Care Coordination and Support Organization (CCSO) Provider Handbook

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Foreword

The Department of Healthcare and Family Services (HFS) is committed to strengthening access to high quality home and community-based services for children with significant behavioral health challenges and their families through the development of a statewide System of Care that is focused on improving outcomes. To help realize this goal, HFS has introduced Care Coordination and Support Organizations (CCSOs) as a critical component within Illinois' community behavioral health service delivery system.

CCSOs serve as hubs of accountability for a Designated Service Area (DSA), responsible for delivering high-quality care coordination, Mobile Crisis Response services, and for facilitating access to other support services to customers with significant behavioral health needs and their families across a range of HFS-administered programs, including:

- The **Pathways to Success** (Pathways) program for Medicaid-eligible children under the age of 21 with complex behavioral health needs;

- The **Family Support Program** (FSP) for children and young adults under the age of 26 with a serious emotional disturbance;

- The **Specialized Family Support Program** (SFSP) for children under the age of 18 who are at risk of custody relinquishment as a result of the child's unmet behavioral health needs;

- The **Screening, Assessment, and Support Services** (SASS) program for children under the age of 21 in the fee-for-service delivery system who are experiencing a behavioral health crisis; and

- **Designated Mobile Crisis Response** (MCR) service and follow-up responsibilities for non-SASS children and Medicaid-eligible adults who are experiencing a behavioral health crisis.

CCSOs operate consistent with the core values and guiding principles of Systems of Care and Wraparound, ensuring that services are delivered in a manner that is family-driven, youth-guided, individualized, strengths and community-based, trauma-informed, culturally and linguistically responsive, and data driven.

CCSO Values:

- **Family Driven and Youth-Guided**: Children and families are full partners in the care planning and decision-making process. The child and family's perspective, values, and preferences are prioritized and are intentionally sought during all phases of the care planning and implementation process.

- **Team-Based and Collaborative**: An interdisciplinary team of formal and natural supports approved by the child and family come together to help support the child and family in achieving their vision and goals. Team members work together cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single plan of care. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan of care prioritizes leveraging and developing natural supports, those individuals from the family's network of interpersonal and community relationships, such as faith leaders, neighbors, friends, and coaches.

- **Strengths-Based and Individualized**: The team develops and implements customized strategies, supports, and services to achieve the child and family's vision, with an emphasis on the identification, use, and development of the knowledge, skills, and assets of the child and their family, their community, and other team members.

- **Community-based**: The team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible, and that safely promote child and family integration into home and community life.

- **Culturally Humble**: Care planning and decision-making processes demonstrate respect for and build on the values, preferences, beliefs, culture, and identity of the child, family, and their community.

- **Unconditional Care**: Regardless of challenges that may occur, the team persists in working toward the child and family's goals.

- **Data and Outcome Driven**: The goals and strategies of the plan of care are tied directly to observable or measurable indicators of success. The team monitors progress in terms of these indicators and revises the plan accordingly.

CCSO Goals:

- Closely coordinate care and services across programs and systems;
- Improve access to crisis supports and to appropriate home and community-based services and supports for customers with behavioral health needs;
- Reduce unnecessary use of inpatient psychiatric hospitalization, residential treatment, and emergency rooms; and,
- Improve clinical and functional outcomes for customers and quality and cost outcomes for the system.

201 Basic Provisions

This handbook has been prepared for the information and guidance of providers enrolled as a CCSO, consistent with 89 Ill. Admin. Code 141, in the HFS Medical Programs. It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the HFS Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes. The updates will be posted to the HFS website on the Provider Notices page. Providers wishing to receive e-mail notification when new provider information has been posted by the HFS may register on the website.

Services provided must be in full compliance with both the general provisions contained in the Handbook for Providers of Medical Services, General Policy and Procedures, and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein. Providers submitting X12 837P electronic transactions must also refer to the Handbook for Electronic Processing. The Handbook for Electronic Processing identifies information specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other healthcare programs funded or administered by HFS.

Providers should always verify a customer's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the customer's coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The Recipient Eligibility Verification (REV) System, the Automated Voice Response System (AVRS) at 1-800-842-1461 and the Medical Electronic Data Interchange (MEDI) systems are available.

Unless otherwise specified, the billing instructions contained within this handbook apply to customers enrolled in the HFS fee-for-service programs and do not necessarily apply to customers enrolled in a HealthChoice Illinois managed care health plan.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Professional and Ancillary Services at 1-877-782-5565. Questions regarding the policies or service requirements outlined within this handbook may be directed to the Bureau of Behavioral Health at 217-557-1000 or HFS.Pathways@illinois.gov.

NOTE: the terms "child," "youth," and "customer" are used throughout this handbook to refer to the individuals served by CCSOs. While the terms are used somewhat interchangeably, "child" generally refers to a Medicaid eligible individual under the age of 21, "youth" generally refers to an individual under the age of 26 regardless of their Medicaid eligibility status, and "customer" refers to any individual served by the CCSO. The term "family" is also utilized broadly to refer to those individuals the customer considers to be their family and can include, but is not limited to: parents, caregivers, legal guardians, significant others, siblings, grandparents, etc.

202 Provider Participation

To receive reimbursement for services delivered, CCSOs must be enrolled for participation in the HFS Medical Programs via the web-based system known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT). Under the IMPACT system, category of service (COS) is replaced with Specialties and Subspecialties.

To enroll as a CCSO, providers must meet the following requirements consistent with 89 Ill. Admin. Code 141:by whom?

- Obtain and maintain a Care Coordination and Support (CCS) Program Approval;
- Be certified as a Community Mental Health Center (CMHC) pursuant to 59 Ill. Admin. Code 132 or as a Behavioral Health Clinic (BHC) pursuant to 89 Ill. Admin. Code 140.499 and 89 Ill. Admin. Code 140.Table O;
- Obtain and maintain a Program Approval for Crisis Services pursuant to 89 Ill. Admin. Code 140.Table N; and,
- Attest to complying with the IMPACT Provider Enrollment Terms & Conditions.

Detailed information regarding certification as a CMHC and BHC, as well as the process for obtaining a Crisis Services Program Approval, can be found within the Community-Based Behavioral Services (CBS) Provider Handbook. CCSOs may not seek reimbursement for the services outlined herein from any public payer until the provider's IMPACT application, including any necessary certifications or Program Approvals, has been approved.

202.1 CCSO Enrollment in IMPACT

Entities selected as a CCSO, pursuant to 89 Ill. Admin. Code 141, must complete and submit an enrollment application or modification through the IMPACT system. All CCSOs must maintain the appropriate Specialty/Subspecialty combinations, consistent with Table 1 below, on their enrollment application to allow the CCSO to bill for outpatient mental health services, CCS, MCR, and Crisis Stabilization services.

Table 1. IMPACT Enrollment Guide – CCSOs

Enrollment Type	Provider Type	Specialty	Subspecialty	Services	Program Approval?
Facility, Agency, Organization (FAO)	Community Mental Health Center	Outpatient	None	IATP, Crisis Intervention, Therapy/Counseling, Community Support, Med. Admin., Med. Monitoring, Med. Training, Case Management, Develop. Screening and Testing, MH Risk Assessment, Prenatal Care At-Risk Assess.	No
		Home and Community Based Services	Care Coordination & Support	Care Coordination & Support, Individual Support Services, Therapeutic Support Services	Yes
		Crisis Response	Mobile Crisis Response	Mobile Crisis Response	Yes
			Crisis Stabilization	Crisis Stabilization	Yes

	Behavioral Health Clinic	BHC Outpatient	None	IATP, Crisis Intervention, Therapy/Counseling, Community Support, Med. Admin., Med. Monitoring, Med. Training, Case Management, Develop. Screening and Testing, MH Risk Assessment, Prenatal Care At-Risk Assess.	No
		BHC Home and Community Based Services	Care Coordination & Support	Care Coordination & Support, Individual Support Services, Therapeutic Support Services	Yes
		BHC Crisis Response	Mobile Crisis Response	Mobile Crisis Response	Yes
			Crisis Stabilization	Crisis Stabilization	Yes

202.2 Program Approval Process

The services of Mobile Crisis Response, Crisis Stabilization, and Care Coordination and Support (CCS) each require that a unique Program Approval be completed, as detailed in 89 Ill. Admin. Code 140.Table N and 89 Ill. Adm. Code 141. Information regarding the Program Approval process for Mobile Crisis Response and Crisis Stabilization can be found in Section 202.4 of the CBS Handbook, while information on CCS Program Approvals is detailed in Section 202.2.1 of this handbook.

When selecting a Specialty/Subspecialty combination in IMPACT that requires Program Approval, providers will be required to enter a pseudo license number (see Table 2 below) under 'Step 5: License/Certification/Other.' If the provider's enrollment is approved, the pseudo license number will be replaced by a license number assigned by HFS.

Table 2. IMPACT Program Approval – Pseudo License Numbers

Provider Type	Specialty	Subspecialty	IMPACT Step 5: Licensing Agency	IMPACT Step 5: Pseudo License Number
CMHC	Home and Community Based Services	Care Coordination & Support	CCS	CCS99999
	Crisis Response	Mobile Crisis Response	HFS	MCR99999
		Crisis Stabilization	HFS	STA99999
BHC	BHC Home and Community Based Services	Care Coordination & Support	CCS	CCS99999
	BHC Crisis Response	Mobile Crisis Response	HFS	MCR99999
		Crisis Stabilization	HFS	STA99999

202.2.1 CCS Program Approval

A Care Coordination and Support (CCS) Program Approval is required for any provider seeking to serve as the CCSO for a DSA. The purpose of the CCS Program Approval is to identify providers who are highly qualified to deliver CCS services to eligible customers consistent with the values, principles, goals, and requirements of CCSOs as outlined in this handbook.

Providers seeking a CCS Program Approval must complete and submit the HFS CCSO provider application. HFS will accept and review CCSO provider applications once every five (5) years for all DSAs and may elect to open CCSO provider applications for any DSA

more frequently as determined necessary to ensure CCSO provider network adequacy. Information on established CCSO provider application timeframes, schedules, and application requirements will be maintained on the HFS website and shared with interested providers via provider notice.

Applicants determined to be approved as a CCSO must pass a readiness review, to be conducted by HFS or its designee, prior to delivering CCS services. The readiness review will examine a provider's readiness to deliver services, including a review of policies, procedures, training materials, staffing levels, and other documents necessary to verify a provider's readiness to begin accepting referrals for services. HFS may, at its sole discretion, elect to perform any or all components of the readiness review on-site. CCSOs will be notified in writing at least ten (10) days in advance of a scheduled on-site review.

Any deficiencies identified as part of the readiness review process will be communicated in writing to the CCSO. CCSOs will be given no less than thirty (30) calendar days to correct or ameliorate deficiencies identified through the readiness review.

202.3 Prohibition on Delivery of Other Home and Community-Based Services

CCSOs may not enroll to provide other home and community-based services covered under the Pathways program, 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. Additional guidance on the requirements for demonstrating sufficient separations and independence will be forthcoming.

202.4 National Provider Identification (NPI) Number

Provider enrollment in IMPACT is issued on a site-specific basis; provider applications submitted in IMPACT will only be approved for one primary service location. Providers are required to obtain a unique NPI number for each site they are seeking to enroll with HFS. Each approved provider site is issued a unique Provider ID number from HFS, meaning providers are required to maintain a unique one-to-one match between NPIs and Provider IDs on file with HFS. Providers that fail to obtain and report a unique NPI for each service location may be subject to claims denial.

202.5 Transfer of Ownership

Participation approval is not transferable. When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation must be completed. Claims paid to the new owner using the prior owner's assigned Provider ID number may result in recoupment of payments and other sanctions.

202.6 Participation Approval

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, outlining the information associated with the provider's enrollment in HFS' files. The provider is to review this information for accuracy immediately upon receipt.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims to ensure all identifying information required is an exact match to that in HFS's files; any inaccuracies found must be corrected and HFS notified immediately via IMPACT.

202.7 Participation Denial

When participation is denied, the provider will receive written notification of the reason for denial. Within ten (10) calendar days after the date of a participation denial notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which HFS's action is being challenged. If such a request is not received within ten (10) calendar days, or is received but later withdrawn, HFS' decision shall be a final and binding administrative determination. HFS' rules concerning the basis for denial of participation are set out in 89 Ill. Admin. Code 140.14. HFS' rules concerning the administrative hearing process are set out in 89 Ill. Admin. Code 104 Subpart C.

202.8 Provider File Maintenance

The information carried in HFS files for participating providers must be maintained on a current basis. The provider and HFS share responsibility for keeping the file updated.

202.8.1 Provider Responsibility

Information contained on the Provider Information Sheet is the same as in HFS' files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found must be corrected and HFS notified immediately via IMPACT.

Failure of a provider to properly update IMPACT with corrections or changes may cause an interruption in participation and payments.

202.8.2 HFS Responsibility

When there is a change in a provider's enrollment status or the provider submits a change, HFS will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

203 Record Requirements

HFS regards the maintenance of adequate clinical records as essential for the delivery of quality behavioral health treatment. Providers are required to maintain a clinical record for each customer. The clinical record must include the essential details of the customer's presenting behavioral health condition and of each service provided. Refer to the Handbook for Providers of Medical Services, General Policy and Procedures for record requirements applicable to all providers. Additional information regarding program specific documentation requirements can be found in the relevant programmatic sections in this handbook.

In the absence of proper and complete clinical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the Office of the Inspector General (OIG) or other appropriate law enforcement agency for further action.

203.1 Monitoring Activities

All required records are to be available for inspection, audit and copying (including photocopying) by authorized HFS personnel or designees during normal business hours for the purposes of conducting quality assurance or post payment reviews, or to ensure compliance with the policies and procedures outlined in this handbook.

204 Administrative Requirements

204.1 Coordination with Managed Care Organizations (MCOs)

CCSOs must negotiate in good faith and enter into an agreement with all HealthChoice Illinois MCOs operating within the CCSO's DSA for the provision of the services outlined in this handbook to MCO enrolled customers.

If a customer is enrolled with an MCO, the CCSO should contact the MCO to determine if the customer is enrolled in the MCO's care management program. If not, the CCSO should work with the customer to determine if they would like to request enrollment in the MCO's care management program. The CCSO is responsible for coordinating the delivery of covered Medical Assistance services with the MCO, including seeking all necessary service authorizations. MCOs are responsible for covering all medically necessary services covered by the HFS Medical Assistance Program and may choose to cover additional services.

The CCSO should be sure to include MCO Care Managers as active participants in the service coordination process for any customer the CCSO serves. This can occur through inclusion of the MCO Care Manager in Child and Family Teams (CFTs) or other interdisciplinary team meetings, as appropriate and as requested by the customer and family, or it can occur through regular communication between the CCSO and the MCO outside of team meetings. Regardless of how coordination occurs, open and regular communication between CCSOs and MCOs regarding customers in care coordination is important to reduce duplication, breakdown any barriers to accessing care, and to ensure the customer and their family is accessing the full array of benefits available to them.

204.2 HFS Application Agent Requirement

CCSOs must enroll as an HFS Application Agent to aid customers with completing and submitting applications and redeterminations for medical assistance benefits, as requested by the customer. If a customer served by the CCSO is not already eligible for a full benefit medical assistance program administered by HFS, the CCSO must educate the customer on the medical assistance program and offer assistance with submitting an application. CCSOs may work with designated MCR partners to fulfill this requirement. Information on becoming an HFS Application Agent can be found on the HFS website.

204.3 Monitoring Changes in Customer Contact Information

CCSOs must confirm any changes in the contact information for customers receiving services pursuant to this handbook minimally once per quarter, particularly any changes in their mailing address, and must encourage customers to make any such updates using the Manage My Case function on the Application for Benefits Eligibility (ABE) portal.

204.4 Health Information Technology

Within three (3) years after enrolling in IMPACT, CCSOs must 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.

204.5 Separation of Duties

CCSOs are expected to maintain sufficient separation between their CCSO duties and other Medicaid service activities that the provider may operate or engage in to ensure that access to Care Coordination and Support (CCS) and other Medicaid services are independent. CCSOs must disclose, in writing, any legal relationships the CCSO has with a hospital a minimum of thirty (30) calendar days prior to entering the legal relationship. The written notice must demonstrate how the CCSO will maintain sufficient separation in governance, clinical functions, and staff duties between the hospital and CCSO.

204.6 Child and Family Protections

CCSOs must establish and communicate processes that clearly outline how families can request a different care coordinator at any time. For Pathways enrolled children, CCSOs must establish policies and procedures to ensure that CCS services are not delivered by staff who are: 1) related by blood or marriage to the child or any caregiver of the customer; 2) financially responsible for the customer; 3) empowered to make financial or health-related decisions on behalf of the customer; or, 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 MCR services.

CCSOs must also establish and maintain an internal grievance process specific to children and families enrolled in Pathways for tracking and resolving complaints related to the CCSO, its staff, or any service providers or supports involved in the child's care. The CCSO's process must include educating families on their rights and the processes for submitting grievances to their MCO, HFS, or to the state's designated protection and advocacy agency (Equip for Equality).

204.7 Annual Cost Reports

CCSOs must, at the request of HFS, file annual cost reporting specific to the delivery of services required pursuant to this handbook in a manner and format defined by HFS. CCSOs will be provided at least ninety (90) days prior written notice before submission of an annual cost report is required.

204.8 Disaster Recovery Plan

CCSOs must establish and maintain a Disaster Recovery Plan that details 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). The Disaster Recovery Plan

must include the steps the CCSO will 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 operations on a temporary or permanent basis.

204.9 Continuous Quality Improvement (CQI) Plan

CCSOs must establish and maintain a CQI Plan that outlines the steps the CCSO will take to internally assess its strengths and weaknesses, with a focus on how the CCSO will utilize data to inform CQI activities, the steps the CCSO will take to correct any identified deficiencies, and how the CCSO will track referrals and compliance with service delivery requirements as outlined in this handbook. The CCSO must include mechanisms for soliciting and integrating youth and family feedback directly into the CQI Plan.

204.10 Staffing and Training Plan

CCSOs must establish and maintain a Staffing and Training Plan that details 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, consistent with the staff requirements outlined in Section 208 of this handbook. The plan must also outline the CCSO's plan for appropriately training staff consistent with their role and in line with Section 208 of this handbook. This includes identifying required training resources, which may include in-house, HFS personnel, resources provided by the Provider Assistance and Training Hub (PATH), or other resources as appropriate, and a brief outline of how staff attendance at training will be monitored and documented.

204.11 Community Outreach and Engagement Plan

CCSOs must establish and maintain a Community Outreach and Engagement Plan that details 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 Department of Children and Family Services (DCFS) offices, and the local Comprehensive Community Based Youth Services (CCBYS) provider. The plan must outline the CCSO's planned efforts to educate stakeholders in the DSA about the services and programs offered by the CCSO.

204.12 Community Stakeholder Council

CCSOs must establish a Community Stakeholder Council that minimally meets on a quarterly basis for the purposes of advising and providing feedback to the CCSO on the implementation of its services. The Community Stakeholder Council membership must include youth and family voice representation, with a youth or family voice representative serving as the co-chair of the council alongside a member of the CCSO's executive

leadership. The CCSO must make efforts to recruit/select Community Stakeholder Council members who reflect the cultural, ethnic, and geographic composition of the DSA. Over time, CCSO's should strive to achieve a Community Stakeholder Council in which youth and families comprise 51% or more of the membership.

The Community Stakeholder Council must establish a standardized meeting schedule, with information on the meeting time, date, and location made publicly available. The meeting agenda and minutes from the previous meeting must also be made publicly available and provided to HFS or the MCOs upon request. Any non-emergency changes to the meeting information must be published at least fourteen (14) calendar days in advance of the scheduled council meeting. Meetings may be held in person, by telephone, or by videoconference and must be open for public attendance.

204.13 Community Resource Directory

CCSOs must establish and maintain a Community Resource Directory that identifies the various social service and community-based resources available to help meet the various social needs of children and families, with a particular focus on those resources that are free or on a sliding fee scale. The directory is intended to serve as a resource for youth, families, CCSO staff, and community partners and must be accessible online. The Community Resource Directory must be updated minimally once every six (6) 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.

205 Pathways to Success

Pathways to Success (Pathways) is a program for Medicaid enrolled children under the age of 21 in Illinois who have complex behavioral health needs and could benefit from additional support. In addition to all Illinois Medicaid covered services, Pathways eligible children have access to the following new home and community-based services:

1. Care Coordination and Support;
2. Intensive Home-Based Services;
3. Family Peer Support;
4. Therapeutic Mentoring;
5. Respite;
6. Individual Support Services; and,
7. Therapeutic Support Services.

The services available under Pathways are intended to augment the child's existing or recommended behavioral health treatment plan and build upon the unique needs and strengths of the child and their family. Pathways services are provided by qualified service providers who engage the child and family in a unique assessment and treatment planning process centered around the formation of a Child and Family Team (CFT).

CCSOs play a critical role in the Pathways program, providing evidence-informed Care Coordination and Support (CCS) services based upon the phases and processes of Wraparound and facilitating access to Individual Support Services (ISS) and Therapeutic Support Services (TSS).

205.1 Pathways Eligibility Criteria

To be eligible for Pathways, the child seeking services must meet the following criteria:

- Be a resident of the state of Illinois;
- Be eligible for comprehensive benefits under Illinois Medical Assistance Program;
- Be under the age of 21;
- Demonstrate a Severe Emotional Disturbance (SED) or Severe and Persistent Mental Illness (SPMI); and
- Be stratified into Tier 1 or Tier 2 of the State's Behavioral Health Decision Support Model.

205.2 Behavioral Health Decision Support Model

The Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS), serves as the standardized mental health assessment and treatment planning tool for community behavioral health in Illinois. At the core of the IM+CANS is the Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessments

(ANSA). These communimetric tools contain a set of core and modular items that are rated using a '0' to '3' scale based on the urgency for action related to the item.

The Illinois Behavioral Health Decision Support Model stratifies children into service tiers based on the combination and complexity of actionable needs on key IM+CANS items. This approach is used to identify children in need of intensive home and community-based services using a standardized set of criteria based around a child's individual assessed needs.

In the Illinois model, children must be stratified into Tier 1 (High Fidelity Wraparound), or Tier 2 (Intensive Care Coordination), to be considered eligible for the Pathways program. Additional information about the Behavioral Health Decision Support Model can be found on the HFS Pathways website.

205.3 Initial Eligibility Determination Process

Children identified as potentially meeting the eligibility criteria for Pathways should be referred to a Community Mental Health Center (CMHC) or a Behavioral Health Clinic (BHC) for an assessment if they are not already receiving services from one of these provider types. The CMHC or BHC will complete an IM+CANS for the child and make initial recommendations and referrals for medically necessary behavioral health services based upon the child and family's identified needs and strengths. This allows the child and family to immediately engage in necessary behavioral health services while Pathways eligibility is being determined.

205.3.1 Automated Process

All CMHCs and BHCs must upload the IM+CANS completed for Illinois Medical Assistance Program customers into the state's secure IM+CANS Provider Portal within ten (10) business days of the authorizing Licensed Practitioner of the Healing Arts' (LPHA) signature. Once per calendar week, HFS will apply the Pathways eligibility criteria, including the Behavioral Health Decision Support Model, to all children with an IM+CANS that has been entered into the IM+CANS Provider Portal. Children who are not eligible for Pathways will continue to have access to the full array of Medicaid covered services, including any services initiated by the CMHC or BHC that completed the IM+CANS.

205.3.2 Requests for Eligibility Determination

In addition to the automated process, a request for a Pathways eligibility determination may be submitted to HFS at any time by the child's parent, legal guardian, an authorized representative, or the child themself if over the age of 18. To request a Pathways eligibility determination, the following information must be submitted to HFS:

- A completed Pathways Request for Eligibility Determination form;

- A copy of the child's completed IM+CANS, signed and dated within the previous 180 days; and
- (Optional) A completed release of information form if the legal guardian requests that a copy of the eligibility determination outcome letter be sent to an additional party, such as a provider helping the family submit the request.

HFS will review complete requests for eligibility determination to determine whether the request is approved or denied within thirty (30) days after the completed request for eligibility determination is received.

205.4 Notice of Pathways Eligibility Determination

If a child is determined eligible for Pathways, the parent/guardian will receive a written letter from HFS notifying them of their eligibility for Pathways. The notice will be issued within fifteen (15) days after the eligibility determination is made and will provide information about Pathways, detail the child's eligibility period, the child's service tier (Tier 1 or Tier 2), and identify the CCSO the child and family has been auto assigned. HFS will assign CCSOs to work with the child and family based upon the child's home address. Families have free choice to switch CCSOs at any point in time by completing and submitting a CCSO Provider Change Request form to HFS. The CCSO assigned to the family and the child's MCO, as applicable, will also be notified of the child's eligibility for Pathways.

Families will receive a denial notice if a request for eligibility determination was submitted to HFS and the child is not determined eligible for Pathways. The denial notice will detail the reason for the denial and will provide information on the customer's rights, including the right and process to appeal the denial.

205.5 Pathways Eligibility Period

Children who are determined eligible for Pathways will be issued six (6) calendar months of eligibility in Pathways, beginning on the first day of the calendar month following the eligibility determination or redetermination, with the following exceptions:

- Pathways eligibility will end the last day of the calendar month following the child's 21st birthday.
- Pathways eligibility will end the date of the parent/guardian or the child's (if over the age of 18) signature on any request for Pathways disenrollment submitted to HFS consistent with Section 205.8 of this handbook.
- Pathways eligibility will end consistent with the child's Medicaid eligibility end date.

205.6 Eligibility Redetermination Process

CCSOs must complete and upload a reassessment of the child's IM+CANS into the IM+CANS Provider Portal 45 days before the end of the child's Pathways eligibility. More

information on CCSO responsibilities related to the IM+CANS is outlined in Section 204.9. HFS will conduct a redetermination of the child's eligibility using the updated information from the child's IM+CANS. The redetermination will be completed by no later than thirty (30) days prior to the end of the child's Pathways eligibility period. If for any reason HFS does not have the information necessary to complete the redetermination (i.e., no reassessment of the IM+CANS in the Portal), HFS will notify the CCSO immediately to prevent any unnecessary disruptions in care.

If the child continues to meet all Pathways eligibility criteria, the child will be issued an additional six (6) calendar months of eligibility in Pathways. The parent/guardian will receive a written letter from HFS notifying them of the child's ongoing eligibility for Pathways.

If the child is determined to no longer be eligible for Pathways, the family will receive a denial notice that details the reason for the denial and provides information on the customer's rights, including the right and process to appeal the denial.

The CCSO and the child's MCO, as applicable, will also be notified of the outcome of the child's redetermination.

205.7 Requests to Change Tier

CCSOs may submit a request to move a Pathways eligible child from Tier 2 to Tier 1 during the initial engagement phase of a child's participation in Pathways, if the CCSO believes the child's IM+CANS used to determine Pathways eligibility has changed significantly and the CFT recommends a step up in care coordination intensity. The request must be submitted within fourteen (14) days after the initial CFT meeting.

Families may request a step down in care coordination intensity (moving a child from Tier 1 to Tier 2) at any time. Such requests must be submitted to HFS on the family's behalf within five (5) business days after the family requests the step down and documented in the child's clinical record maintained by the CCSO.

CCSOs must submit the following to HFS to request a tier change:

- Pathways Tier Change Request Form;
- A copy of the child's updated IM+CANS; and,
- Notes from the CFT meeting recommending the tier change (as applicable).

Families retain the right to appeal the child's assigned tier following receipt of the notice of eligibility determination. The notice of eligibility will include information on the process and timelines for filing a formal appeal.

205.8 Families/Youth that Request Disenrollment from Pathways

Families and youth age 18 and older have the right to decline or request disenrollment from Pathways at any time by contacting their CCSO and completing the Pathways Discharge Request form. CCSOs must inform families who decline Pathways enrollment about their rights and the process for re-engaging in Pathways, consistent with HFS guidance. CCSOs must submit the signed and completed Pathways Discharge Request form to HFS within five (5) business days after the family requests disenrollment.

Families and youth who decline Pathways enrollment may request to re-engage in the program at any time so long as the child continues to meet Pathways eligibility criteria. If at any time the child is identified by HFS through the automated eligibility process as meeting Pathways eligibility criteria for a new six (6) month eligibility period, the CCSO must take steps to offer enrollment in Pathways to the family, consistent with the outreach and engagement policies outlined in Section 205.9.1 of this handbook.

205.9 Care Coordination and Support Services

Care Coordination and Support (CCS) is the foundational service that CCSOs provide to Pathways enrolled children and families. It is an evidence-informed, structured approach to care coordination that is based upon the values, principles, and phases of Wraparound. CCS includes a broad set of activities designed to assess, plan, and monitor the service needs of the child and family and includes:

1. Engagement and outreach to children and families, including education on Systems of Care and Wraparound processes;
2. Organization and facilitation of a CFT that meets on a regular basis;
3. Reviewing and updating the child's IM+CANS regularly, which includes identifying needs and strengths and the developing a strengths-based service plan;
4. Crisis assessment, safety and prevention planning, and response activities;
5. Coordinating and consulting with MCOs, providers, other child-serving systems, and any other supports involved with the child's care. This includes helping transition children from an institutional setting, including from an out-of-state setting, to a community-based living arrangement; and,
6. Referring, linking, and following-up with service providers and social service agencies for services recommended by the CFT on the service plan.

Pathways offers two tiers of CCS services, consistent with the tier assigned to Pathways eligible children by HFS:

- **Care Coordination and Support: High Fidelity Wraparound (CCSW)**. CCSW is provided to children stratified into Tier 1. Designated CCSW Care Coordinators work with an average of 10 families at a time and are never assigned to work with more than 12 families at once.

- **Care Coordination and Support: Intensive Care Coordination (CCSI)**. CCSI is provided to children stratified into Tier 2. Designated CCSI Care Coordinators work with an average of 25 families at a time and are never assigned to work with more than 30 families at once.

Both CCS tiers adhere to the processes of Wraparound but differ in the intensity of care coordination activities provided and the degree of fidelity to National Wraparound Initiative (NWI) standards. CCS services are conducted according to the four phases of Wraparound: Phase 1 – Engagement and Preparation; Phase 2 – Initial Plan Development; Phase 3 – Plan Implementation; and, Phase 4 – Transition.

Expectations for each phase are described below, with key activities and timelines summarized in Table 3. The information throughout Section 205.9 applies to both tiers of care coordination (CCSW and CCSI) unless otherwise noted. The term "care coordination" is generally used throughout this section when content applies to both tiers of CCS. Information on billing for CCS services is detailed in Section 211.

Table 3. Core CCS Requirements/Activities and Maximum Timeframes for Completion

Requirement/Activity	CCSW (Tier 1)	CCSI (Tier 2)
Care Coordinator caseload	1:10 average, 1:12 maximum	1:25 average; 1:30 maximum
Supervisor caseload	1:8 average, 1:10 maximum	1:8 average, 1:10 maximum
Initial outreach to family	7 days after receiving referral	7 days after receiving referral
Initial Crisis Prevention and Safety Plan (CPSP)	10 days after enrollment	10 days after enrollment
Initial strengths, needs, and cultural discovery process completed	21 days after enrollment	21 days after enrollment
CFT meeting frequency	Initial: 30 days after enrollment Ongoing: Every 30 days or 48 hrs. after MCR event	Initial: 30 days after enrollment Ongoing: Every 60 days or 48 hrs. after MCR event
IM+CANS Development and Ongoing Review	Every 30 days	Every 60 days
CPSP Review	Every 30 days	Every 60 days
In-person contacts	2 x month	1 x month
Telephonic contacts	2 x month	3 x month

205.9.1 Initial Engagement/Outreach Efforts

HFS will notify CCSOs when a child is determined newly eligible for Pathways. CCSOs must use a multifaceted approach to locate, engage, and educate Pathways eligible children and their families beginning immediately after receiving the referral from HFS.

There will be circumstances in which reaching referred families requires persistence; it is expected that the CCSO employ various methods of contact to reach the family. CCSOs must complete 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 within seven (7) calendar days of receiving the referral from HFS. This may include outreach to

the family by telephone (including leaving a voicemail when possible), email, text messaging, in-person visits, or any other form of communication based upon the needs and preferences of the family. The CCSO must continue to make three (3) attempts to contact the child and family each week until successful contact is made to facilitate the child's enrollment into CCS services. The CCSO must track the number of attempts to reach the family, including methods used. It is expected that the assigned Care Coordinator or the Care Coordinator Supervisor will conduct most of the initial engagement/outreach efforts. While other staff may assist in initial outreach/engagement efforts (e.g., peer support workers, engagement specialists), the Care Coordinator or their supervisor must be the one to conduct the initial face-to-face meeting described in Section 205.9.2.1.

A child is considered effectively enrolled in Pathways once the child's legal guardian has signed the Pathways to Success Program Consent form and once a successful contact has been made by the CCSO. A successful contact means that an oral communication (telephonic, video, or in-person) has occurred between the CCSO and the child and/or their parent/guardian. CCSOs must complete and submit the Pathways Discharge Request Form to HFS if they are unsuccessful in engaging, making contact, or otherwise completing the Pathways enrollment process for a referred child within sixty (60) days of receiving the referral from HFS.

205.9.2 Phase 1 – Engagement and Preparation

During this phase, the groundwork for trust and shared vision among the child, family, and CFT members is established. The tone is set for teamwork, consensus-building, and team interactions that are consistent with the Wraparound principles, particularly through the initial conversations about strengths, needs, and culture. This phase emphasizes empowering the child and family by placing them at the center of the process, always prioritizing their perspective and preferences. Phase 1 should be completed relatively quickly (no later than thirty days after initial contact with the family) so that the CFT can begin meeting and establish ownership of the process as quickly as possible.

205.9.2.1 Initial Face-to-Face Meeting

Once initial contact is made with the child and family, the Care Coordinator's priority is to schedule an initial face-to-face meeting with the family. The initial face-to-face meeting should take place in the family's home or other natural setting in the community unless another setting is preferred by the family. The family's preference for meeting location and time should be documented in the child's clinical record. The initial face-to-face meeting has several purposes: introducing Pathways and care coordination, describing the System of Care approach and the Wraparound model, and initiating the Strengths, Needs, and Cultural Discovery process.

The Care Coordinator should also use the first face-to-face meeting to obtain informed consent from the child and family to participate in the Pathways program by reviewing the Pathways to Success Program Consent Form, including the family's rights and

responsibilities under Pathways. The Care Coordinator must ensure they go over all components of the consent form and spend time reviewing with the child and family that participation in Pathways, as well as receipt of any of the services offered under the program, is voluntary but does require ongoing family participation. The Care Coordinator should explain the role of CCS services in Pathways and how the Wraparound values and principles drive the process using family-friendly language. The child and family's understanding of their role and needed participation in the process is imperative for positive outcomes. Although children under age 12 are not required to consent for treatment, the Care Coordinator should engage the child and help them understand that their voice is important to the process.

The Care Coordinator should also obtain any needed releases of information, including to speak to collateral contacts (particularly those identified for CFT participation) and to receive a copy of the child's current IM+CANS.

205.9.2.2 Strengths, Needs, and Cultural Discovery (SNCD) Process

The Care Coordinator continues child and family engagement through a process called Strengths, Needs, and Cultural Discovery (SNCD). The SNCD process focuses on understanding, and then documenting, the family's story as described by the family. It allows the Care Coordinator to get to know the family and to identify who the family is in terms of their strengths, needs, and culture. This process also allows the Care Coordinator to gain additional information that may not be reflected in the IM+CANS but that will be relevant and important to include in discussions with the CFT. During this process, the Care Coordinator helps the family develop their vision, identify CFT members, and prioritize needs for the initial CFT meeting. Care Coordinators are expected to support all family members including the child in sharing relevant information from each of their perspectives.

As the Care Coordinator engages the family, it will be important to be sensitive to expecting the family to retell their story. In some instances, a family has told their story multiple times to different professionals in their effort to obtain help for their child. The Care Coordinator should address this issue openly with the family, sharing what information the Care Coordinator knows/was able to review prior to the first meeting about the needs of the family, always asking the family if the information that the Care Coordinator has is accurate and if there is anything they would change or add to the Care Coordinator's understanding of their needs. This approach also allows the family to raise any concerns about the information, especially if the family feels it is not an accurate representation of their needs or if there are multiple perspectives within the family. It is expected that Care Coordinators will need more than one discussion with the family to complete the SNCD process.

205.9.2.3 Responsibility for the IM+CANS

CCSOs are responsible for maintaining and regularly reviewing and updating the IM+CANS for Pathways enrolled children. If the Care Coordinator does not already have

the child's current IM+CANS, they should obtain the necessary release of information from the family to receive the child's current IM+CANS as soon as possible during engagement. The Care Coordinator does not need to conduct a new IM+CANS, but is expected to discuss the IM+CANS, help the family understand the importance of the IM+CANS, and explain the ongoing use of the IM+CANS as part of the CFT. The Care Coordinator is expected to use the information gathered from the SNCD process to review and update the IM+CANS, going over the information and any changes with the family to make sure that it is accurate.

The IM+CANS must be updated prior to the initial CFT meeting and by no later than 21 days after the family signs consents and agrees to participate in Pathways. The full IM+CANS, inclusive of all attachments, is then shared and used to prepare CFT members prior to the first team meeting. This allows CFT members to all work from the same information and shared understanding. The IM+CANS must be reviewed and updated, as needed, at each CFT meeting.

205.9.2.4 Crisis Prevention and Safety Planning

CCSOs play a vital role in helping children and families reduce their reliance on and utilization of the MCR system. During the initial face-to-face meeting, a priority for the Care Coordinator is to identify any immediate unmet needs related to safety that need to be addressed. The Care Coordinator will begin to identify any potential circumstances that may precipitate a crisis for the child and/or family and will work with the family to establish a supportive Crisis Prevention and Safety Plan (CPSP) within ten (10) days of the child's effective enrollment date. The goal of crisis planning is to assist the families with strategies and supports that can be used to respond at the earliest sign of escalation, and to foster and practice skill building that enables the family to move toward managing crises on their own. The CPSP must minimally include:

- What a crisis would be for the family;
- Risk Factors and triggers that precipitate crises;
- Concrete, functional strategies that reduce the likelihood of or the severity of a crisis;
- Resources that may help them in a crisis, including how to contact the CCSO after hours; and,
- Functional strengths of the youth and family and how they can assist in a crisis.

Care Coordinators should help families identify multiple strategies to use in a crisis. The strategies should be specific to the crisis situations identified by the family and include responses to triggers for both the child and the family. The Care Coordinator must help educate and support families to recognize crisis triggers and utilize the strategies outlined within their CPSPs for preventing and de-escalating potential crises. Care Coordinators must encourage and provide families with information on how to reach out to the CCSO as part of the family's CPSP or whenever the family needs help in following their CPSP. When a family calls after hours, to the extent possible, the CCSO is responsible for

helping them implement their CPSP, aiming to help resolve the crisis before it escalates to the level of need requiring MCR services. This may occur through contact directly with the family's assigned Care Coordinator or through a rotation of other on-call staff who are knowledgeable about the family or who can access the family's CPSP.

If families have an existing Crisis Safety Plan in place from involvement in MCR services, the Care Coordinator should review the existing plan with the family and make updates as needed. CPSPs shall be reviewed and updated, as needed, minimally at each CFT meeting.

205.9.2.5 Establishing the Child and Family Team (CFT)

The CFT is a group of people important in the life of the child and family that is responsible for the development, implementation, and monitoring of a unified strengths-based service plan. The Care Coordinator is responsible for convening a unique CFT for each child receiving CCS services and for facilitating all meetings of the CFT. The CFT drives all care coordination activities and is the mechanism by which all assessment and service planning for the child and family is accomplished. The general goal of the CFT is to support the child and family in addressing their needs while assisting them in building strengths and a natural support system, which will allow the child and family to coordinate supports for themselves.

As part of the engagement and SNCD process, the Care Coordinator helps the family identify the formal and natural supports who should be part of the CFT. The CFT members include:

- The child and their parent/caregiver(s);
- The Care Coordinator;
- Natural supports identified by the family, such as other family members, friends, faith leaders, neighbors, or coaches;
- Clinical providers involved in the child's treatment (e.g., mental health, substance use, developmental disabilities) if desired by the family;
- For children involved in child welfare, the DCFS Case Manager and any other child welfare professionals or foster parents involved with the child;
- Professionals from other service systems involved with the child, such as probation/parole officers, teachers/other school personnel, if desired by the family;
- The child's primary care provider, the prescriber of any medications, or any medical specialists;
- For children receiving SASS/MCR services, a member of the MCR team;
- For children enrolled in an MCO, the assigned MCO Care Manager, if requested by the family.

The child and their legal guardian retain full choice in determining the members of their CFT. Based on the releases of information obtained from the family, the Care Coordinator is responsible for engaging potential team members, securing their participation in the

CFT, gathering information that may inform the development of the initial strengths-based service plan, and helping prepare the team member for the initial CFT meeting. This includes educating them about Pathways, CCS services, and the CFT process, and sharing any relevant documentation in advance of the initial CFT meeting, such as the IM+CANS and the SNCD. The Care Coordinator will schedule the initial CFT meeting to take place within thirty (30) days of the child's effective enrollment date, selecting a time and location based on the preferences of the child and family and in consideration of the availability of CFT members.

205.9.3 Phase 2 – Planning

During this phase, trust and mutual respect is built amongst CFT members while the team creates an initial strengths-based service plan using the IM+CANS. This phase should be completed during one or two CFT meetings that take place within 1-2 weeks, a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal. The initial CFT meeting must be held within thirty (30) days of the child's effective enrollment date.

CFT meetings are to be held in person, and in person participation by CFT members is to be encouraged by the Care Coordinator. If in person participation by CFT members is not possible, the Care Coordinator should explore member participation through other means, such as technology or through information gathered ahead of time.

The Care Coordinator's primary role is to facilitate, implement, and monitor the informed decisions of the CFT. They are responsible for framing the CFT process and for setting the tone and managing the pace of each CFT meeting. At the initial convening, and as needed throughout the process, the Care Coordinator ensures team members are introduced to one another and that the goals, values, and principles of Pathways and the CFT process are fully described.

During Phase 2, the Care Coordinator helps the team with the following core activities:

- **Establish ground rules for the team.** This should include a discussion of legal and ethical issues, including confidentiality and mandated reporting responsibilities. The agreed upon ground rules are recorded and distributed to all team members.

- **Develop the team mission**. The family's vision should first be reviewed with the team. The Care Coordinator then leads the team in the establishment of a one or two sentence team mission statement that reflects the long-term goal the team is working toward.

- **Identification of needs**. The team identifies those items preventing the family from reaching their vision. Needs are not equivalent to services; they point toward

strategies that may include a service, but may also be addressed through other methods, such as informal or community supports.

- **Identification of strengths**. Strengths are different than attributes. Attributes are characteristics of a person, whereas strengths refer to skills or abilities that someone has and may include skills or abilities used to manage challenges in the past. Strength identification is an intentional process during which strengths inherent to the child, family, and other team members are explored and identified. Strengths identified should be functional, meaning they can be used as a basis for strategies designed to meet the family's needs. The Care Coordinator will facilitate a discussion of the strengths of each team member, guiding them toward functional strengths.

- **Introduction of the IM+CANS.** The Care Coordinator will introduce the family and team members to the IM+CANS, its elements, and the process by which it is used to document the child and family's needs, strengths, and service plan. Care Coordinators will facilitate a discussion within the CFT to prioritize the identified needs based on the immediacy and severity of the needs, as well as those which reflect the family vision.

- **Review of the Crisis Prevention and Safety Plan (CPSP).** The Care Coordinator will review the CPSP with the team, focusing the conversation on how team members can support the child and family's safety. The CPSP should be amended, as appropriate, based on feedback from the team.

- **Develop an initial service plan using the IM+CANS.** The Care Coordinator will lead the CFT in developing an individualized, strengths-based service plan using the IM+CANS. The service plan should consider the preferences of the child and family, the child and family's holistic needs and strengths, information from the child's existing IM+CANS and any other existing assessments (e.g., psychological, psychiatric evaluation), and the expertise/recommendations of CFT members. Strategies utilized in the service plan should be strengths based and reflect the steps the CFT will take to address the domains of need. These strategies should have measurable goals and time frames, identify specific individuals responsible for each strategy, and identify the roles and responsibilities of all CFT members. Strategies should be geared toward developing skills and building strengths to support long term sustainability of the plan. The service plan must identify all supports and services that will be used by the child and family to meet their goals. The Care Coordinator is responsible for being familiar with a wide breadth of local and state level resources, both formal and informal, and being able to describe them to the CFT to assist them in determining the most appropriate, least restrictive, and most sustainable resource to meet a need. CCSOs are encouraged to tap into other internal or external resources (e.g., community engagement specialist) to help support Care Coordinators and CFTs in identifying and selecting from available community

resources. The Care Coordinator must ensure the child and family have full, informed choice of the services, providers, and settings from which they can receive recommended services. The Care Coordinator must document the affirmative choices made by children and families regarding service delivery.

For all Pathways enrolled children, the CCSO must obtain signatures on the IM+CANS from the child (as appropriate), their parent/guardian, and all individuals and providers responsible for service implementation following each significant update to the IM+CANS. A Licensed Practitioner of the Healing Arts (LPHA), as defined in 89 Ill. Adm. Code 140.453, within the CCSO must review, approve, and sign off on any significant changes to the IM+CANS. Updates and reassessments of the IM+CANS must be uploaded to the IM+CANS Provider Portal within ten (10) business days. CCSOs must provide a copy of the IM+CANS to the family and all service providers identified on the IM+CANS.

205.9.3.1 CFT Meeting Documentation

The Care Coordinator is responsible for preparing CFT members for each team meeting by providing clear, accurate, and thorough documentation. This starts with the Care Coordinator sharing a CFT meeting agenda with all team members prior to the meeting, ideally at least 48 hours before the meeting when possible. During the meeting, the Care Coordinator should use a CFT meeting attendance sheet to document the team members in attendance at the meeting, including whether they joined in person, by phone, or by video. After the meeting, the Care Coordinator is responsible for developing meeting minutes and for making updates to the IM+CANS and CPSP, as needed, that reflect the discussion and decisions made during the meeting. The meeting minutes and updated plans must be shared with all CFT members within seven (7) days after the CFT meeting.

205.9.4 Phase 3 – Implementation

During this phase, the service plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented. The activities of this phase are repeated until the team's mission is achieved.

The service plan is reviewed during CFT meetings and in between meetings through contacts with the child, family, and other CFT members to ensure that the plan and identified strategies are being implemented and to assess the progress being made. The development and monitoring of the plan is a collaborative effort of all team members. Care Coordinators are required to maintain contact with the child and family minimally weekly through a mix of face-to-face visits and telehealth contacts, conducted in addition to the CFT meeting, ensuring that the required minimum number of contacts (see Table 3) is maintained for each child and family. The number of visits will vary depending on family needs and circumstances, as discussed in the CFT and supervision. When Care Coordinators have persistent challenges in connecting with a family, they will seek supervision to explore further options.

The CFT continues to meet regularly based upon the needs of the child and family and consistent with the model requirements outlined in Table 3. A family may elect to convene the CFT outside of the timeframes due to their availability or the availability of key CFT members. In this instance, the Care Coordinator must clearly document the reason and family-driven need for meeting outside of the required timeframes.

At each CFT meeting, the Care Coordinator facilitates the discussion and reviews the elements of the IM+CANS and the CPSP, including the family vision, strengths, needs, strategies, desired outcomes. If the CFT determines that the current care plan is not effective in helping the child and family meet their goals, additional strategies, supports, and services will be explored.

The CFT can, and should, meet more frequently if there is a change in child or family circumstances, an emerging or emergent need, or any situation that warrants planning revisions. Any team member can request a CFT meeting at any time. The Care Coordinator is the point person for setting up the CFT meeting. The Care Coordinator will contact team members to schedule the meetings, which take place at a time and location convenient for the family members. The Care Coordinator should make every effort to assure participation of all persons requested by the family to be on the CFT. If the Care Coordinator is unable to secure participation of a family-requested member despite diligent efforts, this should be documented in the progress notes and CFT meeting documentation.

The CFT may expand or change in membership/composition based on family request, changing circumstances, or revised treatment goals. The team should always be looking to expand to include informal supports as they are identified or developed. The goal for CFT membership is to have a CFT primarily composed of informal and community supports, so that the family continues to have a network of support long after transitioning out of Pathways.

As the family builds skills through the CFT process, the family should be encouraged to coordinate and facilitate their CFT, with support and encouragement from the Care Coordinator, with the goal of empowering the families to coordinate their own supports and services after transition from Pathways.

205.9.5 Phase 4 – Transition Planning

All children and youth will experience transitions during their participation in Pathways for various reasons. Children may experience transitions from higher levels of care (e.g., inpatient psychiatric hospitals, residential treatment), across care coordinators (within a CCSO and across CCSOs), or into the adult service system. In other cases, the CFT will determine the child and family are ready for a purposeful transition out of formal CCS services to a mix of other formal and natural supports. Therefore, it is important to anticipate possible transitions as best as possible and develop a plan to ensure that such transitions are as seamless as possible, and that care coordination and other services are not interrupted.

The focus on transition is continual throughout the CCS process, and the preparation for transition is apparent even during initial engagement activities. The ultimate goal of the CFT process is to empower families to be able to manage their own care plan within the community and to navigate future needs independent of formal care coordination services.

205.9.5.1 Transitions To/From Institutional Care

When a child receiving CCS services transitions to or from an institutional setting (e.g., hospital, residential facility, group home), the Care Coordinator is responsible for supporting the transition. The ongoing support of CCSOs throughout the child's institutional care is vital; the Care Coordinator and CFT provide continuity of support for the child and family, ensure there is a focus on discharge planning starting from the point of admission, and help put into place the services and supports needed to prepare for the child's return to the home and community.

It is expected that all required CCS activities, including CFT meetings, will continue to occur while the child is admitted to an institutional facility. The Care Coordinator should contact the facility as soon as possible upon the child's admission, or prior to admission if possible, to educate the facility about the CCS services the child and family are receiving, to explain the Care Coordinator's role, and to solicit the facility's participation and cooperation in the ongoing Wraparound process. If the CCSO is unable to engage the facility for purposes of facilitating ongoing care coordination activities, despite multiple good faith efforts, the CCSO must contact HFS for assistance.

If the child is admitted to an institutional facility for more than a short-term stay (more than fourteen (14) calendar days), the CCSO must notify HFS by submitting the Pathways Institutional Notification form as soon as possible after it is identified the stay will not be short-term. In such instances, the CCSO must also notify HFS as soon as possible once the child is discharged from the institutional facility, no later than five (5) business days after the CCSO becomes aware of the discharge.

205.9.5.2 Transitions Out of Care Coordination

Transition planning requires the Care Coordinator to balance the family's current need for support with preparing them to transition out of CCSO by teaching the family the process of the CFT. From the initial meeting forward, the Care Coordinator will encourage the family to drive the CFT process by reinforcing their strengths, highlighting their successes, and empowering them to apply the skills learned to problem solve on their own. A transition plan is formally developed if one or more of the following criteria are met:

- The goals of the care plan have been substantially achieved;
- The CFT determines the child no longer requires the intensive level of care management provided by the CCSO;

- The family requests to be transitioned out of CCS services or out of enrollment in Pathways; or
- The child no longer meets Pathways eligibility criteria pursuant to Section 205.1.

205.9.6 Families that Decline CCS Services

Families have the right to decline CCS services at any time while remaining enrolled in Pathways by contacting their CCSO and completing the Pathways Discharge Request form. Pathways eligible children and families who decline CCS services have the right to request to re-engage in CCS services at any time while the child is enrolled in Pathways. CCSOs must inform families who decline CCS services of their rights and the process for re-engaging in Pathways, consistent with HFS guidance. CCSOs must submit the signed and completed Pathways Change Request form to HFS within five (5) business days after the family declines CCS services.

Families who remain enrolled in Pathways must continue to engage with the CCSO for the purposes of accessing other Pathways covered benefits. The CCSO must complete and maintain the IM+CANS for these children, ensuring the IM+CANS is reviewed and updated no less frequently than once every 180 days. The CCSO must assist families in accessing other recommended services, including other Pathways services, that the family is interested in pursuing.

206 Mobile Crisis Response (MCR) Responsibilities

CCSOs serve as the designated MCR provider for their DSA, ensuring that all SASS and Medicaid enrolled children and adults, both in fee-for-service and managed care, receive necessary MCR services on a no-decline basis consistent with the timeframes and requirements outlined in the Handbook for Providers of Mobile Crisis Response. This includes responding to all eligible Illinois customers presenting in crisis in a county contiguous to Illinois consistent with Appendix B.

206.1 MCR Partnerships

CCSOs may establish partnerships with other providers of MCR services to fulfill the CCSO's MCR responsibilities. CCSOs must provide a detailed, written partnership agreement (e.g., Memorandum of Understanding, contract) that outlines any proposed MCR partnership, or of any proposed changes to an existing MCR partnership that significantly alters how MCR responsibilities will be handled within the DSA, to HFS at least thirty (30) days prior to the proposed effective date of the partnership or of the change. The partnership agreement must minimally address the following:

- Clear identification of each party's role and responsibilities in meeting designated MCR provider responsibilities, including plans for handling 24/7 MCR coverage and responsibilities related SFSP consistent with Section 208;
- The CCSO's plan for overseeing the MCR partner to ensure compliance with core MCR responsibilities;
- The MCR partner's commitment to participate in CFT meetings for Pathways enrolled children while the child is engaged in crisis stabilizing services; and,
- Disclosure of any legal relationships between the MCR partner and a hospital. If such a relationship exists, the MCR partner must demonstrate sufficient separation between MCR and hospital operations, consistent with Section 204.5.

Prior approval from HFS is required before the CCSO may enter any MCR partnerships or before implementing any changes to an existing MCR partnership agreement that significantly alters how MCR responsibilities will be handled within the DSA.

206.2 Involvement of Pathways Care Coordinators in MCR Services

It is expected that all designated MCR and CCSO teams work together collaboratively to ensure seamless coordination and communication for Pathways enrolled families that may access MCR services. For children enrolled in Pathways, the CCSO and any MCR partners must establish protocols to notify the child's Care Coordinator real-time or as soon as possible if the child requires MCR services. This must include a process for including the Care Coordinator, whether in person or via telehealth, in the MCR service to the extent possible.

If a Pathways enrolled child escalates into crisis during a face-to-face contact with their Care Coordinator, and the Care Coordinator is unable to de-escalate the situation, the Care Coordinator may complete an MCR screening and, as clinically appropriate, facilitate hospitalization without engaging the designated MCR team. CCSOs should only utilize this option if the Care Coordinator has the appropriate clinical knowledge, training, and experience to conduct an MCR screening without the support of the MCR team. If the child does not already have crisis eligibility, the Care Coordinator must contact the CARES line within 24 hours of the event to establish crisis eligibility. The outcome of the MCR screening must be reported in CRS within five (5) business days of the crisis event.

206.3 Notification to DCFS for Youth in Care

If a DCFS Youth in Care experiences an MCR screening event, the CCSO must 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.

207 Family Support Program (FSP)

The FSP is a state-funded program that provides access to intensive mental health services and supports to youth with a severe emotional disturbance. The goal of FSP is to support eligible youth and their families by strengthening family stability, improving clinical outcomes, and promoting community-based services. FSP is governed by 89 Ill. Adm. Code 139 and receives administrative and clinical support from Kepro, a designated quality improvement organization contracted with HFS. FSP covers the following medically necessary services and supports for eligible youth:

1. Mental Health Rehabilitation Option (MH-MRO) and Targeted Case Management (TCM) services as defined in 89 Ill. Adm. Code 140.453 and the corresponding CBS Handbook;
2. Individual Support Services;
3. Therapeutic Support Services; and,
4. Residential treatment services.

CCSOs serve as the FSP Coordination Agency for their DSA, employing one or more FSP Coordinators responsible for educating families about FSP, helping families with the FSP application process, and providing case management to FSP eligible youth.

207.1 FSP Eligibility Criteria

Youth will be determined eligible for FSP if they meet the following criteria:

- The youth's parent/guardian is a resident of the state of Illinois;
- The youth is under the age of 26;
- The youth is not be under the guardianship or in the legal custody of any unit of the federal, state or local government;
- The youth's parent/guardian agrees to meet the terms of the FSP Parent or Guardian Responsibilities as outlined in 89 Ill. Adm. Code 139.120;
- The youth demonstrates a severe emotional disturbance;
- The youth demonstrates a severity of need indicating their clinical needs are not being met through active participation in traditional outpatient mental health services;
- The youth demonstrates sufficient cognitive capacity to respond to psychiatric treatment and intervention;
- The youth's history of mental health challenges and treatment efforts demonstrate a chronic condition rather than an acute episode; and,
- The youth demonstrates behaviors or symptoms that are likely to respond to the treatment services available in the FSP.

207.2 FSP Eligibility Determination Process

Eligibility for FSP is determined following the submission of a completed FSP application to Kepro. CCSOs are required to help all families within their DSA who request assistance with preparing, submitting, and tracking FSP applications. Completed FSP applications are submitted by the youth's legal guardian or, as requested, by the CCSO to Kepro for review. The FSP application form and information on the process for submitting completed applications to Kepro can be found on the HFS website.

Kepro will make a determination of the youth's eligibility for FSP within thirty (30) days after Kepro receives a completed FSP application. The legal guardian of the youth will receive written notification of the outcome of the eligibility determination from Kepro and how to appeal the determination if necessary.

If an FSP application is submitted but missing required information, the legal guardian will be notified and given instructions on what must be done to complete the application. If the missing information is not provided to Kepro within thirty (30) days, an eligibility review will not be completed. The CCSO will receive a copy of all communications between Kepro and the family if the CCSO submitted the FSP application on the family's behalf.

Youth who are determined eligible for FSP will receive 180 days of program eligibility. The CCSO covering the DSA where the youth's home address is will receive notification of all youth determined eligible for FSP.

207.3 FSP Continued Eligibility Process

During the last thirty (30) days of a youth's FSP eligibility period, a request for continued FSP enrollment may be submitted to Kepro. CCSOs must assist families in preparing, submitting, and tracking all FSP continued eligibility requests. Kepro will review the request for continued FSP eligibility and will determine whether the youth continues to meet the FSP eligibility criteria within three (3) business days of receiving the continued enrollment request. If a youth is found to be eligible for continued FSP enrollment, the youth will receive an additional 180 days of program eligibility.

207.4 Discharge from FSP

If Kepro determines a youth no longer qualifies for FSP, a letter of discharge will be sent to youth or guardian and the CCSO notifying them of the discharge reason and discharge date. Youth will be determined ineligible for ongoing enrollment in FSP if one or more of the following occurs:

- The youth or guardian requests discharge from FSP;
- The youth reaches the age of 26;
- The parent/guardian is no longer an Illinois resident;

- Legal guardianship or custody of the youth is ordered by a court to a State or federal agency, except for the Illinois Office of State Guardian (OSG);
- The parent/guardian fails to comply with the FSP Parent or Guardian Responsibilities;
- The youth does not receive FSP services for a period of ninety (90) consecutive days or more;
- The youth or guardian fails to complete the Continued Enrollment Request process; or
- The youth is determined to no longer meet the FSP eligibility criteria.

207.5 FSP Case Management Responsibilities

CCSOs, through the FSP Coordinator, are responsible for providing case management to FSP eligible youth and their families. The CCSO must make direct contact (telephonic or in-person) on a weekly basis with the FSP eligible youth, the youth's legal guardian, and the youth's residential treatment provider, when applicable, throughout the youth's enrollment in FSP.

207.5.1 Initiating FSP Service Planning

Once a youth is determined eligible for FSP, the FSP Coordinator's priority is to schedule an initial face-to-face meeting with the youth and their family to initiate the service planning process. If the FSP Coordinator wasn't involved in the FSP application process, the initial meeting provides an opportunity for the FSP Coordinator and the youth and family to meet and begin to establish rapport. The FSP Coordinator should review the benefits and processes of FSP and their role with the youth and family, ensuring the youth and family know what to expect and where to direct any questions or concerns. The FSP Coordinator is also expected to discuss the IM+CANS, help the youth and family understand the importance of the IM+CANS, both for accessing needed services and for maintaining ongoing eligibility in the FSP.

The FSP Coordinator should also use the initial face-to-face meeting to obtain any needed releases of information, including to speak to collateral contacts and to receive a copy of any relevant clinical documents that might assist in the service planning process, including the youth's FPS application and current IM+CANS.

207.5.2 Crisis Prevention and Safety Plans (CPSPs)

FSP Coordinators are required to develop and regularly review and update a CPSP for all FSP eligible youth, consistent with the guidance outlined in Section 205.9.2.4. The initial CPSP must be established, or reviewed and updated as appropriate, within ten (10) days of the youth's FSP enrollment. The CPSP must be reviewed and updated following an MCR event or minimally once every 180 days.

207.5.3 Service Plan Responsibilities

CCSOs are responsible for developing, regularly reviewing, and updating the IM+CANS for FSP enrolled youth, incorporating the youth, family, and other treatment providers, as applicable, in the service planning process. The FSP Coordinator must provide linkages and referrals to other providers, as appropriate, for the delivery of recommended services on the youth's IM+CANS, working collaboratively with the youth's MCO as applicable to identify in-network providers capable of providing necessary services. The CCSO is also responsible for coordinating and arranging the delivery of ISS and TSS services to FSP eligible youth. More information on ISS and TSS can be found in Section 211.

The IM+CANS should be updated as frequently as needed for FSP youth, but no less frequently than once every 180 days. An LPHA must review, approve, and sign off on the IM+CANS. The CCSO is responsible for uploading the IM+CANS to the IM+CANS Provider Portal within ten (10) business days. CCSOs must provide a copy of the IM+CANS to the youth, family, and all service providers identified on the IM+CANS.

207.6 FSP Funded Residential Treatment

HFS covers the residential treatment when medically necessary for youth in FSP. HFS partners with Kepro to conduct prior authorization and continued stay requests for FSP funded residential treatment. The FSP Coordinator is responsible for helping youth and families access residential treatment and for providing ongoing case management, including transition planning, while the youth is receiving residential treatment. More information about the processes for requesting and facilitating FSP funded residential treatment can be found on the Kepro website.

207.6.1 Residential Prior Authorization Requests

If it is determined that residential treatment may be required to meet the youth's needs, the FSP Coordinator is responsible for completing and submitting a prior authorization request to Kepro. Kepro will review completed prior authorization requests and make a determination to either approve or deny the request. Only a physician reviewer can deny a residential prior authorization request. The outcome of the prior authorization review will be communicated in writing to both the family and the FSP Coordinator.

If the request is denied, the FSP Coordinator may submit a Reconsideration Request on the youth and family's behalf within five (5) calendar days after notification of the prior authorization outcome. A reconsideration means that another physician reviewer, not involved in the initial prior authorization, will conduct a second review of the prior authorization request and make a determination to either uphold (deny) or to overturn (approve) the original determination. The outcome of the reconsideration request will be communicated in writing to both the family and the FSP Coordinator. Youth and families have the right to appeal any denials of residential prior authorization requests. The process for appealing a denial will be outlined in the denial notice to the youth and family.

If the prior authorization is approved, the youth, family, and FSP Coordinator have ninety (90) calendar days to facilitate the youth's admission to a residential treatment facility before another prior authorization approval is required. Once prior authorization is received, the FSP Coordinator must assist youth and family identify a residential treatment facility (RTF).

207.6.2 Facilitating Admission to Residential Treatment

After potential RTFs have been identified, the FSP Coordinator must help the youth and family complete and submit the standardized Residential Admissions Packet (RAP) to in-network FSP RTFs for an admissions determination. Once an RTF accepts the youth for admission, the FSP Coordinator is responsible for coordinating admission with the family and the RTF, supporting the youth and family as they prepare for the youth to go into an out-of-home placement and helping educate the family on any pre-admission requirements of the RTF.

After the youth has been admitted to an RTF, the FSP Coordinator must report the admission to Kepro by no later than three (3) calendar days after the admission occurs. The youth will then be issued sixty (60) days of authorization at the RTF. At the end of the initial sixty (60) day authorization, it is the responsibility of the RTF to submit continued stay requests to Kepro. The family and the FSP Coordinator will receive written notices of the outcome of the RTF continued stay reviews.

207.6.3 Case Management While the Youth Receives Residential Treatment

While the youth is receiving residential treatment, the FSP Coordinator must continue to provide case management and support to the youth and family, including the following:

- Actively participate in all residential staffing and discharge planning meetings;
- Maintain weekly contact with the youth, family, and the RTF;
- Coordinate the provision of mental health and other supportive services to the family in preparation for supporting the youth following discharge;
- Maintaining the IM+CANS, in coordination and with input from the RTF to ensure continuity of services for both the youth and family; and
- Support the youth's transition out of the RTF.

207.7 Youth Eligible for FSP and Pathways

If a youth eligible for both FSP and Pathways accepts CCS services, the CCSO must provide all care coordination activities in accordance with the requirements of Pathways, as outlined in Section 205 of this handbook. This includes transferring, as necessary, the youth and family to a Pathways Care Coordinator.

208 Specialized Family Support Program (SFSP)

The SFSP is a ninety (90) day program of crisis stabilization, community mental health, and assessment services designed to prevent youth at risk of custody relinquishment from entering the child welfare system solely to access behavioral health services. HFS covers the following medically necessary services and supports for SFSP enrolled youth:

1. Mental Health Rehabilitation Option (MH-MRO) and Targeted Case Management (TCM) services as defined in 89 Ill. Adm. Code 140.453 and the corresponding CBS Handbook;
2. Individual Support Services; and,
3. Therapeutic Support Services.

CCSOs serve as the SFSP Coordination Agency for their DSA, utilizing SFSP Coordinators to educate families about SFSP, identify and link eligible youth and families to the services and supports needed to stabilize the family crisis, and to make recommendations to the state regarding the ongoing services needed to support the youth's behavioral health needs.

Note: CCSOs may utilize their approved MCR partners to complete any or all the SFSP requirements outlined in this Section 208.

208.1 SFSP Eligibility Criteria

To be eligible for SFSP, the following criteria must be met at the time of enrollment:

- The youth's parent/guardian must be a resident of the state of Illinois;
- The youth must be under the age of 18;
- The youth must not be under the guardianship or in the legal custody of any unit of federal, state, or local government;
- The youth is admitted to a hospital or similar treatment facility for the primary purpose of psychiatric treatment and be determined clinically appropriate for discharge from that facility;
- The youth's parent/guardian refuses to take the youth home from the hospital or similar treatment facility because the parent or guardian has a reasonable belief that the youth will harm themself or other family members upon returning home; and,
- The youth's parent/guardian consents to program participation.

208.2 SFSP Parent/Guardian Responsibilities

The active participation of the youth's parent/guardian is a requirement of participation in SFSP. The SFSP Parent Guide has been developed as a resource to help families referred to SFSP understand the benefits and requirements of the program, including the expectations for the active participation of the youth's parent/guardian.

208.3 Youth and Family Engagement

CCSOs and partnering MCR agencies must make every effort to engage with youth and families involved in SFSP in a manner and frequency that is consistent with System of Care values and principles while ensuring the responsibilities and duties required by SFSP are met. CCSOs are responsible for educating youth and families about SFSP, minimally addressing the following:

- Purpose and goals of the SFSP;
- Benefits provided by the SFSP, including services available through the program;
- Role of the SFSP Coordinator;
- Process for accessing services and additional supports, including how and when to call the CARES line;
- Role of the State's Interagency Clinical Team (ICT);
- Privacy and confidentiality, including the provider's responsibilities as a mandated reporter;
- Requirements for active participation in the program during the youth's SFSP eligibility period;
- Review of SFSP the Parent Guide, the Parent Agreement, and the Multi-Agency Consents.

CCSOs are responsible for ensuring the parent/guardian understands how to access the SFSP Parent Guide and that the contents of the SFSP Parent Guide are understood by the parent/guardian.

208.4 SFSP Referral Process

The process for referring a child into SFSP is described below:

1. The DCFS Child Abuse Hotline is notified by the hospital or similar treatment facility when a youth is determined to be at risk of custody relinquishment.

2. Either a Comprehensive Community Based Youth Services (CCBYS) provider (for youth ages 11 to 17) or an Intensive Placement Stabilization (IPS) provider (for youth younger than age 11) will be contacted to work with the family to attempt to stabilize the crisis, reunite the family, and eliminate the potential of custody relinquishment.

3. If CCBYS/IPS is unable to successfully stabilize the crisis and DCFS determines the youth is not otherwise abused or neglected, DCFS will contact the Crisis and Referral Entry Service (CARES) line to make a referral to SFSP. The CARES line will only accept SFSP referrals from DCFS.

4. If CARES determines the youth meets SFSP eligibility criteria, the youth will be issued ninety (90) days of SFSP eligibility. CARES will refer the call to the

designated MCR provider responsible for the DSA where the youth is currently located (referred to as the responding MCR agency) to conduct a 24-hour non-emergency MCR screening and to initiate the SFSP enrollment process. CARES will complete an eligibility report for all youth successfully referred to SFSP, providing a summary of the youth's various medical and special program eligibilities. CARES will fax the eligibility report to the youth's home CCSO (the CCSO responsible for the DSA where the youth's parent/guardian lives) within three (3) business days of the youth's enrollment in SFSP to assist the CCSO with required service planning activities.

208.5 SFSP Intake Process

208.5.1 Initial Outreach to the Parent/Guardian

Following the receipt of an SFSP referral from CARES, the responding MCR agency is responsible for contacting the youth's parent/guardian to initiate the SFSP intake process and obtain consent to conduct the initial 24-hour non-emergency MCR screening.

Prior to contacting the parent/guardian, the responding MCR agency must make every effort to contact the home CCSO (or their designated MCR partner), if the responding and home agency are not the same entity. The responding MCR agency and the home CCSO must discuss and coordinate outreach and engagement activities, clearly identifying who will complete each of the SFSP intake steps. Whenever possible, the responding MCR agency and home CCSO should make the initial contact to the parent/guardian together. This allows the home CCSO to be involved in the family engagement and rapport building process from the outset of the youth's SFSP enrollment. Ongoing coordination between the responding MCR agency and the home CCSO is necessary to ensure clear delineation and communication of roles and responsibilities related to the youth's SFSP participation.

208.5.2 Non-Emergency MCR Screening

With consent from the parent/guardian, the responding MCR agency must complete a non-emergency, face-to-face MCR screening of the SFSP youth within 24 hours of receiving the referral from CARES. The MCR screening must be conducted consistent with the requirements outlined in the CBS Handbook, including usage of the IM-CAT decision support tool. The outcome of the IM-CAT must be uploaded into the HFS web-based Crisis Reporting System (CRS) within five (5) business after the MCR screening.

208.5.3 Consent to Participate Process

Within 72 hours of a youth's referral to SFSP, the home CCSO is responsible for meeting with the youth's parent/guardian to seek their consent for SFSP participation, demonstrated through the parent/guardian's signature on both the SFSP Parent Agreement and the Multi-Agency Consents to Disclose Confidential Information (Multi-

Agency Consents) form. The SFSP Parent Agreement functions as the parent/guardian's consent for the youth to participate in SFSP, as well as their informed consent concerning the terms of program participation. The Multi-Agency Consents is a document that must be signed by the parent/guardian and the youth, when appropriate, for confidential behavioral health information regarding the youth to be shared with the state's Interagency Clinical Team (ICT). Information on the role of the ICT is provided in Section 208.11 of this handbook.

During this meeting, the provider should overview and explain the forms and take time to answer any of the parent/guardian's questions. A youth is considered fully enrolled in SFSP once their parent/guardian signs both documents to verify their interest and active participation in SFSP.

In some cases, the home CCSO and responding MCR agency may determine it is more appropriate for the responding MCR agency to facilitate the completion of the consent to participate process. The responding MCR agency and the home CCSO must work together to clearly establish, communicate, and document who will complete this process within the required timeframes. It is important that both providers maintain close communication, providing one another with important updates related to the youth and the family, until such time that the youth is discharged from the inpatient facility or that the parent/guardian declines SFSP participation.

208.5.4 Parent/Guardian Decline of SFSP Services at Intake

Participation in SFSP is voluntary. However, if the parent/guardian does not consent to participate in SFSP and remains unwilling to accept the youth back into the home or find a suitable alternative living arrangement for the youth, the CCSO must complete the following process:

1. Inform the parent or guardian that the CCSO is required to refer the case back to the DCFS Hotline within ninety (90) minutes of the failed referral;
2. Contact the DCFS Hotline and indicate that the provider has a failed SFSP referral; and,
3. Notify CARES of the failed SFSP referral following the contact with the DCFS Hotline.

208.6 Hospital Discharge Plan

Once the parent/guardian agrees to participate in SFSP, the primary goal for the responding MCR agency and the home CCSO is to develop and support a plan for the safe transition of the youth from the psychiatric hospital to a home or community setting. The responding MCR agency and the home CCSO must work on the hospital discharge plan in collaboration with the youth, the parent/guardian, the hospital treatment team, the appropriate CCBYS or IPS provider, and other involved providers as applicable. The

hospital discharge plan must include the development of a Crisis Safety Plan specific to the setting to which the youth will be transitioned.

208.7 Crisis Safety Planning

CCSOs and partnering MCR agencies are responsible for developing and periodically updating a Crisis Safety Plan for SFSP youth. The Crisis Safety Plan should start to be developed during the 24-hour non-emergency MCR screen and completed as soon as possible to support the SFSP youth's transition from the inpatient setting. The Crisis Safety Plan should be updated in collaboration with the youth and the parent/guardian and should be coordinated with other providers involved with the youth's treatment (e.g., CCBYS, IPS, hospital). CCSOs must leave a physical copy of the Crisis Safety Plan with the youth and their family. The Crisis Safety Plan should include information on how to directly contact the designated MCR crisis team, access crisis services, and other contacts necessary to stabilize the SFSP youth. The Crisis Safety Plan should be reviewed and updated following every crisis event or a minimum of every thirty (30) days while the youth is enrolled in SFSP.

208.8 Role of the SFSP Coordinator

CCSOs designate an SFSP Coordinator to work with SFSP enrolled youth and families. SFSP Coordinators maintain responsibility for the management and coordination of all SFSP service delivery and case coordination activities, including submission of the SFSP Assessment Report (see Section 208.10). When possible, efforts should be made to involve the SFSP Coordinator during the SFSP intake process and should continue throughout the youth's SFSP eligibility period. The SFSP Coordinator is responsible for contacting the youth, the parent/guardian, and the staff from any out-of-home treatment setting, as applicable, no less than once per week; all contact efforts must be clearly documented. SFSP Coordinators must be available on days and at times convenient to the families of SFSP youth and make every effort to communicate in methods preferred by the family.

208.9 SFSP Service Planning

Upon completion of the SFSP intake process, the SFSP Coordinator coordinates the immediate delivery of short-term, intensive mental health and family support services necessary to stabilize the SFSP youth in the community and work to remediate the presenting problem(s) while facilitating the completion of the SFSP Assessment Report.

208.9.1 Responsibility for the IM+CANS

SFSP Coordinators are responsible for coordinating the completion of the IM+CANS for SFSP youth within five (5) calendar days of the youth's enrollment in SFSP. The SFSP Coordinator must ensure the IM+CANS is regularly reviewed and updated throughout the youth's enrollment in SFSP, incorporating the youth, family, and other treatment providers

in the service planning process whenever possible. The SFSP Coordinator must provide linkages and referrals to other providers, as appropriate, for the delivery of the recommended services on the youth's IM+CANS, working collaboratively with the youth's MCO as applicable to identify in-network providers capable of providing necessary services. The CCSO is also responsible for coordinating and arranging the delivery of ISS and TSS services to SFSP eligible youth. More information on ISS and TSS can be found in Section 211.

208.9.2 Crisis Intervention and Stabilization Services

Crisis intervention services are activities performed to address behavioral or emotional conditions of a youth with the goal of immediate symptom reduction and restoration to previous levels of role functioning. Crisis stabilization services, therapeutic and behavioral, are intended to mitigate ongoing factors (e.g., relational, environmental) that contribute to episodes of crisis with the goal of supporting the youth in a community-setting. CCSOs are responsible for ensuring the availability of crisis intervention and crisis stabilization services to SFSP youth. Stabilization services should be provided in collaboration with the appropriate CCBYS or IPS provider.

208.9.3 CCBYS/IPS Services

A key component of the SFSP is the collaboration and coordination between the State's various crisis programs for children. CCSOs will work collaboratively as a team with providers of the CCBYS and IPS programs to share resources and coordinate responsibilities for SFSP youth, drawing on the respective strengths of each of the programs and effectively wrapping crisis and stabilization services around SFSP youth and their families. SFSP youth ages 11 and older have access to the services available through their assigned CCBYS provider, while youth ages 10 and under have access to the services available through their assigned IPS provider throughout the duration of their enrollment in SFSP.

208.9.4 Assessment Services

SFSP Coordinators are responsible for assisting SFSP youth and their families in urgently accessing the evaluations and assessments necessary to determine long-term treatment recommendations. A copy of any assessments or evaluations accessed must be submitted as part of the SFSP Assessment Report.

208.9.5 Treatment Services

Treatment services are to be provided as part of the plan for transitioning the SFSP youth safely out of inpatient care and maintaining the youth at a lower level of care. The SFSP Coordinator must coordinate and/or provide ongoing treatment and case management services necessary for successful post-hospitalization stabilization. The SFSP Coordinator will determine whether the SFSP Youth is currently receiving mental health,

substance use, post adoption, or other services and coordinate ongoing case coordination and service delivery with the existing providers. Families receiving treatment services through SFSP must be provided choice of treatment services and providers.

208.10 SFSP Assessment Report

The SFSP Assessment Report is developed by the SFSP Coordinator, signed by an LPHA, and submitted to the Interagency Clinical Team (ICT). The SFSP Assessment Report provides the ICT with a summary of the youth's clinical presentation, state program eligibilities, needs, and ongoing treatment recommendations. The SFSP Assessment Report packet must be completed and submitted along with all applicable items included on the SFSP checklist within 75 days after the youth's SFSP referral.

208.11 Role of the ICT

The ICT is a multi-agency management team, comprised of staff from HFS, DCFS, and the Department of Human Services (DHS), and supported by staff from the Department of Juvenile Justice (DJJ), the Department of Public Health (DPH), and the Illinois State Board of Education (ISBE). The ICT's role is to administer SFSP and ensure the linkage of SFSP youth to the most clinically appropriate services to avoid custody relinquishment and stabilize families. The ICT's responsibilities include:

- Review completed SFSP Assessment Reports;
- Facilitate access to ongoing treatment for transition out of SFSP;
- Provide assistance and consultation on individual SFSP cases; and,
- Review and remove any systemic obstacles that may be preventing linkage with the treatment recommendations found in the SFSP Assessment Report.

208.11.1 Referring a Case to the ICT

From time to time, a CCSO may find it necessary to refer a case for clinical consultation with the ICT due to individual case challenges, population specific issues, or other systemic barriers. In cases when a conflict or barrier arises that cannot be resolved by the CCSO in collaboration with all other involved parties, the case should be referred to the ICT for assistance. Contact with the ICT should be directed via email (HFS.BBH@illinois.gov) using the subject line "SFSP ICT Consultation Request."

208.12 Ongoing Service Linkage

It is the responsibility of the SFSP Coordinator to work in collaboration with other service providers and the ICT to assist with linkage to the ongoing services recommended within the SFSP Assessment Report prior to the youth's discharge from the SFSP. Linkage to ongoing services should begin as soon as sufficient clinical information is gathered to complete the LPHA treatment recommendations within the SFSP Assessment Report.

The SFSP Coordinator must identify and report any barriers to ongoing treatment to the ICT as soon as possible.

208.13 SFSP Early Discharge Process

An SFSP early discharge occurs when the parent/guardian, after consenting to participate in SFSP, is no longer willing to actively participate in the SFSP process. This can occur while the youth is still in the hospital if the parent/guardian refuses to accept the youth back into the home or find a suitable alternative living arrangement for the youth or if the parent/guardian refuses to work with the CCSO to plan for the youth's safe transition out of the hospital. A disagreement between the parent/guardian and the hospital or other involved parties regarding the hospital discharge plan does not constitute a refusal on the part of the parent/guardian to work with the CCSO.

If either situation occurs, the CCSO must complete the following process to execute an early discharge:

1. Identify to the parent/guardian the situation that has constituted the need for an early discharge and verify in writing, to be included in the clinical record, agreement, acknowledgement or an attempt to identify and remedy the situation with the parent/guardian;
2. Inform the parent/guardian the provider is required to refer the case back to the DCFS Hotline within 24 hours;
3. Contact the DCFS Hotline and indicate the provider has a failed SFSP referral; and,
4. Notify the ICT of the failed SFSP referral following the contact with the DCFS Hotline. Contact with the ICT should be directed to the ICT via email (HFS.BBH@illinois.gov) using the subject line "SFSP ICT Failed Referral."

Nothing in this handbook is intended to interfere with or supersede a provider's responsibilities as a mandated reporter, pursuant to the Abused and Neglected Child Reporting Act (325 ILCS 5/1 et seq.); when in question, the Abused and Neglected Child Reporting Act will always prevail.

208.14 Lack of Parent/Guardian Participation

The parent/guardian of the SFSP youth is required to actively participate and meet the SFSP Parent or Guardian Responsibilities throughout the youth's SFSP enrollment. If the parent/guardian is unable or unwilling to continue meeting the SFSP Parent or Guardian Responsibilities for participation after the youth has been discharged from the hospital, the CCSO must immediately notify the ICT and seek technical assistance on how to proceed with the case.

209 Collaboration with Community and System Partners

Regardless of which program they are enrolled in (i.e., Pathways, FSP, SFSP, MCR/SASS), children and youth served by a CCSO are often involved in multiple child-serving systems (e.g., child welfare, education, juvenile justice, substance use, developmental disabilities, managed care) and often require services and support from multiple providers. A primary goal of the CCSO is to reduce the burden and stress on families associated with navigating the responsibilities and requirements of these multiple systems by coordinating and collaborating with other organizations around a single plan of care to the extent possible. It is important that cross-agency and cross-system collaboration occur not only on individual cases, but also at the organizational level. This type of relationship building reinforces System of Care values and principles in service delivery and establishes clearer chains of communication across child-serving organizations, ultimately enhancing the overall service delivery experience for children, youth, and families.

Requirements for collaboration with specific community and system partners are outlined in this Section 209.

209.1 Coordination with DCFS for Youth in Care

For children under the legal custody or guardianship of DCFS (DCFS Youth in Care), close collaboration between the CCSO and the child's assigned DCFS Case Manager is critical for reducing duplication of efforts and maximizing the benefits available under each child-serving system.

CCSOs are expected to participate in case staffings as requested by DCFS staff, including Administrative Case Reviews (ACRs) and court hearings for any DCFS Youth in Care the CCSO serves. Additionally, CCSO staff must provide written reports, upon request, for any case staffing, including an ACR or court hearing.

If at any time the CCSO determines the stability of a DCFS Youth in Care's placement may be at risk, the CCSO must work with the DCFS Case Manager to provide linkages and referrals to Intensive Placement Stabilization (IPS) providers.

209.2 Coordination with DCFS Post Adoption Providers

Children whose parent/guardian receives an adoption subsidy from DCFS are eligible to receive adoption preservation services from a DCFS-contracted provider of Post Adoption Services. When appropriate, CCSOs should outreach the appropriate Post Adoption Services provider to understand the supports the provider can offer to assist in meeting a child and family's needs, providing referrals and linkages as needed. More information about support to adoptive families can be found on the PATH Beyond Adoption website.

209.3 Coordination with Local School District

CCSOs are expected to be familiar and to establish relationships with the schools (traditional, alternative, and therapeutic) within their DSA. Schools are a primary referent of youth to the mental health system, including the MCR system, and will be key partners for CCSOs in coordinating service access and delivery for youth.

CCSOs should identify if the youth they are working with have an Individualized Education Program (IEP) or a 504 Plan, or if an evaluation for educational accommodations needs to be requested. CCSOs should work to obtain a copy of the youth's most recent IEP or 504 Plan, as applicable, to assist in coordination of care. CCSOs are expected to support youth and families with navigating the special education system, including attending IEP or 504 Plan meetings and including a school representative within a Pathways enrolled child's CFT, when appropriate.

210 Staffing and Training Requirements

210.1 Required Staff and Qualifications

CCSO must establish, consistent with the timeframes and guidance of HFS, the staffing capacity necessary 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 MCR services. This includes minimally establishing and maintaining the following staff roles:

- CCSO Clinical Manager. The CCSO Clinical Manager is a full-time employee who is designated only to providing clinical oversight and direction for the CCSO's services and responsibilities outlined in this handbook. The CCSO Clinical Manager must meet the qualifications of an LPHA and maintain annual certification in the IM+CANS.

- CCS Supervisors. CCS Supervisors are designated only to overseeing and providing direct supervision and coaching to CCS Care Coordinators. CCS Supervisors must minimally meet the qualifications of a Qualified Mental Health Professional (QMHP) as defined in 89 Ill. Adm. Code 140.453 and maintain annual certification in the IM+CANS. CCS Supervisors must not exceed an average supervisor to care coordinator caseload of 1:8, with no more than ten (10) CCS Care Coordinators on their caseload at one time. CCS Supervisors may also oversee FSP Coordinators, so long as the required CCS Supervisor caseloads are maintained.

- CCS Care Coordinators. CCS Care Coordinators must minimally meet the qualifications of a Mental Health Professional (MHP) as defined in 89 Ill. Adm. Code 140.453 and maintain annual certification in the IM+CANS. CCS Care Coordinators must be designated only to providing CCS services, with the following exceptions:

    - CCS Care Coordinators may participate in MCR team-based events for children on their caseload.
    - CCS Care Coordinators may fulfill the duties of the FSP Coordinator for FSP or SFSP eligible youth, so long as the required CCS Care Coordinator caseloads are maintained.

  CCS Care Coordinators must be designated to only one CCS tier and may not have mixed tier caseloads, with the following exception:

    - If a sibling of a child 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.

CCSW Care Coordinators must not exceed an average care coordinator to family caseload of 1:10, with no more than twelve (12) families on their caseload at one time. CCSI Care Coordinators must not exceed an average care coordinator to family caseload of 1:25, with no more than thirty (30) families on their caseload at one time.

- FSP and SFSP Coordinators. FSP Coordinators must minimally meet the qualifications of an MHP and must maintain annual certification in the IM+CANS.

- MCR Screening Staff. Staff delivering MCR services must meet the minimal staff qualifications, including maintaining annual certification in the Illinois Medicaid Crisis Assessment Tool (IM-CAT), as outlined in the CBS Handbook. MCR screeners must be supervised by and have immediate access to a QMHP for consultation during MCR screening events.

All staff must clear a background check before delivering services to any customer. In addition to these required staff roles, CCSOs must have a mechanism for interpreting sign and other languages, including offering translation services, to communicate with customers as needed.

210.2 Training Requirements

The CCSO must provide and document training to new and current staff. Training in required topics should be completed within thirty (30) days of any new staff's start day and annually thereafter for all staff. Topics should include, but are not limited to:

- The CCSO's program plan and internal policies and procedures;
- The relevant HFS-issued Provider Handbooks and policies relevant to the staff member's role and responsibilities;
- System of Care, Wraparound, and Family Driven Care values and principles;
- Cultural humility;
- Ethics;
- Crisis intervention and de-escalation techniques;
- Care coordination and case management techniques that are consistent with Wraparound principles;
- Mandated reporter responsibilities, including those under the Abused and Neglected Child Reporting Act (325 ILCS 5) and the Adult Protective Services Act (320 ILCS 20);
- 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 DCFS;
- Child development;
- Family systems/parenting;

- Engagement strategies and techniques, including motivational interviewing;
- Identification of symptoms of trauma and the use of trauma informed interventions; and,
- Relevant State data systems.

210.3 Training Requirements for CCS Staff

Staff providing CCS services, including the Clinical Manager and CCS Supervisors, must complete the HFS approved wraparound and supervisor trainings, as applicable, through PATH prior to delivering services to Pathways eligible children. This training meets the requirement for training in “care coordination and case management techniques” as outlined in Section 210.2. CCS staff are also required to participate in all required booster trainings and coaching sessions conducted by PATH and as required by HFS. Additional detail on the CCS training process and requirements can be found on the HFS website.

211 Provider Reimbursement and Fiscal Responsibilities

211.1 Charges

Providers are to submit charges only after services have been rendered. Charges are to reflect the provider's usual and customary charges to the general public for the services provided. To be eligible for reimbursement, all claims, including claims that are corrected and resubmitted, must be received within 180 days of the date of service, or within 24 months from the date of service when Medicare or its fiscal intermediary must first adjudicate the claim, unless one of the exceptions to the timely filing rule applies. Refer to the Timely Filing Override Submittal Instructions for a list of exceptions to the 180-day rule and billing instructions for each.

Unless otherwise stated in this handbook, charges for services provided to children enrolled in HealthChoice Illinois must be billed to the managed care plan according to the provider's contractual agreement with the managed care plan. Please refer to the policies and procedures of each individual plan.

211.2 Payment and Reimbursement

Payment made by HFS for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by HFS. Refer to Handbook for Providers of Medical Services, General Policy and Procedures, for HFS payment procedures. HFS is responsible for establishing rates for all eligible services in the Illinois Medicaid Program. The HFS established rate is the maximum allowable rate for each eligible service. Reimbursement of a Medicaid service by a public payer in any amount up to the maximum allowable rate published by HFS shall be considered payment in full and cannot be supplemented in any way. HFS authorized rates for CCSO services are published on the HFS website.

211.3 CCSO Fiscal Agent Responsibilities

CCSOs serve as the fiscal agent for Individual Support Services (ISS) and Therapeutic Support Services (TSS) for children enrolled in Pathways, FSP, and SFSP. CCSOs must work to identify and engage local providers, social service organizations, and other entities who offer the types of services and supports reimbursable under ISS and TSS, building a network of ISS and TSS providers for their DSA.

CCSOs are to establish a unique, dedicated revolving fund for the management and reimbursement of ISS and TSS. Utilizing this fund, CCSOs are responsible for directly reimbursing organizations for authorized ISS and TSS. CCSOs must then submit claims directly to HFS (for both fee-for-service and managed care enrollees) for the reimbursement of expended funds. CCSOs must replenish the fund with the payments received from adjudicated ISS and TSS claims, always ensuring that sufficient funding is

available to ensure all eligible children have access to ISS and TSS up to the annual service limits outlined in Sections 211.4.3 and 211.4.4.

The CCSO must have written policies and procedures to ensure accountability, verify provider qualifications, verify actual costs, verify the delivery of ISS and TSS, and to ensure that annual state fiscal year dollar limits for ISS and TSS are not exceeded.

211.4 Covered Services

Services covered under the Illinois Medical Assistance Program include only those reasonably necessary medical and remedial services that are recognized as standard medical care required for immediate health and well-being because of illness, disability, infirmity or impairment. A full listing of the services for which CCSOs may receive payment is detailed in this section.

211.4.1 Reimbursement of MRO-MH and TCM Services

Medically necessary MRO-MH and TCM services delivered to customers pursuant to this handbook, including MCR services, must be delivered consistent with the policies outlined in the CBS Handbook. These services will be reimbursed consistent with the CBS Handbook and corresponding fee schedule.

211.4.2 Care Coordination and Support — HCPCS: G9001/G9002

Program Benefit: ☒ Pathways ☐ FSP ☐ SFSP

Care Coordination and Support (CCS): CCS is 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. CCS services are provided at two intensity levels (CCSW and CCSI) to eligible children and must be conducted in line with the policies outlined in Section 205.9.

Requirements for Reimbursement: CCS services are reimbursed at a monthly case rate based on the child's assigned tier. The monthly case rate is reimbursable for each calendar month a child receives CCS services, consistent with the following requirements.

- For children 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.
- After the first calendar month of payment, claims for CCS services are only reimbursable when the CCSO has:
    - Completed 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 each week of the month, except for those weeks that occur after the child's discharge date; and,
- Completed two (2) oral communications (telephonic, video, or in-person) with the family within the calendar month. At least one of the oral communications must be conducted in-person.

Staff Qualifications: CCS services must be delivered by staff who minimally meet the qualifications of an MHP and who meet the training requirements as outlined in Section 210.

Medical Necessity: CCS services are deemed medically necessary at the assigned tier for children enrolled in Pathways.

Prohibition Against Duplication of Services: Case Management services are not reimbursable to any provider during the calendar months in which a child receives CCS services. CCSOs may not submit any supplemental claims for discrete services that are in the same scope of the CCS service and that are accounted for in the monthly CCS case rate. This includes: Integrated Assessment and Treatment Planning (IATP), all forms of Case Management, MCR events conducted solely by child's designated CCS Care Coordinator, and Crisis Intervention services, except when immediately following a MCR event.

211.4.3 Individual Support Services HCPCS: T1999

Program Benefit: ☒ Pathways ☒ FSP ☒ SFSP

Individual Support Services (ISS): ISS are 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 eligible children. ISS are intended to promote health, wellness and behavioral health stability through community stabilization and family stability. ISS services may only be provided for the direct benefit of the child. The following activities, services, and goods are covered under ISS:

- Physical wellness activities and goods that promote a healthy lifestyle through physical activity (i.e., sports club fees or gym memberships; bicycles, scooters, roller skates and related safety equipment) and nutrition education (i.e., cooking classes, non-credit nutrition courses);
- Special or therapeutic youth development programs offered by a community-based organization that serve individuals with disabilities who otherwise would not be able to successfully participate in traditional youth development programs. These programs focus on developing social skills through youth development opportunities that are supported by staff with specialized training;
- Strengths-developing activities (i.e., music lessons, art lessons, therapeutic summer camp);

- Sensory items ordered by a licensed occupational therapist, speech-language pathologist, physical therapist, or LPHA; and
- Parent education and training.

Medical Necessity: The specific ISS interventions must be documented as a recommended service by the authorizing LPHA, in collaboration with the CFT as applicable, on the participant's IATP and must be directly tied to supporting the achievement of one or more goals on the service plan.

Prior Authorization Requirements: All ISS require prior authorization. Prior authorization requests for all eligible children, including those children enrolled in an MCO, must be submitted to HFS or its designee and approved before the service begins.

Limitations on ISS Services: TSS are limited to $1,500 of funding per child per State fiscal year.

211.4.4 Therapeutic Support Services HCPCS: H0046

Program Benefit: ☒ Pathways ☒ FSP ☒ SFSP

Therapeutic Support Services (TSS): TSS are adjunct therapeutic modalities not otherwise covered under the Illinois Medical Assistance Program that support individualized goals as part of the child's service plan. TSS are designed to help children 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. The following interventions are covered under TSS: art therapy, dance/movement therapy, equine-assisted therapy, horticultural therapy, music therapy, and drama therapy.

Staff Qualifications: TSS interventions may only be provided by an individual qualified in the specific intervention being delivered, consistent with the table below.

Intervention	Staff Qualifications
Art Therapy	Credentialed by the Art Therapy Credentials Board
Dance/Movement Therapy	Credentialed or board certified by the American Dance Therapy Association
Equine-Assisted Therapy	Certification or credential in equine-assisted therapy from a recognized national or international non-profit association
Horticultural Therapy	Professional registration with the American Horticultural Therapy Association
Music Therapy	Certified by the Certification Board for Music Therapists
Drama Therapy	Credentialed by the North American Drama Therapy Association

Medical Necessity: The specific TSS interventions must be documented as a recommended service by the authorizing LPHA, in collaboration with the CFT as

applicable, on the participant's IATP and must be directly tied to supporting the achievement of one or more goals on the service plan.

Prior Authorization Requirements: All TSS require prior authorization. Prior authorization requests for all eligible children, including those children enrolled in an MCO, must be submitted to HFS or its designee and approved before the service begins.

Limitations on TSS Services: TSS are limited to $3,000 of funding per child per State fiscal year.

211.4.5 FSP: Application Assistance — HCPCS: G9012

Program Benefit: ☐ Pathways ☐ FSP ☐ SFSP ☒ Other

Application Assistance: The service of Application Assistance includes the completion of the FSP application as well as the compiling and submission of all the necessary documentation, in conjunction with the family and/or youth, to determine the youth's clinical eligibility for the FSP.

Staff Qualifications: Application Assistance must be delivered by staff who minimally meet the qualifications of an MHP.

Service Approval: The service is only approved for youth who are not enrolled in one of the full benefit healthcare programs administered by HFS and who require assistance in the completion of an FSP application for the purposes of determining FSP eligibility. If the youth is enrolled in a full benefit healthcare program, the appropriate case management service should be used for billing this service.

Usage of Pseudo RIN: HFS has established a unique nine-digit pseudo-RIN to be used for billing this service. This service should only be billed for non-Medicaid customers, consistent with HFS policy. The pseudo-RIN for FSP Application Assistance is detailed in the table below:

RIN	First Name	Last Name	DOB	Program Description
212771711	ICG	Application	4/21/2000	ICG Application Assistance

Registration Number: Providers must enter a youth-specific identifying registration number into the Patient Control Number field (Loop 2300) on the claim for this service. The registration number consists of the youth's name – first initial of the first name and up to eleven (11) characters of the last name and date of birth. The entry should not exceed twenty (20) characters in total and must be alpha and numeric characters, consistent with the following example:

FSP Applicant Youth Name: John Smith
FSP Applicant Youth Date of Birth: 9/8/2005

FSP Application Assistance Registration No.: 09082005JSMITH

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual

Limitations on Application Assistance Services: 8 units (2 hours) per unique application.

211.4.6 FSP: Case Participation HCPCS: T1016

Program Benefit: ☐ Pathways ☒ FSP ☐ SFSP

Case Participation: The service of Case Participation includes the FSP Coordinator's participation in individual youth-specific case meetings to discuss case or clinical issues, with or without the youth present, and should only be utilized when the Medicaid eligible Targeted Case Management service codes are not appropriate for the service.

Staff Qualifications: Case Participation must be delivered by staff who minimally meet the qualifications of an MHP.

Service Approval: The service is only approved for youth enrolled in the FSP and for whom other Targeted Case Management services are not appropriate or not otherwise covered but who require case coordination services.

Allowable Service Delivery Modes: Face-to-face, phone, and video.

Allowable Service Delivery Types: Individual

212 Billing Requirements

212.1 Claiming Requirements

When billing for services, the claim submitted for payment must include a diagnosis and the coding must reflect the services provided consistent with the guidance in this handbook. Any payment received from a third-party payer or other persons applicable to the provision of services must be reflected as a credit on any claim submitted to HFS bearing charges for those services or items.

212.2 Billing NPI

The Billing NPI (formerly referred to as Payee NPI) must be reported in loop 2010AA, Billing Provider. The address associated with the NPI entered into this loop is the address where HFS will send Remittance Advice and Payments.

212.3 Rendering Provider

The Rendering Provider must be entered in loop 2310B, Rendering Provider. This data should be a NPI that is connected to the provider site/HFS Provider ID number enrolled with HFS as a CCSO. The Rendering Provider is not required if the provider NPI is the same as the Billing Provider, Loop 2010AA.

212.4 Reporting Place of Service for CCSO Services

Providers must specify a location of service delivery on each claim by reporting the appropriate two-digit Place of Service (POS) code, consistent with HFS billing guidance and national HIPAA guidelines. CCSOs are to utilize POS 99 (Other Place of Service) on all claims for CCS, ISS, and TSS services. Claims for FSP: Application Assistance and FSP: Case Participation must reflect the true location off services rendered, consistent with the guidance outlined in Section 207.3.5 of the CBS Handbook.

213 Monitoring, Data, and Reporting

Ongoing data collection, program monitoring, analysis, and shared learning is essential for the successful implementation of CCSOs. These quality assurance and quality improvement activities serve as a platform for improving outcomes for children and families receiving behavioral health services in Illinois. HFS will partner with MCOs, PATH, and the Office of Medicaid Innovation (OMI) to measure and monitor CCSO compliance and performance and to develop, implement, and measure quality improvement activities. CCSOs must comply with all monitoring visits, data reporting, requests for document reviews, technical assistance, quality efforts, and follow-up activities undertaken by HFS or its partners. CCSO quality assurance and improvement activities will minimally include:

- Monitoring adherence to the requirements outlined in this handbook;
- Analyzing characteristics of children enrolled in Pathways, FSP, and SFSP to determine any potential disparities or barriers to enrollment and ongoing engagement in the programs;
- Analyzing the engagement of children who receive an MCR screening and their family in follow-up behavioral health services;
- Monitoring engagement and inclusion of the child and family in all aspects of their own care;
- Measuring child and family satisfaction;
- Monitoring IM+CANS interrater reliability;
- Ongoing measurement of fidelity to the National Wraparound Initiative standards;
- Ongoing measurement of outcomes for children and families;
- Reporting critical incidents; and,
- Participating in quality improvement projects.

213.1 CCS Fidelity Monitoring

CCS services are based upon the principles, phases, and activities of wraparound. CCSOs must participate in ongoing fidelity monitoring, conducted by PATH, to measure compliance with the wraparound-informed model for children receiving CCSI services and with high-fidelity wraparound for children receiving CCSW services. Fidelity monitoring will be conducted utilizing instruments from the Wraparound Fidelity Assessment System (WFAS), designed to review the CCSO's fidelity to National Wraparound Initiative standards. The WFAS instruments to be utilized include surveys of stakeholders, including the child and family, and a team observation measure. CCSOs will be provided with a summary of findings from the fidelity reviews. PATH will schedule a time to meet with the CCSO to discuss the findings from these reviews and, if needed, discuss any strategies to improve performance.

To help facilitate fidelity monitoring, CCSOs will be required to regularly enter data into WrapStat. WrapStat is a web-based data collection, management, and feedback system designed to evaluate wraparound fidelity based on the WFAS measures. CCSOs will be

provided with additional information on how to access WrapStat and the data entry requirements as part of the readiness review process.

213.2 Immediate Reporting Requirements

CCSOs shall comply with the following immediate reporting requirements for all children and families served pursuant to this handbook.

213.2.1 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.

213.2.2 Mandated Reporting

The CCSO and its staff are Mandated Reporters of child, elder, and disabled adult 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 Adult Protective Services Act (320 ILCS 20). Suspected child abuse or neglect must be reported to the DCFS Child Abuse Hotline and suspected abuse, neglect, or financial exploitation of elders or adults with disabilities 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.

213.2.3 Fraud and Abuse Reporting

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.

213.3 Critical Incident Reporting

CCSOs are required to track and report critical incidents for children served pursuant to this handbook. The purpose of tracking critical incidents is to: 1) ensure the immediate health, safety, and welfare of participating children; 2) inform the development and implementation of preventive practices; and identify and analyze trend patterns for the purpose of developing meaningful oversight and monitoring practices.

A critical incident is defined as actual or alleged abuse, neglect, exploitation, or any incident that has the potential to place a child at risk, including events that may cause substantial or serious harm to the physical or mental health of a child or jeopardize the safety of services the child receives. CCSOs must establish policies, procedures, and systems for tracking and reporting the following critical incidents:

- Abuse: the injury, confinement, control, intimidation, or punishment of an individual, that has resulted in physical harm, pain, fear, or mental anguish. Abuse includes, but is not limited to physical, emotional, verbal and/or sexual abuse, the use of unauthorized restraint, seclusion, or restrictive intervention; or use of authorized restraint, seclusion, or restrictive intervention that results in, or could reasonably be expected to result in, physical harm, pain, fear, or mental anguish to the individual.

- Neglect: a failure to provide an individual with any treatment, care, goods, or services necessary to maintain the health or welfare of the individual when there is a duty to do so and may include passive neglect (non-malicious failure), willful deprivation, and isolation.

- Exploitation: the misuse or withholding of an individual's assets or resources (belongings and money). It includes, but is not limited to, the misappropriation of assets or resources by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion, or in any manner contrary to law.

- Serious Injury/Medical Incident: any unexpected incident that causes significant physical harm to the individual to the extent that emergency room treatment, inpatient observation, or hospital admission is required (e.g. overdose, self-harm, suicide attempts, gun violence, car accidents).

- Unnatural or Accidental Death: An unnatural or accidental death, that could not reasonably have been expected, and the circumstances are suspicious, or the cause of death are not related to any known medical condition of the individual. Includes medical errors, suicide, overdoses, accidents, or homicides.

- Other: any other incident not covered by another category that places, or has the potential to place, an individual at risk of significant physical or mental distress.

Critical incidents must be reported to HFS and the child's MCO, when applicable, using the CCSO Critical Incident Reporting Form within 72 hours of the CCSO learning of the incident. For children receiving CCS services, the CCSO should also ensure the CFT is provided with information regarding critical incidents as appropriate to determine when a CFT meeting should occur to address the incident.

Nothing in this section replaces or negates the CCSO's responsibility to refer critical incidents as required by federal or state law or regulation to the appropriate authority.

213.4 Monthly Reporting

CCSOs, in collaboration with any MCR partners, must submit a monthly report to HFS by the fifteenth business day of the following month, utilizing a standardized reporting template provided by HFS. The monthly report will minimally include the following:

- Number of Pathways eligible children assigned, aggregated by demographic categories, assigned tier, and enrollment status;
- Average caseload of CCSW and CCSI Care Coordinators and CCS Supervisors;
- Compliance with required care coordination activities and timeframes (e.g., the number of children in CCS services receiving CFT meetings within established timeframes);
- Statistics detailing the number of MCR events performed for the month and their disposition, with population specific breakouts;
- Percentage of MCR events occurring at the location specified by CARES;
- Percentage of MCR events initiated within ninety (90) minutes of receipt of a crisis referral from CARES;
- Percentage of Pathways Youth with an MCR event in which the designated Care Coordinator participated in the MCR event; and,
- The number of MCR screened customers waiting in an Emergency Room for a psychiatric hospital bed for a period of 24 hours or greater.

213.5 Additional Reporting

CCSO may be required to periodically provide ad hoc data or additional reports to HFS and the MCOs. CCSOs must work collaboratively with HFS and the MCOs to establish processes and methods for the establishment of any new, standard reporting requirements determined necessary for the purposes of customer, contract, program, and system monitoring and evaluation, consistent with the timelines required by HFS.

Appendix A: CCSO Designated Service Area (DSA) Descriptions

DSA	Geographic Area Covered
1	Alexander, Pulaski, Union, Jackson, Johnson, Massac, and Williamson Counties
2	Monroe, Randolph, St. Clair, Washington, Clinton, and Perry Counties
3	Jefferson, Franklin, Hamilton, White, Saline, Gallatin, Pope, and Hardin Counties
4	Fayette, Effingham, Jasper, Crawford, Lawrence, Richland, Clay, Marion, Wayne, Edwards, and Wabash Counties
5	Calhoun, Jersey, Greene, Macoupin, Montgomery, Bond, and Madison Counties
6	Hancock, Adams, Pike, Brown, Schuyler, and McDonough Counties
7	Mason, Menard, Scott, Morgan, Cass, Sangamon, Christian, and Logan Counties
8	Macon, Shelby, Moultrie, and Piatt Counties
9	Champaign, Vermilion, Douglas, Edgar, Coles, Cumberland, and Clark Counties
10	Ford, Iroquois, and Kankakee Counties
11	Will County
12	Livingston, McLean, and DeWitt Counties
13	Tazewell, Woodford, Marshall, Putnam, Stark, Peoria, and Fulton Counties
14	Henderson, Warren, Mercer, Knox, and Rock Island Counties
15	Whiteside, Henry, Bureau, and Lee Counties
16	Jo Daviess, Stephenson, Winnebago, Ogle, and Carroll Counties
17	Boone and McHenry Counties
18	DeKalb and Kane Counties
19	LaSalle, Grundy, and Kendall Counties
20	DuPage County
21	Lake County
22	All or parts of Barrington, Hanover, Palatine, Schaumburg, Wheeling, and Elk Grove Townships (zip codes 60004, 60005, 60006, 60007, 60008, 60009, 60010, 60038, 60056, 60067, 60070, 60074, 60078, 60089, 60090, 60094, 60095, 60103, 60107, 60118, 60120, 60133, 60159, 60168, 60169, 60172, 60173, 60179, 60192, 60193, 60194, 60195, 60196)
23	Evanston and all or parts of Northfield, Maine, New Trier, and Niles Townships (zip codes 60015, 60016, 60065, 60018, 60022, 60025, 60026, 60029, 60043, 60053, 60062, 60068, 60019, 60017, 60076, 60077, 60091, 60093, 60082, 60201, 60202, 60203, 60204, 60208, 60712, 60714)
24	O'Hare, River Forest, Norwood Park, Riverside, Oak Park, Berwyn, Cicero, and all or parts of Leyden, Proviso, Lyons, and Stickney Townships (zip codes 60104, 60126, 60480, 60130, 60131, 60546, 60141, 60534, 60153, 60154, 60155, 60160, 60526, 60162, 60163, 60459, 60458, 60164, 60165, 60171, 60176, 60521, 60501, 60513, 60301, 60302, 60303, 60525, 60304, 60305, 60402, 60455, 60558, 60666, 60804, 60523, 60161, 60527, 60499)
25	All or parts of Lemont, Palos, Worth, Orland, Rich, Thornton, Bloom, and Bremen Townships (zip codes 60406, , 0409, 60465, 60411, 60415, 60475, 60419, 60473, 60422, 60423, 60425, 60426, 60472, 60428, 60429, 60464, 60463, 60430, 60438, 60439, 60443, 60469, 60466, 60467, 60445, 60452, 60453, 60471, 60456, 60457, 60461, 60462, 60476, 60477, 60478, 60482, 60487, 60655, 60803, 60805, 60454, 60418, 60412, 60484)

DSA	Geographic Area Covered
26	Northwest Chicago and parts of Leyden Township (zip codes 60631, 60646, 60656, 60630, 60634, 60707, 60639, 60641, 60647, 60706)
27	Northeast Chicago (zip codes 60645, 60626, 60659, 60660, 60625, 60640, 60618, 60613, 60657, 60614)
28	West Central Chicago (zip codes 60651, 60622, 60644, 60624, 60612, 60623, 60608)
29	East Central Chicago (zip codes 60642, 60610, 60689, 60654, 60611, 60694, 60601, 60693, 60602, 60606, 60607, 60605, 60603, 60616, 60661, 60684, 60699, 60681, 60678, 60675, 60685, 60695, 60669, 60682, 60680, 60673, 60670, 60664, 60674, 60604, 60677, 60668, 60696, 60687, 60691, 60697, 60690, 60688)
30	Southwest Chicago and parts of Stickney Township (zip codes 60638, 60632, 60629, 60609, 60636, 60621)
31	Southeast Chicago (zip codes 60653, 60615, 60637, 60649)
32	Far South Chicago and parts of Thornton Township (zip codes 60652, 60620, 60619, 60617, 60628, 60643, 60827, 60633)

Appendix B: DSA Contiguous County Responsibilities

The CCSO, or partnering MCR agency, responsible for covering the Illinois County identified in the column "County Within IL Responsible" is also responsible for responding to MCR referrals for eligible customers presenting in crisis in the contiguous county identified below as "Contiguous Bordering Counties."

Bordering State	Contiguous Bordering Counties	DSA Responsible	County Within IL Responsible
Indiana	Lake	25	Cook
Indiana	Newton	10	Kankakee
Indiana	Benton	10	Iroquois
Indiana	Warren	9	Vermilion
Indiana	Vermilion	9	Vermilion
Indiana	Vigo	9	Edgar
Indiana	Sullivan	4	Crawford
Indiana	Knox	4	Crawford
Indiana	Gibson	4	Wabash
Indiana	Posey	3	White
Iowa	Louisa	14	Mercer
Iowa	Scott	14	Rock Island
Iowa	Muscatine	14	Rock Island
Iowa	Clinton	15	Whiteside
Iowa	Jackson	16	Carroll
Iowa	Dubuque	16	Jo Daviess
Iowa	Lee	6	Hancock
Iowa	Des Moines	14	Henderson
Kentucky	Union	3	Gallatin
Kentucky	Crittenden	3	Hardin
Kentucky	Livingston	3	Hardin
Kentucky	McCracken	1	Massac
Kentucky	Ballard	1	Pulaski
Missouri	Mississippi	1	Alexander
Missouri	Scott	1	Alexander
Missouri	Cape Girardeau	1	Alexander
Missouri	Perry	2	Randolph
Missouri	St. Genevieve	2	Randolph
Missouri	Jefferson	2	Monroe
Missouri	St. Louis	2	St. Clair
Missouri	St. Louis City	2	St. Clair
Missouri	St. Charles	5	Madison
Missouri	Lincoln	5	Calhoun
Missouri	Pike	6	Pike
Missouri	Ralls	6	Pike
Missouri	Marion	6	Adams

Bordering State	Contiguous Bordering Counties	DSA Responsible	County Within IL Responsible
Missouri	Lewis	6	Hancock
Missouri	Clark	6	Hancock
Wisconsin	Grant	16	Jo Davies
Wisconsin	Lafayette	16	Jo Daviess
Wisconsin	Green	16	Stephenson
Wisconsin	Rock	16	Winnebago
Wisconsin	Walworth	17	McHenry
Wisconsin	Kenosha	21	Lake

*Maps providing a visual representation of the geography covered by each DSA can be found on the HFS Pathways to Success website.