**February 1, 2021**

In accordance with Senate Bill 1851, 20 ILCS 505/5.45, the Illinois Department of Children and Family Services (DCFS) submits an annual report to the House and Senate Human Services Committees on measures of access to and the quality of healthcare services for youth in care enrolled in Medicaid managed care plans. For purposes of this report, youth in care refers to youth who are currently under the legal custody or guardianship of DCFS. The transition of youth in care to a Medicaid Managed Care Organization (MCO) occurred on September 1, 2020. The following summarizes the early transition period.

DCFS is required to report annually on the following measures:

(A) **Children enrolled in Medicaid managed care plans have continuity of care across placement types, geographic regions, and specialty service needs.**

The Illinois Department of Healthcare and Family Services (HFS), working closely with DCFS, developed the YouthCare health plan. YouthCare is a specialized model of care designed to improve the existing system of healthcare for youth in care. Youth in care transitioned to the YouthCare health plan on September 1, 2020. The Guardianship Administrator can opt a youth out of YouthCare into another managed care health plan if the Guardianship Administrator determines it is in the youth’s best interest. Less than twenty youth in care have been opted out of the YouthCare health plan since the transition.

YouthCare implemented a 180-day continuity of care period that will end on February 28, 2021. During this continuity period, all providers are considered in-network, meaning that providers do not need to be a part of the YouthCare network for youth to continue to use their services. This ensures minimal disruption in care and allows youth in care access to their current providers while YouthCare works on contracting with each provider. If a provider does not want to serve the entire Medicaid population, or even youth in care, generally, they have the option to sign single case agreements to serve specific youth. YouthCare has expanded the provider network by contracting with additional primary care providers, psychiatrists, dentists, and other specialists who did not previously serve youth in care.

1. (B) **Each child is receiving the early periodic screening, diagnosis, and treatment services (EPSDT) as required by federal law, including but not limited to, regular preventative care and timely specialty care.**

Federal law requires that children and young adults under the age of 21 who are enrolled in Medicaid receive a comprehensive array of healthcare services under EPSDT. This includes regular physical, dental, vision, hearing, and other necessary health screenings.

Youth in care are required to receive an initial health screening within 24 hours of DCFS assuming legal custody of the child and before placement. A comprehensive health evaluation (CHE) that meets EPSDT requirements is required within 21 days of the date on which DCFS was given legal custody of the youth in care. Youth in care receive regular physical, dental, vision, and hearing exams pursuant to DCFS rules. These requirements continue under managed care, with the addition of care coordination to enhance the communication among healthcare providers.

When screenings, exams, and diagnostic services identify the need for treatment, YouthCare health care coordinators work with caregivers and child welfare caseworkers to arrange treatment through primary or specialty care providers. Network readiness activities were completed prior to the implementation date to ensure that providers are located within a reasonable distance of the family’s home. Additionally, YouthCare has continued to expand its network of providers in order to ensure that a full continuum of care is available to all youth in its plan.

YouthCare utilizes health assessments to collect and identify immediate and long-term needs of the members. These needs are then developed into a comprehensive care plan that addresses member goals and healthcare needs. Families have a personal care coordinator who helps manage the youth’s overall healthcare, research providers, schedule appointments, and arrange transportation services. The YouthCare team ensures preventative and specialty care occurs by removing any barriers related to access to care.

1. As set forth in the YouthCare contract, DCFS has included quality measures under the Healthcare Effectiveness Data and Information Set (HEDIS) and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which include EPSDT measures.
2. (C) **Children are assigned to health homes.**

Integrated Health Homes (IHHs) have not yet been implemented for the Medicaid population in Illinois. It is anticipated that IHHs will be introduced in the future.

1. (D) **Each child has a health care oversight and coordination plan as required by federal law.**

Section 205 of the federal Fostering Connections to Success and Increasing Adoptions Act requires states to develop a plan for the ongoing oversight and coordination of healthcare services for youth in care.

The statute requires an overarching plan for how the state will identify and address the health needs, including behavioral health needs, of Youth in Care and provide for continuity of services. It does not mandate individualized plans for each youth. This requirement is intended to ensure that Youth in Care receive quality healthcare.

Further details are set forth in the [Fiscal Year 2020 Healthcare Oversight and Coordination Plan](https://www2.illinois.gov/dcfs/brighterfutures/healthy/Medicaid/Documents/Addendum_C_-_FY20_Healthcare_Oversight_and_Coordination_Plan_8-13-19.pdf).

1. (E) **Whether there exist complaints and grievances indicating gaps or barriers in service delivery.**

Since the initial implementation on September 1, 2020, YouthCare has received few complaints or grievances related to gaps or barriers in service delivery. To date, YouthCare has received 16 grievances and 5 appeals. Common grievance categories include provider office staff complaints, dissatisfaction with a durable medical equipment company, or difficulty obtaining an appointment with a provider. The YouthCare appeals have been related to Pharmacy denials that were later reviewed and overturned.

YouthCare tracks and performs barrier analysis for member grievances and appeals in order to identify trends by type, practitioner/facility, as well as to identify early indicators of educational opportunities both internally and externally. This data, along with corrective action recommendations is reviewed by the YouthCare Quality Improvement Committee. All grievances and appeals are shared with DCFS and HFS in real-time and discussed, as necessary, during weekly Joint Resolution Team meetings.

1. (F) **The Workgroup and other stakeholders have and continue to be engaged in quality improvement initiatives.**

The Child Welfare Medicaid Managed Care Implementation Advisory Workgroup (Workgroup), established by PA100-0646 (SB1851), has been meeting regularly since September 2019. The Workgroup is comprised of DCFS, HFS, and YouthCare staff, as well as providers, parents, former youth in care, and experts in physical and behavioral health. The Workgroup and members of the public have provided ongoing input into the transition into managed care, and their feedback has been incorporated into implementation processes and communications about the transition.

Workgroup members will continue to provide input into processes until the Workgroup dissolves. Public comment will also be accepted and integrated into processes as permitted by law, and as appropriate until the Workgroup dissolves.

Since the launch of the program, a summary of reporting requirements has been discussed in the Workgroup. HFS and DCFS receive routine reports monitoring call center statistics, grievances and appeals, care coordination activities, rapid response inquiries, and pharmacy trends.

During the Workgroup’s meetings, DCFS and HFS have discussed a more proactive approach to managing children who frequent hospital emergency departments and children who are hospitalized beyond medical necessity. HFS will also ensure ongoing quality improvement through measurement of outcomes in the Healthcare and Quality of Life Performance Measures. During the initial implementation of the YouthCare program, baseline data will be collected for CY2021.

Additional performance measures are currently being developed for CY2022. These measures will be reviewed and discussed with Workgroup.

Failure to achieve the agreed upon outcomes related to HEDIS results and performance outcomes may result in the development of a corrective action plan by YouthCare, as well as financial penalties assessed by HFS.