance of the crisis call and its disposition within one (1) business day after the event.

6.5. For DCFS Youth in Care age nine (9) and younger who experience a MCR screening event, the CCSOs shall fax the completed IM-CAT to the DCFS Clinical Division at the fax number designated by DCFS. This requirement must be completed within 72 hours after the MCR screening occurs.

6.6. When the stability of a DCFS Youth in Care's placement is at risk, the CCSO shall provide linkages and referrals to DCFS Intensive Placement Stabilization (IPS) providers via the DCFS Case Manager.

6.7. CCSOs shall comply with all program requirements specifically related to DCFS Youth in Care as included in any HFS-issued provider handbooks, policy notices, and memos regarding CCSO responsibilities.

SECTION 5 – STAFFING AND TRAINING REQUIREMENTS

1. **Staff.**

1.1. CCSOs shall hire and retain staff that are reflective and representative of the diversity of the communities the CCSO is responsible for serving.

1.2. CCSOs must employ a full-time, Clinical Manager who is 100% dedicated to the CCSO responsibilities and meets the qualifications of an LPHA. The Clinical Manager shall be responsible for overseeing CCS services and providing clinical direction to the CCSO operations.

1.3. CCS Supervisors, responsible for overseeing CCS Care Coordinators, must at a minimum meet the qualifications of a QMHP. CCS Supervisors shall not exceed an average Supervisor to Care Coordinator caseload of 1:8. with no more than 10 Care Coordinators on their caseload at one time.

1.4. CCSW and CCSI Care Coordinators must minimally meet the qualifications of an MHP. CCSW Care Coordinators shall not exceed an average Care Coordinator to Pathways Youth caseload of 1:10 with no more than 12 youth on any CCSW Care Coordinator's caseload at one time. CCSI Care Coordinators shall not exceed an average Care Coordinator to Pathways Youth caseload of 1:25 with no more than 30 youth on their caseload at one time.

1.5. MCR Screening Staff: An MHP, under the supervision of a QMHP immediately available for consultation through the screening event, may provide the initial face-to-face Mobile Crisis Response screening and assessment.

1.6. Staff delivering services pursuant to the CBS Handbook and 89 Ill. Admin. Code 140.453 must meet the minimal staff requirements, as outlined within those policy documents.

1.7. All staff must clear a background check before delivering services to any customer.

2. **Training Requirements.**

2.1. The CCSO must submit a detailed training plan with timeline as an Attachment to their application. The training plan shall include timelines for completing training requirements and plans for the retraining of all staff on an annual basis.

2.2. The CCSO shall ensure that all staff providing CCS services, including the Clinical Manager and CCS Supervisors, complete the following training requirements:

2.2.1. Certification and annual re-certification in the IM+CANS;

2.2.2. Wraparound training and supervisor training, as applicable, through the University of Illinois' Provider Assistance and Training Hub (PATH); and,

2.2.3. Attendance in quarterly boosters and ongoing coaching as made available through PATH.

2.3. The CCSO shall ensure that all staff members responding to crisis calls are certified and annually re-certified in the IM-CAT or IM+CANS through PATH prior to delivering MCR services.

2.4. The CCSO shall provide and document training to new and current staff. Topics should include, but are not limited to:

2.4.1. The CCSO's Program Plan and internal policies and procedures;

2.4.2. The relevant HFS-issued Provider Handbooks and policies relevant to the staff member's role and responsibilities;

2.4.3. System of Care, Wraparound, and Family Driven Care values and principles;

2.4.4. Cultural humility;

2.4.5. Ethics;

2.4.6. Crisis intervention and de-escalation techniques;

2.4.7. Care coordination and case management techniques that are consistent with fidelity Wraparound principles;

2.4.8. Mandated reporter responsibilities, including those under the Abused and Neglected Child Reporting Act (325 ILCS 5), the Elder Abuse and Neglect Act (320 ILCS 20), and DHS Rule 50 (59 Ill. Admin. Code 50).

2.4.9. Confidentiality and privacy laws and rules, including but not limited to: Mental Health and Developmental Disabilities Code (405 ILCS 5), Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), Health Insurance Portability and Accountability Act (HIPAA), and 89 Ill. Admin Code 431 regarding Confidentiality of Personal Information of Persons Served by the Department of Children and Family Services;

2.4.10. Child development;

2.4.11. Family Systems/parenting

2.4.12. Engagement strategies and techniques, including motivational interviewing;

2.4.13. Identification of symptoms of trauma and the use of trauma informed interventions; and,

2.4.14. Relevant State data systems.

2.1. Training Costs. The CCSOs shall identify training resources sufficient to address the needs of all staff listed in the proposed personnel matrix. The training resources shall be identified and may include in-house, Department personnel, PATH resources, or other resources as appropriate.

3. **Required Meetings.**

CCSOs shall attend all regional and other required meetings when notified more than fourteen (14) days in advance by HFS.

SECTION 6 – REIMBURSEMENT AND FISCAL RESPONSIBILTIES

1. CCSOs shall have a mechanism in place to facilitate the direct submission of claims to HFS or the appropriate MCO for reimbursement of approved services provided to eligible customers. The CCSO is responsible for determining and verifying a customer's eligibility prior to the provision of services.

2. CCSOs shall, at the request of the Department, file annual cost reporting in a manner and format as defined by the Department.

3. Alternative Community Services. For the purposes of this section, alternative community services refers to Therapeutic Support Services (TSS), Individual Support Services (ISS), and FSP Alternative Community Services. CCSOs shall serve as the fiscal agent for the TSS and ISS for Pathways Youth, as well as the fiscal agent for FSP Alternative Community Services for FSP and SFSP Youth.

    3.1. CCSOs shall utilize alternative community services for eligible customers, up to the HFS defined annual service limit, based upon identified clinical needs and supports of the child, as informed by the child and family team process.

    3.2. CCSOs shall identify and engage local providers, social service organizations, and other entities who offer the types of services and supports reimbursable under the alternative community services, building a network of alternative community service providers for the DSA.

    3.3. CCSOs shall request prior authorization from the Department, or its designee, prior to utilizing alternative community service spending.

    3.4. CCSOs shall be responsible for directly reimbursing providers and organizations for authorized alternative community services. CCSOs shall then submit claims directly to HFS for the reimbursement of expended funds.

    3.5. CCSOs shall establish a unique, dedicated revolving fund for the management and reimbursement of alternative community services. CCSOs shall replenish the fund with the payments received from adjudicated alternative community service claims.

    3.6. CCSO's acknowledge the requirement to make alternative community service funding available to all eligible customers and shall report alternative community service funding on a quarterly and annual basis consistent with Section 8 of this RFQ.

    3.7. CCSOs shall provide the necessary accounting using generally acceptable accounting principles (GAAP) to ensure that Pathways, FSP, and SFSP Youth do not exceed the annual state fiscal year dollar limits for alternative community services.

4. CCS services shall be reimbursed at a monthly case rate. The monthly case rate may be reimbursed for each calendar month a Pathways Youth is enrolled in the Pathways program, consistent with requirements outlined below.

    4.1. For Pathways Youth newly referred to the CCSO, the first claim for reimbursement for CCS services may be submitted for the calendar month in which the Pathways Youth was effectively enrolled into CCS services, consistent with Section 4, item 2.2.6 of this RFQ.

    4.2. After the first calendar month of payment, claims for CCS services shall only be reimbursed for Pathways Youth for whom the CCSO has minimally:

        4.2.1. Completed weekly Contact Attempts, consistent with the CCS Service Requirements outlined in Section 4, item 2; and,

4.2.2. Completed two (2) Successful Contacts within the calendar month. At least one of the Successful Contacts must be conducted in-person.

4.3. CCSOs must document the completion of or their attempts to complete all CCS Service Requirements within the established timeframes and service guidelines outlined in this RFQ as a condition of payment. Failure to demonstrate compliance with this expectation may result in an audit finding and recoupment of CCS service payment.

5. Prohibition Against Duplication of Services.

5.1. Pathways Youth may not receive Case Management services from any other provider during the calendar months in which the child is receiving CCS services.

5.2. CCSOs may not supplement the CCS monthly case rate through the submission of claims for discrete services delivered to Pathways Youth receiving CCS that are in the same scope of the CCS service. CCSOs may not submit claims for:

5.2.1. Integrated Assessment and Treatment Planning (IATP) for Pathways Youth receiving CCS services; and

5.2.2. Crisis Intervention services, except when immediately following a Mobile Crisis Response (MCR) event.

6. MCR screenings shall be reimbursed separately on a per-event basis, consistent with the CBS Handbook and fee schedule.

7. Services delivered to FSP and SFSP Youth shall be reimbursed consistent with the CBS Handbook and fee schedule.

SECTION 7 – IMMEDIATE REPORTING REQUIREMENTS

CCSOs shall comply with the following immediate reporting requirements:

- Notification to DCFS Case Manager. The CCSO will immediately notify a DCFS Youth in Care's DCFS Case Manager of any significant events, changes in family circumstances, or unusual incidents involving the child or family members. Examples of such events and incidents would include the following: incidents of suspected abuse or neglect which have been or are to be reported to the Child Abuse Hotline; police involvement/intervention with the family; major health problems or death in the immediate family; emotional, mental or physical deterioration; change in household composition; change in residence; suspected drug or alcohol abuse; any circumstance or incident which poses a threat to the safety and well-being of any involved children, or would pose such a threat if the children were in the current custody of the parent; other significant information or changes in family circumstances.

- Mandated Reporting. The CCSO and its staff are Mandated Reporters of child and elder abuse or neglect. CCSOs must comply with the Abused and Neglected Child Reporting Act (325 ILCS 5) and its implementing rules at 89 Ill. Admin. Code 300 and the Elder Abuse and Neglect Act (320 ILCS 20). Suspected child abuse or neglect must be reported to the DCFS Child Abuse Hotline and suspected elder abuse, neglect, or financial exploitation must be reported to the Illinois Department on Aging's Adult Protective Services Hotline. The acquisition of privileged information regarding abuse or neglect does not excuse the failure to report.

- DHS Rule 50 Reporting. The CCSO shall report to the DHS Office of Inspector General any suspected instances of abuse or neglect witnessed or reported during the standard operations of the CCSO, consistent with 59 Ill. Admin. Code 50.

- Medical Assistance or Child Support Enforcement Program Fraud and Abuse. The CCSO shall report to the HFS Office of Inspector General (HFS OIG) any suspected financial fraud and abuse in the Medical Assistance Program or Child Support Enforcement Program, or suspected misconduct of HFS employees, as soon as the provider learns of the suspected fraud, abuse, or misconduct. The provider shall not conduct any investigation of the suspected fraud and abuse or misconduct without being specifically directed to do so by the HFS OIG. The provider shall cooperate with the investigations of suspected fraud and abuse or HFS employee misconduct.

SECTION 8 – MONITORING

1. **Compliance.** The CCSO shall comply with all program requirements and timelines as outlined in this RFQ, the HFS Provider Enrollment Terms and Conditions, and any HFS-issued provider handbooks, policy notices, and memos regarding CCSO responsibilities. The CCSOs shall comply with any and all changes or additions to CCSO provider requirements or programmatic expectations within 30 days written notice from HFS of those changes or additions.

2. **Data and Reporting:** The CCSO shall provide requested data and reports on customers served through the Pathways, SASS, FSP, and SFSP programs, in the manner defined by HFS, for the purposes of customer, contract, program and system monitoring and evaluation.

    2.1. Monthly Reporting. The CCSO shall submit a monthly report to HFS by the tenth business day of the following month, utilizing a standardized reporting template as defined by HFS, that minimally includes the following:

        2.1.1. Number of Pathways Youth assigned, aggregated by demographic categories, assigned tier, and enrollment status;

2.1.2. Average caseload of CCSW and CCSI Care Coordinators and CCS Supervisors;

2.1.3. Compliance with required care coordination activities and timeframes (e.g. the number of Pathways Youth in CCS services receiving CFT meetings within established timeframes);

2.1.4. Statistics detailing the number of MCR events performed for the month and their disposition, with population specific breakouts;

2.1.5. Percentage of MCR events occurring at the location specified by CARES;

2.1.6. Percentage of MCR events initiated within ninety (90) minutes of receipt of a crisis referral from CARES;

2.1.7. Percentage of Pathways Youth with an MCR event in which the designated Care Coordinator participated in the MCR event; and,

2.1.8. The number of MCR screened customers waiting in an Emergency Room for a psychiatric hospital bed for a period of 24 hours or greater.

2.2. Quarterly Reporting. The CCSO shall submit a quarterly report to HFS, consistent with the quarterly submission timelines detailed below, utilizing a standardized reporting template as defined by HFS, that provides information on the utilization of alternative community services, as detailed in Section 6, item 3 of this RFQ.

2.2.1. Quarterly Reporting Timelines.

	Service Date Range	**Submission Due Date**
Quarter 1	July 1 through September 30	October 15
Quarter 2	October 1 through December 31	January 15
Quarter 3	January 1 through March 31	April 15
Quarter 4	April 1 through June 30	July 15

2.3. Annual Reporting. The CCSO shall submit an annual report to HFS and the MCOs by September 30 of each calendar year, beginning in calendar year 2022. The CCSO agrees to work collaboratively with HFS and the MCOs in the first year of implementation to define the scope and format of the annual report.

2.4. The CCSO may be required to periodically provide ad hoc data and reports to HFS and the MCOs.

2.5. The CCSO agrees to work collaboratively with HFS and the MCOs to establish processes, methods, and timelines for the establishment of any new, standard reporting requirements determined necessary for the purposes of customer, contract, program, and system monitoring and evaluation.

3. **Monitoring:** The CCSO shall comply with all off-site and on-site program, quality, and fidelity monitoring visits, requests for document reviews, technical assistance, quality efforts, and follow-up activities undertaken by HFS, its contracted MCOs, or other designee(s).

SECTION 9 – APPLICATION CONTENT AND REQUIREMENTS

Providers interested in applying to operate as a CCSO for a DSA must complete Appendix B, RFQ Cover Sheet, and submit the completed document along with a written proposal that addresses how the applicant plans to meet the CCSO responsibilities, as detailed in this RFQ, with a particular focus on those service requirements detailed in Section 4. The proposal should be no more than 50 pages in length (not inclusive of any Attachments), double-spaced, with a standard font size (recommended Times New Roman in 12 point font, Calibri in 11 point font, or Arial in 10 point font). The proposal should minimally address the applicant's:

1. Familiarity with Systems of Care, Wraparound, and Family-Driven Care philosophies and the applicant's experience in operating clinical programs based upon these values and principles.

2. Current or prior experience delivering care coordination and/or case management services to children with significant behavioral health needs, including any experience in delivering services consistent with the Wraparound approach and any experience in coordinating care and/or facilitating service planning within an interdisciplinary team. Please include the years of experience and a description of services delivered.

3. Plan for delivering CCS services consistent with the requirements of Section 4. The response should include a description of how the applicant will utilize care coordination to enhance crisis service delivery, reduce crisis recidivism and psychiatric hospitalization for children receiving CCS services.

4. Current or prior experience providing crisis services, including mobile crisis screening and assessment services, to children and adults. Please include the years of experience.

5. Plan for delivering MCR services consistent with the requirements of Section 4 and in consideration of HFS' goals of reduced inpatient psychiatric hospitalization, decreased recidivism in the usage of crisis services, and increased access to follow-up services following a crisis event. In the response, the applicant should minimally identify:

    a. How it will ensure 24/7 MCR coverage and meet required response timeframes;

    b. The applicant's approach to delivering crisis intervention and stabilization services in promotion of community stabilization whenever possible and clinically appropriate; and,

    c. Any proposed partnerships the applicant plans to enter into for the provision of the MCR responsibilities outlined in this RFQ, including detailed information on the geographic area, populations, and duties the partner organization(s) will cover, and how the applicant will monitor and oversee the performance of any partners.

6. Capacity to meet the requirements of the SFSP, including the applicant's capacity and plan for staffing SFSP cases.

7. Capacity to meet the requirements of the FSP program, including the applicant's plan for assisting families with the FSP application process and fulfilling the case coordination duties of the FSP Coordinator.

8. Current or prior experience delivering services in the home and community and during non-traditional business hours, including weekends.

9. Strategies for engaging customers, particularly children and families, in services, addressing how the applicant will partner with family advocates, Family Peer Supporters, youth advocates and peer providers, and customers to promote and embed Family Driven Care principles within CCSO operations.

10. Plan for ongoing community engagement and outreach, particularly to key stakeholder groups such as DCFS Case Managers, law enforcement, courts, schools, and hospitals.

11. Plan for internally assessing, on an ongoing basis, the organization's strengths and weaknesses related to its CCSO functions and monitoring the quality of care delivered to customers, including which internal staff are to be involved and how families and customers are to be involved.

12. Current financial soundness and plans or strategies for ensuring long-term financial viability as a CCSO for the DSA, including a commitment from the organization that all required CCSO services shall be provided independently and financially sustained by the operational practices and billing activities associated with the program and not supplemented by local funds.

13. Experience with and capacity to submit claims for reimbursement directly to HFS and MCOs for the services described herein, including the applicant's current billing rejection rates across Medicaid payers.

In addition to the written proposal, applicants must submit the following attachments for their application to be considered complete:

Attachment I – Organizational Chart
A copy of the applicant's proposed organizational chart, including how the CCS and MCR teams will fit into the overall organizational structure.

Attachment II – Proposed Staffing Plan
The staffing plan should demonstrate how the applicant proposes to staff for each of the core CCSO responsibilities (CCS, MCR, FSP, and SFSP), including an outline of the proposed staff qualifications and staff to customer ratios.

Attachment III – Statement on Legal Relationship with Hospital
If the applicant, or any proposed MCR partners, has a legal relationship with a hospital, a description of the relationship must be submitted as Attachment III. The description must document: (1) a demonstrated ability to separate hospital functions from community functions; (2) how the applicant's governance structure overseeing CCSO functions is separate from the hospital; (3) a distinct line between the MCR screening functions and the hospital part of the applicant's structure; and, (4) how a conflict of interest will not occur between the CCSO part and the hospital part of the entity. If the applicant and any proposed MCR partners do not have a legal relationship with a hospital, they still must submit Attachment III, indicating that the agency does not have such a legal relationship.

Attachment IV – Training Plan
Applicants shall supply a detailed training plan, consistent with Section 5 of this RFQ, including timelines for completing the training requirements with new staff upon hire and retraining all staff on an annual basis.

Attachment V – Letters of Support
Applicants must provide two (2) Letters of Support from an individual, group, organization, or entity. Applicants will not receive additional points for submitting more than two letters of support. Letters of Support cannot be from the HFS, DCFS, DHS, the University of Illinois, or an MCO operating within Illinois.

SECTION 10 – RFQ EVALUATION AND SELECTION PROCESS

Submitted applications will be reviewed for completeness utilizing the Proposal Checklist provided as Appendix B. Incomplete applications will not be evaluated as part of the selection process. Three (3) designated representatives will evaluate complete applications utilizing a standardized scoring sheet developed prior to the submission of applications.

Following the RFQ evaluation process, HFS will notify applicants of the outcome of this RFQ application evaluation process by the close of business on Tuesday, November 30, 2021. Agencies determined to be qualified and selected as a CCSO will be expected to attend a CCSO kick-off meeting with HFS and the MCOs in early December to begin implementation preparation. All selected CCSOs must be prepared to implement the services outlined in this RFQ by the effective dates listed on the RFQ title page.