Williams v. Rauner, et al., No. 05-4673

Williams Consent Decree FY 19 Implementation Plan Amendment

Pursuant to the requirement in the *Williams* Consent Decree that the State of Illinois Co-Defendants annually amend the Implementation Plan, the following represents the State's FY19 Amendment. This Amendment reflects the State's continuing commitment to identify and implement approaches to augment or enhance current *Williams* operations, strengthen Community-Based service delivery, better analyze and measure performance outcomes and otherwise comply with the requirements of the Decree. This Amendment is hereby incorporated into and enforceable as part of the Decree.

FY19 Transition Targets and Oversight

The State has consistently forecasted a realistic and manageable target number for *Williams* Class Member transitions from Institutes for Mental Disease ("IMD") or Specialized Mental Health Rehabilitation Facility ("SMHRF") settings to Community-Based Settings. Class Members are transitioned to Community-Based housing/alternatives (Permanent Supportive Housing ("PSH") or Supervised Residential sites) in accordance with the provisions and requirements of the Decree and based on two premises: that Class Members are deemed clinically and functionally appropriate for transition based on the current Evaluation process, and that the Class Member has a desire to live in the community and chooses to participate in the transition process. Toward this end, through the service planning process, the State ensures that approved transitions are done in a careful and thoughtful manner and that services are in place to address the safety and stability of the Class Member, during and post-transition.

The State recognizes that the rate of transition of Class Members to Community-Based Settings has slowed in comparison to previous years and is making every effort to ascertain what an appropriate transition target should be. However, the State remains committed to transitioning 400 Class Members during FY19. The State will work with each Community Mental Health Center ("CMHC") contracted to provide a full array of *Williams* services to ensure they are able to transition their assigned number of Class Members while doing so safely and appropriately.

Action Steps	Lead	Due Date
1. Release projected transition target numbers for each of the eight 'full array' community mental health centers (CMHCs) contracted to provide Williams transition services.	Brenda Hampton	June 1, 2018
2. Convene meeting with the eight Williams CMHCs (Agency Executive Directors, Quality Administrators and key administrative staff) to review targets and identify actions needed to meet transition goals.	Brenda Hampton	June 15, 2018
3. Track weekly transitions achieved against projections.	Williams Compliance Officer	Weekly, effective July 1, 2018
4. Prepare and release monthly dashboard indicator charts to CMHCs by the 5th business day of the month to further encourage compliance with transition targets.	Williams Compliance Officer	ongoing

5. Convene semi-annual meetings with Williams/Colbert CMHCs on the Multi-Year Growth Plan recommendations and implementation status.	Brenda Hampton IDoA	October 31, 2018

Development of a Performance-Based Payment Model for CM Transitions

DMH proposes modifying the current payment model for provider agencies working with transitioning Williams Class Members to encourage and further incentivize providers to meet their transition targets. It should be noted that this is an initial proposal, which the Defendants intend to further explore for FY19 implementation, but it will require input from IDoA as the model may affect their transitions under *Colbert*. This payment model will also have to be negotiated with the providers, so any specifics identified below are to be considered initial proposals that are subject to modification.

Under the current payment model, provider agencies are paid on a graduated scale, which is dependent on the length of time from the point of referral (case assignment to the provider agency) to transition. The current payment structure ranges from $963 for each Class Member engaged in transition planning but who ultimately does not transition, to a maximum of $1653 for each transition that occurs within an 8-week time frame. Currently, providers submit monthly invoices and are typically paid after the transition has occurred.

DMH proposes modifying the current system to both increase the maximum funding available as well as modifying the timing of payments to encourage providers to work diligently to meet or exceed their transition targets, and to create fiscal accountability in the event those targets are not met. The proposed revisions would reduce the reimbursable amount for transition efforts for a CM who ultimately does not transition from $963 to $500 per Class Member. Conversely, for those who are transitioned, the payment amount would be raised from a maximum amount of $1,363 to a flat rate of $2,500 per transition. Payments will be based on provider's quarterly target (a reasonable number set by DMH). In the event the provider does not meet the quarterly target number of transitions, the payment rate will be reduced by the percentage of unrealized transitions for the period. If provider exceeds the quarterly target number of transitions, the payment rate will remain at the increased amount of $2,500 per transition. Quarterly payments will be made at the $2,500 per transition target number at the beginning of each quarter and reconciled at the end of each quarter.

Action Steps	Lead	Due Date
1. DMH will vet and feasibility and obtain feedback to make changes to existing Transition Coordination contracts through the GATA process.	DMH fiscal	June 15 - 30, 2018
2. DMH will draft operational guidance for this payment model	DMH fiscal	July 15, 2018
3. DMH will schedule a conference call to discuss with Williams CMHC provider agencies to review this performance based Transition Coordination payment methodology and fiscal accountability.	DMH fiscal	July 30, 2018

4. DMH will finalize all related paperwork for implementation	DMH fiscal	August 30, 2018
5. Full execution and tracking transitions	Williams Compliance Office	September 1, 2018

SSI/SSDI Outreach, Access and Recovery (SOAR)

Transitions of Class Members into the community is based on an assumption that the individual is Medicaid eligible and will be able to access and receive Medicaid allowable services and supports to address both their medical and psychiatric needs. To remain in the community post-transition, the Class Member must have some viable means of income to support their independence and daily expenses, which is typically present in the form of either benefits (SSI or SSDI) or employment. There are, however, a group of Class Members who do not have any source of income and are not receiving SSI or SSDI. This group, which currently is over 170 individuals, is therefore unable to transition. The reasons these Class Members do not receive SSI or SSDI vary and include:

- Individual has not applied for SSI or SSDI;
- Individual has an application pending and is awaiting a decision;
- Individual has applied, received a denial, and is currently appealing the decision;
- Individual's application has been denied as a final determination (either not appealed or appeal was denied) and/or
- Individual is undocumented and ineligible for SSI/SSDI.

CMHCs have historically not continued transition efforts for Class Members who do not have any source of income, as the individual will not be financially able to sustain community tenure. DMH provided instruction to the CMHCs at the outset of the Decree's implementation that Class Members would not be transition candidates if there was no viable means of income to support community tenure. The SMHRFs/IMDs facilities have traditionally started the SSI/SSDI application process, and many have staff that actively pursue benefits on behalf of the individual. These efforts at the SMHRF/IMD level are largely successful, as evidenced by the vast majority of Class Members who have transitioned with active SSI/SSDI. However, there remain a number of individuals who require additional assistance in obtaining benefits beyond what they may receive in the SMHRF/IMD.

In order to address the additional application needs of Class Members, DMH entered into a contract during FY18 with NAMI of Chicago for SSI/SSDI Outreach Access and Recovery ("SOAR") services, with an initial annualized contractual amount of approximately $14,000. This figure remains the same for FY19. NAMI's work with SOAR will be in addition to their existing responsibilities with respect to In-Home Recovery Support. NAMI's In Home-Recovery and Support staff is already trained in the SOAR process. They have mastered the techniques needed to locate, compile and package documentation to most effectively support SSI/SSDI applications needed to substantiate a disability. SOAR applications have an average 64% approval rate, with an average 96 days turn around. This support has been contracted with NAMI in FY18 for full implementation in FY19.

Action Steps	Lead	Due Date
1. Negotiate and execute contract for SOAR with NAMI Chicago	DMH	Completed FY18
2. Compile names of Class Members from CAST Financial who have no income.	DMH	Completed
3. Send list of names Class Members to CMHC to ascertain status of SSI/SSDI eligibility and follow up.	DMH	Completed
4. Send list of names of Class Members to SMHRFs/IMDs to obtain status of SSI/SSDI application processes and determinations.	DMH	Completed
5. Provide NAMI with a list names of Class Members (excluding those in appeal process, those undocumented), prioritized by facilities to begin SOAR process.	DMH	Completed
6. Release communication to the SMHRFs/IMDs administrators regarding implementation of SOAR in the facilities	DMH	Completed
7. Begin active work with Class Members, as scheduled and prioritized by NAMI	NAMI	Start date June 2, 2018

Identify Strategies to Strengthen and Enhance *Williams*-Related Processes and Efforts to Reverse FY18 Non-Compliance and Achieve Compliance in FY19

As we approach the end of FY18, it is apparent that despite the State's best efforts, the FY18 transition target of 400 will not be met. This should not distract from the very deliberate and concerted energies expended by most *Williams*' provider agencies, Executive Directors, key administrators and direct care teams that consistently understand and embrace the mission and vision of the Consent Decree, as well as their individual contributions to the overall transition outcome. It would be remiss not to acknowledge the hard work of these agencies in serving Class Members, as well as the larger audience of individuals who have diagnosed mental illness and who seek community mental health services.

In FY18 (to date), there were 1,024 Resident Review assignments made to *Williams* provider agencies. These assignments are a result of Resident Review assessments, conducted by Lutheran Social of Illinois (LSSI) and Metropolitan Family Services (MFS), in which a Class Member was determined to be appropriate for transition. The State believes Resident Review entities have had to consistently err on the side of approving Class Members to begin transition activities in order to generate referrals for assignment to the community agencies. This over-approval has been necessary to produce Resident Review assignments to provider agencies of a sufficient number in light of annual transition targets, offsetting to the number of Class Members who refuse to be assessed or who are not recommended for transition consideration based on clinical, functional, behavioral and high-risk indicators.

The Resident Review entities are required, via contract, to reassess Class Members annually, with provisions built into their contracts to reassess quarterly if requested by the Class Member. Protocols have also been established for Resident Review reassessments to occur if requested by NAMI Outreach or an Ambassador or through collateral contact based on the consent of the Class Member. The State ensures adequate funding is available to the Resident Review entities for all assessment approaches, attempts, interruptions, refusals and completions. The final FY18 transition count achieved is not due to a lack of sufficient Resident Review assessments or re-assessments. On the contrary, the State has consistently encouraged over assessments to generate potential transition candidates. There were 1,648 unduplicated Resident Review assessments completed between July 1, 2017 and June 22, 2018[1].

NAMI Outreach Workers have had a deliberate and calculated presence in the 24 IMD/SMHRFs since 2011 under the Consent Decree. NAMI's work in these facilities is based on full engagement with Class Members, including face-to-face discussions, videos, brochures, community meetings, and other outreach activities. NAMI Outreach Workers have engaged or will reach every Class Member in the 24 facilities, but only if the Class Member chooses to receive their efforts. As of June 22, 2018, NAMI Outreach has achieved 1,474 unduplicated Class Member contacts. While the boundary of choice is respected, NAMI staff will continue to make repeated attempts to provide Outreach services to Class Members, including those who may have prior refusals.

Outreach is further enhanced by the utilization of Ambassadors, who serve as "Good-Will" agents, and examples of recovery and the possibilities associated with independence and self-determination. Ambassadors are not clinical staff or advocates for Class Members. Ambassadors are a resource to share and support Class Members' understanding about their personal journey and to answer questions about challenges or benefits of this journey. The Ambassadors have been a vibrant and refreshing presence in the facilities. Although this data point has not previously been collected, upon inquiry, NAMI approximates that Ambassadors have engaged roughly 493 Class Members during the past 12 months. As NAMI affirms through their supervision of Ambassadors, the lack of Class Member engagement with Ambassadors is not due to a limited number of Ambassadors. Conversely, (as NAMI reports and supports) it is due to the lack of ongoing interest by some Class Members to engage with the Ambassadors. Since the introduction of Ambassadors, the rate at which Class Members refuse Outreach has decreased slightly to 27%. However, the rate for Class Members refusing to have a Resident Review assessment has been consistent at approximately 55% even after the introduction of Ambassadors.

However, in order to continue to further Outreach efforts, the State will work with NAMI to increase the count of Ambassadors by approximately 10 during fiscal year FY19.

Action Steps	Lead	Due Date
1. Initiate discussion with NAMI about feasibility to increase Williams Ambassadors.	Brenda Hampton	June 25, 2018

[1] Numbers provided by LSSI and MFS. The official count will be generated from the *Williams* database.

2. Determine need and budgetary cost for contract increase.	Brenda Hampton	June 30, 2018
3. Work with DMH fiscal to complete necessary paperwork for contract adjustment and execution.	Brenda Hampton	July 30, 2018
4. NAMI develop solicitation campaign to identify potential Ambassador candidates.	NAMI	August 30, 2018
5. NAMI interview and hire Ambassadors.	NAMI	September 30, 2018
6. NAMI provides orientation and training.	NAMI	October 2018

Promotion of Services and Resources for Class Members in need of Alcohol and Substance Abuse Services

The State recognizes that there is a significant percentage of Class Members (approximately 50%) who, in addition to a serious mental illness, have a co-occurring substance or alcohol abuse disorder. These Class Members can be particularly difficult to serve in the community as these issues can be exacerbated in a community-based setting. DHM will collaborate with the Division on Substance Abuse Prevention and Recovery to create training resources and partnerships with SUPR licensed providers to increase the availability of recovery programs to Class Members. In addition, ACT/CST teams will be provided training will on the use of medication-assisted treatment options that are available to Class Members, which may encourage some to begin the path to recovery.

Action Steps	**Lead**	**Due Date**
1. Meet with SUPR director regarding service options for Class Members	Diana Knaebe	July 2018
2. Develop plan regarding SUPR services/MAT for Class Members	Diana Knaebe	August 2018

IDPH/DMH Collaboration

In addition, IDPH and DMH will hold internal discussions to determine whether a consolidated effort between the two agencies to identify and reach *Williams* Class Members for potential transition is feasible. IDPH's role is limited to oversight of IMD/SMHRF compliance with various licensure and safety regulations, and any consolidated effort will not expand IDPH's role with respect to *Williams* Class Members or the transition of those individuals. As this potential option is at the beginning stages of discussion, the State has sole discretion to determine next steps based on the outcome of these discussions.

These discussions will explore the possibility of consolidating efforts to identify Class Members who are potential transition candidates, with the expectation that this collaboration will increase the number of transitions of Class Members to Community-Based Settings. IDPH conducts annual surveys at the 24 IMDs, during which IDPH staff routinely engage with IMD residents, and have opportunities to observe

their interactions and daily activities. The hope is that as IDPH surveyors conduct their survey activities, they may be able to simultaneously identify individuals who may not currently meet necessity for the level of care provided in a SMHRF, and who may therefore be appropriate for a Resident Review assessment. Once identified by the IDPH staff, these individuals will be prioritized by the Resident Reviewers for an assessment. All Class Members would continue to be able to refuse the Resident Review, and this process will not be used as a means to coerce a Class Member to participate in any transition-related activities. Depending on the outcome of discussions, further Action Steps may be supplemented at a later date.

Action Steps	Lead	Due Date
1. Discussion between IDPH/DMH to determine feasibility of Collaboration	Brenda Hampton	7-1-18
2. Report on Outcome of Discussions to Parties and Monitor	Brenda Hampton	7-15-18

Community Capacity – Expansion

The existing community mental health service delivery system currently has a finite number of community based, Medicaid certified vendors that offer Assertive Community Treatment (ACT) and/or Community Support Team (CST) services. Over the past seven years, based on the transition services and activities necessary for successful transition of Class Members from IMD/SMHRFs into Community-Based Services, it has become apparent that more and more Class Members are in need of intensive team-based services, such as ACT, to effectively transition to and remain in Community Based Settings. Providers have reported that the service needs of Class Members have become greater and more challenging, including increasing numbers of Class Members with multiple medical and psychiatric complexities, behavior management challenges and associated risk factors including a high prevalence of substance use. In addition, both Resident Reviewer agencies have reported that over 50% of individuals reviewed have co-occurring substance abuse issues, which in many cases increase in severity upon transition to a community setting. The existing mental health provider network, particularly the limited number of providers offering ACT and CST services, is becoming saturated. Further, the Decree mandates that the Defendants provide services under the State Plan and Medicaid Community Mental Health System, but a number of Class Members require services and supports or a level of care that is not included or available through these systems. In addition, current data reflects that there are a significant number of vacant slots in existing ACT/CST teams, meaning the current capacity is not fully utilized. There are currently 153 open ACT slots and 241 CST slots, many of which are with *Williams* Provider Agencies. Additional exploration of the reason for the vacancies and the impact on Class Member services is needed. However, FY19 remains a prime opportunity for the State to more fully utilize the available capacity as well as increasing the network of Community Mental Health Centers that can provide intensive ACT or CST services. This will then increase the ability of *Williams* Class Members to transition to Community-Based Settings, as well as provide services to individuals with a diagnosed serious mental illness who may require these services in lieu of admission to Long Term Care.

DHS-DMH has funds available for start-up of new ACT and CST teams, in areas that are determined to be of high need of such services, to assist in the transition and stabilization of *Williams* Class Members. For FY19, DMH has approximately $500,000 for ACT start up and an additional $200,000 for CST start up. There is also an additional reserve of funding that has some flexibility for use with Williams Class Members, although the NOFO process will need to be used to move any such funds based on a determination of necessary services to the contracting process. Services that may be expanded or started utilizing this funding reserve will be based on the assessment of information and data from the participating CMHCs, Resident Reviewer Organizations, NAMI Ambassadors, and the CAST review process. It is anticipated that identification of any such services will be determined during the first quarter of FY19, NOFO(s) will be sent out by early October 2018 and start-up will begin in January 2019.

Illinois plans to enhance fidelity to the ACT model, including the use of Evidence Based Practices ("EPBs") within ACT programs through the development of a Mobile ACT Institute, which will provide targeted training and technical assistance to teams on areas of need as assessed by the Tool for Measurement for ACT (TMACT). Illinois will establish internal training expertise within the DMH project and leadership staff involved in this grant, who will then provide targeted training to Illinois ACT teams. By utilizing a mobile institute design, Illinois will be able to specifically target training and technical assistance to the areas of need identified through the TMACT and will also be able to have participation of an agency's full ACT team. A challenge experienced in previous attempts to provide such assistance has been the capability of an agency to make their Psychiatrists or Advance Practice Nurses available to participate in trainings as a part of the team. In bringing the training onsite, there will not be valuable time lost in travel to a remote training location.

In addition to specifically targeting areas identified by teams, the Mobile ACT Institute will also provide universal training in evidence-based practices, including Motivational Interviewing to improve teams' ability to engage individuals. All teams will have access to Illinois expert trainers for Individual Placement and Support (IPS) and Nutrition, Exercise and Wellness for Recovery (NEW-R) an EBP focused on physical wellness for individuals with mental illnesses. This will assist all ACT teams in more adequately addressing the vocational/employment and whole health needs of individuals served. A training in smoking cessation will be developed as well.

The following represents the Action Steps that will be taken during FY19 to determine the feasibility of expanding the CMHC network to provide additional services to Class Members and others in need of such an intensive level of services:

Action Steps	Lead	Due Date
1. Develop a concept paper on the "Crisis in Illinois" mental health service delivery system, which will discuss access issues, resource gaps, service needs, coordination and interface with primary health care (including MCOs) and coordination of care with other state divisions DASA, DRS, DDD, etc.	Brenda Hampton Dan Wasmer Lee Ann Reinert	August 31, 2018

Action Steps	Lead	Due Date
2. Compile and analyze data from the *Williams* and *Colbert* Consent Decrees' Resident Review recommendations on the need for additional ACT and CST services; provide close contract management and enforcement to ensure utilization of existing ACT/CST capacity.	*Williams* Compliance Officer IDoA designee	September 31, 2018; ongoing thereafter
3. Convene an internal DHS meeting to review data and analysis. Explore the feasibility of CMHC vendor expansion beyond current participants.	TBD	October 15, 2018
4. Submit concept paper and data to DHS Secretary and attorneys for review and feedback.	TBD	November 1, 2018
5. Contingent on approval, convene discussions with HFS on the potential expansion of Medicaid billing for ACT and CST services and explore any management or other collateral ramifications.	TBD	November 15, 2018
6. Contingent on agreement with HFS for expansion of Medicaid billing, convene a meeting with existing CMHC Executive Directors and key leadership serving *Williams* and *Colbert* Class Members to discuss the feasibility and/or practicality of expanding community based resources, i.e., adding new CMHC vendors to specifically increase ACT/CST service array to meet transition needs of *Williams* and *Colbert* Class Members.	Brenda Hampton IDoA designee	November 30, 2018
7. Contingent on a commitment by DHS/HFS to expand CMHC vendor pool, develop a budget for review and submission to GOMB.	DMH fiscal DoA fiscal	December 15, 2018
8. If submitted to GOMB, a final decision to be rendered by GOMB on the feasibility to move forward and develop a Notice of Funding Opportunities (NOFOs) to expand CMHCs to add service capacity for ACT and CST services to assist in transition of and provide services to *Williams* and *Colbert* Class Members.	Governor's Office DHS Secretary GOMB	January 15, 2019

ACT/CST Expansion Action Steps

Action Steps	Lead	Due Date
1. Compile and analyze data from source documents, past years Class Members' transition trends (geo preferences/provider preferences), current provider team capacities, and projections of case assignments for estimating new capacity.	HFS and DMH	July 31, 2018
2. Hold discussion forums with existing *Williams* providers and interested Medicaid certified	HFS and DMH	August 30, 2018

vendors to elicit interest in service expansion for ACT and CST.		
3. Develop and release NOFO for ACT / CST service expansion or start up.	DMH	October 15, 2018
4. ACT / CST applications submitted back to DMH, reviewed, scored and fiscal paperwork completed.	DMH	December 1, 2018
5. ACT / CST awards for start-up	DMH	January 2019

Multi-Year Growth Plan

At the request of Denny Jones, former *Williams*/*Colbert* Court Monitor, the network of *Williams* and *Colbert* Consent Decree CMHC provider agencies prepared a Multi-Year Growth Plan documenting their collective suggestions and recommendations on resource needs, policy decisions and operational realignment that could potentially increase the ability to transition Class Members under both Decrees from Long Term Care to community-based living options. To achieve this task, a short-term meeting and planning process was co-convened by two Executive Directors over the course of three months, with a final document presented to DHS and IDoA in late February 2018. In mid-March, DHS and IDoA Consent Decree leads reviewed this document and organized it into five distinct focus areas:

- Areas to be addressed by the Decree's lead State agency;
- Areas requiring HFS discussion/input;
- Areas requiring Executive Level (including GO) discussion/input;
- Areas for *Williams*/*Colbert* policy alignment and directives and
- Areas not related to transition efforts - not applicable to the Consent Decrees.

In April and May 2018, DHS convened meetings with HFS and IDoA to review the Multi Year Growth Plan document and to develop strategies and/or the feasibility and capacity to address the identified challenges. A subsequent meeting was held with IDoA staff to discuss those areas where possible alignment between the two Decrees can be achieved, and to coordinate time frames to develop policy documents. Executive level discussions will continue throughout FY19 to explore feasibilities with other areas identified in this Plan, and the Defendants will continue to update the parties and Monitor on progress.

Action Steps	Lead	Due Date
1. DMH will provide IDoA with Exhibits executed with UIC for neuropsychological assessments and occupational assessments.	Brenda Hampton	Completed
2. DMH and IDoA will schedule a series of internal meetings to dissect existing practices of both Consent Decrees and explore where alignments can best be achieved.	IDoA DMH	July 1, 2018

3. DMH and IDoA will collect reporting documents from CMHC to review and compare where there are differences or similarities.	IDoA DMH	July 30, 2018
4. DMH and IDoA will schedule meeting with CMHCs to obtain stakeholder input on the realignment of documentation.	IDoA DMH	August 30, 2018
5. DMH and IDoA will review current transportation reimbursement methods to determine how to best realign and draft policy.	IDoA DMH	August 30, 2018
6. DMH and IDoA will meet to ascertain how to best align practices for repeat transitions and re-appropriation of transition funds (if feasible), and to develop accompanying policy.	IDoA DMH	September 30, 2018
7. DMH and IDoA to convene first semi-annual CMHC stakeholders' meetings.	IDoA DMH	November 2018 (date to be identified)

Housing Capacity Expansion

The Illinois Housing Development Authority (IHDA) along with its sister agencies: Department of Human Services, Department on Aging and Department of Healthcare and Family Services) is committed to the continued development of Supportive Housing for *Williams* Class Members.

Since 2007, IHDA has incentivized the creation of integrated supportive housing units by offering points within the Low-Income Housing Tax Credit (LIHTC) Qualified Allocation Plan (QAP) for Statewide Referral Network unit creation. LIHTC Targeting (development of properties in communities of preference as designated by needs data for Class Members within the online housing waiting list) was included in the 2015 QAP, the 2016-2017 QAP, and the 2018-2019 QAP, with additional points awarded to projects proposing developments that include State Referral Network (SRN) units. Class Members receive preference in the SRN waiting list for available units. Between 150-200 SRN units will be coming online in FY2019 and an additional 30-50 units are available upon turnover every month (360-600 for the year). Section 811 Project-based Rental Assistance is layered over SRN units, making them even more affordable to very low-income populations. Approximately 50-100 811 units will be available over FY2019. Only *Williams, Ligas* and *Colbert* Class Members, Front Door Diversion participants and persons wishing to move out of nursing facilities are eligible for 811 units. To ensure access to these resources developed for Class Members, *Williams* providers are now required to add all pre-transition Class Members to the SRN and 811 housing waiting lists, as well as all transitioned Class Members who are interested in moving to a different location or unit.

IHDA currently has the Fourth Round of Permanent Supportive Housing (PSH) small-sites funding open. Last year, Round 3 funded 119 units of PSH in the Chicagoland area. These units will be filled by the SRN waiting list where Class Members have preference to rise to the top of the list. In addition, the Long-Term Operating Support (LTOS) Program under the Rental Housing Support Program continues to have open

application. These 15-year rental subsidies, when awarded, must be filled from the SRN waiting list where Class Members have preference to rise to the top of the list. To date, 50 LTOS units have been funded, with the potential for at least 50 more units to be awarded in FY2019.

IDHS will continue to work with Public Housing Authorities who have provided match Housing Choice Vouchers (HCVs) for the two Section 811 Project-based Rental Assistance applications. The Chicago Housing Authority will process at least 100 *Williams* and *Colbert* Class Members for HCV acquisition during FY2019 with the potential for another 100-200 HCVs to be awarded. The Housing Authority of Cook County will provide 50 HCVs in FY2019, the Lake County Housing Authority will provide 45 HCVs in FY2019, the Decatur Housing Authority will provide 5 HVs in FY2019 and the Rockford Housing Authority will provide access to 50 Public Housing units. IHDS encouraged and supported multiple Public Housing Authorities (including CHA, HACC, LCHA) in applying for Mainstream Vouchers from HUD during a recent application period. These rental subsidy vouchers are specifically for persons with disabilities at risk of nursing home placement or homelessness, currently experiencing homelessness or currently residing in a nursing facility. These awards will be announced later in calendar year 2018 and will provide additional federal supportive housing resources.

State partners continue to be involved with the National Association of State Health Policy Health and Housing Initiative and hope to learn new ways to leverage services dollars, Medicaid and healthcare providers to create more supportive housing.

Community Based Housing Alternatives

As *Williams* Class Members are assessed and recommended for community transition in accordance with the provisions of the Decree, an array of appropriate housing options is critical to meet their diverse needs. Currently, the majority of Class Members have transitioned to the community into their own lease-held rental units made possible by Bridge Subsidies to augment rent payments for a Permanent Supportive Housing unit. However, a significant number of Class Members have been recommended for a less intensive, "step-up" to independent living option – Supervised Residential housing. As of the date of this Amendment, there are approximately 473 *Williams* Class Members (out of 2,670 who have been approved for and are actively seeking to transition) who have been recommended via the Resident Review assessment for a Supervised Residential setting as the most integrated setting appropriate for their current service needs.

The Illinois Housing Development Authority (IHDA) continues in its role as the State's Housing Finance Agency to identify high preference areas for *Williams* Class Members and target the development of housing resources in the geographic areas preferred by Class Members. Only Olmstead Class Members (*Williams*, *Colbert* and *Ligas*) are eligible for Section 811 units, and have priority (the highest level) for Statewide Referral Network (SRN) units. Front Door participants have priority status as well. Each year, between 250-400 SRN units are awarded funding, and IDHA provides incentives for the development of units in geographic areas that have been identified as preferred by Class Members. However, the ability of Class Members to obtain housing is complicated by the fact that despite the resources available,

many *Williams*, *Colbert* and *Ligas* providers do not utilize the online SRN and 811 waiting lists and are therefore unable to access those units. IHDA and DMH have provided multiple trainings and meetings to encourage the use of the SRN and 811 networks, and will continue to do so. IHDA has worked with property management entities to replace cluster model bride subsidies (to ensure affordability) to HUD 811 Project Rental Assistance, resulting in some cost shifting for the state. More than 300 *Williams* Class Members who transitioned from IMDs through Bridge Subsidies have been provided federally funded Housing Choice Vouchers. While Bridge Subsidies are routinely available to *Williams* CMs transitioning from IMD settings and are not specifically limited in number, the ability to recycle these subsidies provides some cost-savings and reduces the cost for additional subsidies. These efforts will continue throughout FY19, as the State continues its efforts to realistically meet Class Members housing preferences, although it must be noted that geographic and financial issues will always be a challenge in instances where Class Members may prefer to live in high-rent areas with little affordable housing options.

The following represents the Action Steps that will be taken throughout FY19 to expand and enhance the housing options available to *Williams* Class Members, consistent with the Decree:

Action Steps	Lead	Due Date
1. Release a Supportive Housing application for small (24 units or less), single site buildings to buy, rehab or build, with no restriction on geographic area. Details will be provided once the application period ends and awards are made, but the last round produced 119 PSH units.	IHDA	July 20, 2018
2. Develop incentives for developers/property management companies to create Statewide Referral Network units through the low-income housing tax credit process.	IHDA	Ongoing
3. Corporation for Supportive Housing will host a Housing Symposium/conference for developers in Chicago, which may further promote opportunities for additional housing resources. The symposium will include: (a) Information to improve and enhance processes and (b) Resource development.	IHDA DHS	Summer 2018
4. Convene meetings with MCOs to explore the feasibility of garnering additional housing resources for post-transition, high-risk Class Members, individuals who frequently present at Emergency Departments, and individuals with high-risk housing issues due to complex medical conditions.	Lore Baker Brenda Hampton	Late fall 2018
5. NOFOs released to increase:	DMH Housing Coordinator,	December 15, 2018

Action Steps	Lead	Due Date
• Supervised Residential settings by 2 sites (each serving 8-12 individuals) located in the city of Chicago (high preference areas); and • Cluster Housing by 2 buildings (each with 10-20 units) located in the city of Chicago (high preference areas).	State Housing Coordinator, DMH fiscal	
6. Meet with *Williams* Providers leadership in order to review the housing opportunities, resources and tools that are currently available (created by the State of Illinois) and determine why these resources are so under-utilized.	Lore Baker Brenda Hampton	August 2018
7. Update SRN unit listings to include whether or not the property has rental subsidies in order to ensure that only deeply affordable units (Tenant paying 30% of income) will be offered to Front Door Diversion Pilot participants.	State Housing Coordinator; IDHA	December, 2018
8. Implement Accessibility Pilot within the Prescreening, Assessment, Intake and Referral (PAIR) housing waiting list module which allows for enhanced matching to SRN and 811 units with specific accessibility features needed by the potential tenant.	IDHS, State Housing Coordinator	June 30, 2018
9. Require *Williams* Providers to add all *Williams* Class Members at their referral to be added to the SRN and Section 811 Project-Based Rental Assistance waiting lists.	Brenda Hampton, DMH	July 1, 2018

Supported Employment (Individual Placement and Supports)

While the *Williams* Consent Decree requires Class Member Service Plans contain information on the individual's preferences and strengths in a variety of environments (including home, community and work environments) and references productive work as an element of community living, the Decree is silent on Individual Placement and Support (IPS -Supported Employment) as a deliverable to accompany transition efforts. However, the State recognizes that although not a requirement of the Decree, the addition of IPS as a non-Medicaid billable service, could tremendously benefit the quality of life and stability of Class Members who live in the community and who are motivated toward employment. To this end, DMH identified and incorporated capacity dollars into the service array of *Williams*' CMHCs to promote better information dissemination on the benefit of IPS as an avenue to better quality of life and self-sufficiency. IPS has been included in the programmatic service array in each Drop-In Center as a means to reach Class Members and encourage Class Members to think about the possibility of employment. Additionally, IPS specialists actively pursue interface with employers based on the focused interest of the Class Member. This has resulted in approximately 90% of those interested in working in a particular field an opportunity to be employed with an employer in that field. Approximately 340 CMs have utilized IPS services. It should be noted, however, that there are other avenues for employment

opportunities for Class Members other than IPS. Nearly 90 CMs have obtained employment outside of IPS services.

There has been a strong relationship with the Division of Rehabilitation Services from the outset of IPS, and will continue in FY19. In addition, the contracts with IPS provider agencies emphasize placement as the agencies are only reimbursed for their efforts once the Class Member is employed. Providers are not paid if performance, i.e., a job secured, is not obtained. It should also be noted that there is an aggressive motivational approach implemented in each Drop-In Center to encourage and stimulate Class Member interest in IPS.

The following represents Action Steps the State plans on taking during FY19 to further encourage Class Members to take advantage of the opportunities offered via IPS:

Action Steps	Lead	Due Date
1. Collect employment interest data from *Williams* Class Members at several key intercept points (first contact, transition engagement and planning process, move-in date and at Drop-In Centers) of engagement, based on responses to a four-question survey as follows: • **Yes**, I have worked since transitioning to the community, but I am not currently employed. • **Yes**, I have worked since transitioning to the community, and I am still employed. • I have not worked since transitioning from the facility and **Yes**, I would like to get a job. • I have not worked since transitioning from the facility and **No**, I am not interested in getting a job.	Deborah Holman	July 1, 2018
2. CMHCs to begin collection and coding of data on IPS services to capture actual participation by *Williams* Class Members.	Deborah Holman Darius McKinney	September 1, 2018
3. Convene meetings with the three *Williams* CMHCs that currently do not have an IPS employment specialist to prompt/encourage hiring, within contracted resources.	Deborah Holman	October 1, 2018
4. IPS Program Directors and IPS staff to implement data programming and an improved tracking system/process to identify *Williams* Class Members interested in and/or participating in IPS.	Deborah Holman Darius McKinney	December 1, 2018
5. Execute a series of training sessions on IPS standards of care for CMHCs.	Deborah Holman Darius McKinney	Ongoing

Front Door Diversion Expansion

The state intends to expand the successful momentum of the current Front Door Diversion Program to high volume areas. The goal remains to divert potential admissions of individuals from Long Term Care to Community-Based service alternatives. During FY19, the Diversion Program will expand to serve the vast majority of hospitals that refer potential Front Door participants to Long-Term Care. This expansion targets the regions and hospitals that will have the biggest impact on admissions to IMDs, while maximizing resources currently available to reach as many "at risk of entering an IMD" individuals as possible. Data shows that the 22 additional hospitals targeted for expansion account for 87.34% of all IMD admissions across the remaining parts of the state. Chicago Behavioral alone accounts for 70% of all outstanding admissions in Region 1 North (Chicago's North Side) that were not captured during the Pilot phase, and UPH Methodist alone accounts for 85% of all IMD admissions in Region 3. The identified expansion hospitals in Region 1 South, Region 1 Central and Region 2 account for 89, 98, and 81%, of all admissions in those regions respectively.

The remaining non-expansion hospitals account for less than 13% of all IMD admissions statewide, with an average of one IMD admission each per month. Hospitals in the southern and eastern sections of Region 3, Regions 4 and 5 account for just over 2% of all IMD admissions, with those regions also having significant resource allocation issues due to location and accessibility. Aside from the non-expansion hospitals, a very small number of LTC referrals come from non-hospital sources, including family, community mental health providers, county jails and shelters as well as other nursing facilities. PASRR screens in hospitals represent 88% of all PASRR LTC eligibility determinations over the past three years. The state recognizes the importance of also offering those individuals the same opportunities as those passing through the expansion hospitals and plans to collect and analyze data during FY19 to determine both the scale of such referrals as well as identify what other steps may be possible to impact these individuals while we work on further expansion planning for FY20.

Weekly meetings with Front Door providers were established at the outset of the Pilot project. These meetings will continue to be held, and during FY19, providers will be encouraged to share best practices, approaches and strategies they have used that have led to successful tenure in the community for participants.

PASRR will remain the anchor for all diversion efforts of persons suspected of having a mental illness and who are seeking or referred for admission to Long Term Care. Any individual seeking admission to Long Term Care, regardless of payor source, must have a Pre-Admission Screen (PAS) completed, as authorized and delegated by the Medicaid Authority. If the person is seeking admission to Long Term Care and there is a suspicion of mental illness, regardless of where that person is physically located, i.e., private psychiatric hospital, state psychiatric hospital, general hospital, community, family, shelter, jail, etc., a PASRR must be initiated. There are federal caveats to this for admissions due to medical convalescent care and/or certain federally applied categorical exemptions, i.e., hospice care, Alzheimer's Disease, terminal illnesses, Parkinson Disease, etc.

Nursing Facilities and SMHRFs will not/cannot receive payment without completion of a 2536 form generated by PASRR. Therefore, PASRR is the anchor for diversion of referral from admission to the front door of SMHRFs and Skilled Nursing Facilities. Diversion efforts apply to both to referral of individuals who may be clinically inappropriate for Long Term Care, as well as those who may be appropriate, but whose needs can be safely and successfully met in the community.

The following Action Steps represent the systematic phase-in of additional Front Door activities:

Action Steps	Lead	Due Date
3. Convene meetings with current CMHCs to discuss roll-out of additional Front Door activities with of the original providers and determine service needs for FY19 contracting.	Michael Pelletier	Completed
4. Continue implementation of current projects, adding one additional north side hospital to the Front Door network.	Michael Pelletier	June 30, 2018
5. Develop and release a Request for Information (RFI) to solicit CMHCs for the FY19 Front Door expansion areas.	Michael Pelletier	June 30, 2018
6. Develop performance tracking and reports (monthly and quarterly) for the additional Front Door entities.	Michael Pelletier	June 15, 2018
7. Sequentially add other geographical areas into the Front Door structure: A. Chicago Region 1N – 1 hospital (addition) B. Chicago Region 1S – 6 hospitals C. Chicago Region 1C – 8 hospitals D. Region 2 (Collar Counties/Rockford) – 6 hospitals E. Region 3 (Peoria) – 1 hospital	Michael Pelletier	**Target dates** A. September 2018 B. November 2018 C. January 2019 D. March 2019[2]
8. Convene monthly status meetings with Front Door Provider agencies to assess diversion activities.	Michael Pelletier	Monthly throughout FY19
9. Convene bi-annual Front Door network enhancement strategy meetings, involving Front Door Providers, PASRR agencies, consumers, MCOs and hospital representatives.	Michael Pelletier	December 2018 May 2019
10. Gather data regarding non-hospital PASRR LTC eligibility determinations.	Michael Pelletier	Ongoing

Front Door Diversion Incentive Payment

The Front Door Incentive Payment Project is a value-based "pay for performance" payment structure for participating Front Door CMHCs to assume a more aggressive and creative approach to pursue

[2] Dates may change based on actual contracting process.

diversions from admission to NF/Long Term Care for individuals who are being discharged from inpatient psychiatric hospitalization and for whom, without this support, will likely be discharged to a nursing home level of care. This payment is in addition to the existing array of Medicaid billable services necessary for participants to successfully stabilize and live in the community.

The following Action Steps will be completed during FY19 in furtherance of the Front Door Payment Incentive Program:

Action Steps	Lead	Due Date
1. Establish rates for the incentive payment "pay for performance" structure.	Michael Pelletier Brock Dunlap	Completed
2. Convene meeting with provider agencies to explain structure and negotiate participation.	Michael Pelletier	Completed
3. Complete needed documentation to establish contracts for payment/invoicing.	Michael Pelletier	Partially complete, ongoing through December 31, 2018
4. Replace the current grant funding structure by implementing a "pay for performance" methodology, to reimburse agencies for diversions and community tenure.[3]	Michael Pelletier	December 31, 2018
5. Monitor payments based on performance tracking reports.	Michael Pelletier	Ongoing

Front Door Expansion: Community-based Diversion Utilization Crisis (DUC) setting

The State recognize that, although the Front-Door Diversion Pilot has thus far been successful in diverting individuals from Long-Term Care settings in certain circumstances, there remains a need for a "step down" setting for individuals who may not be clinically or functionally ready to be discharged from a hospital setting directly to an apartment or other private residence. In such circumstances, other options to stabilize and prepare the individual to return to community living may be needed. Plaintiffs disagree that such housing is necessary or appropriate to get individuals "ready" to live in supported housing. As a result of this need, the State will create an additional resource: Diversion Utilization Crisis (DUC) setting.

When the recommendation from an inpatient hospital is for admission of an individual to Long-Term Care ("LTC") due to a suspected serious mental illness (SMI) or co-occurring SMI and substance use disorder, the process is to secure a Pre-Admission Screening/Resident Review (PASRR). This PASRR screen is conducted by a state authorized PASRR entity to determine if the individual meets established

[3] Actual financial incentive methodologies are still under negotiation-once finalized, the Defendants will update the parties and Monitor on the specific methodology.

eligibility criteria for admission to LTC or is a potential candidate for diversion to a community alternative. If the individual is assessed by the PASRR screen to need LTC, consents to diversion services and diversion would be clinically appropriate, i.e., the diversion would not compromise the medical, physical or life safety needs of the individual and would not adversely affect the individual's functional capabilities, the individual may be offered a short-term stay at a Diversion Utilization Crisis (DUC) setting.

Four DUC settings will be developed in the following geographic areas: one each on the north, west and south side of Chicago and one in south suburban Cook County. A DUC setting must have structural capability for 10 double occupancy units (assumed to be two-bedroom apartments), estimating 15 – 20 referrals, with a stay ranging from 90 to 120 days. The DUC will meet the State's requirements for a Supported Residential (Option 820) setting but will also include two additional levels of add-on services: one to offer crisis-level services and supports, or a medium level of services and supports intended to replicate Supervised Residential settings, as needed. Individuals will be able to transition within the same physical setting from a higher level of services and supports (i.e. crisis level), through the other levels until discharge to a PSH (SRN or HUD 811 vouchers), family or private residence or other independent setting as clinically and functionally appropriate. In addition to providing typical mental-health services, the DUCs will also include substance use disorder services, as an estimated 50% or more of Front Door participants have co-occurring substance use disorders. These additional DUC supports will be provided via a pilot-program, which will both provide the add-on services to consumers as needed, but also collect data to further inform on the duration and need for the add-on services. Individuals diverted to a DUC will be required to participate in the services identified as necessary for their stabilization and eventual move to another Community-Based Setting. At the point of admission, Front Door participants will be registered with PAIRS, to be matched with either an IHDA SRN unit or HUD 811 unit. Front Door participants referred to a DUC will have applications submitted on their behalf for SRN and/or 811 units.

The following represents the Action Steps that will be taken to establish the DUC pilot during FY19:

Action Steps	Lead	Due Date
1. Convene three processing meetings among State entities to construct the operational design of DUC, the programming/service array, staffing mix, management oversight, reporting requirements and linkage interface.	DMH designees DASA designees HFS designees	June 15, 2018 June 29, 2018 July 13, 2018
2. Hold discussions with Corporation for Supportive Housing (CSH) on properties needed, locations, sizing, etc., and assist in property search.	Brenda Hampton Lore Baker TBD	June 30, 2018
3. Establish cost methodology on the number of Front Door Participants who can be served in each type of setting, estimating overall operating cost for budgetary needs.	DMH fiscal	June 30, 2018

Action Steps	Lead	Due Date
4. Design brochures and flyers for use by PASRR to promote the Front Door as an alternative resource.	Brenda Hampton Dan Wasmer	July 30, 2018
5. Draft NOFO summary and application requirements	DMH Fiscal DMH Program Staff	July 31, 2018
6. Release NOFO.[4]	DMH fiscal	August 15, 2018
7. NOFO responses due from community providers	DMH fiscal	September 30, 2018
8. NOFO applications reviewed, scored and submitted to DMH fiscal services.	NOFO review committee	October 15, 2018
9. Schedule and conduct training for PASRR on DUC services/resources.	Brenda Hampton	August 30, 2018
10. Draft program participation guidance, policy and procedures.	Dan Wasmer DMH program staff	August 30, 2018
11. DMH fiscal analysis	DMH fiscal	September 30, 2018
12. Notice of State Award (NOSA) sent to provider and returned with signature	DMH fiscal	October 8, 2018
13. DHS contracting process initiated	DMH fiscal	October 31, 2018
14. Post awarded contracts for signature and execution.	DHS fiscal	October 31, 2018
15. Identify properties and negotiate lease agreements between awarded and participating provider agencies and landlords/property management companies.	Lore Baker Brenda Hampton CSH	September 15, 2018
16. Execute lease contracts between provider agencies and property management/landlords.	Awarded providers	October 15, 2018
17. Develop participation service contracts, with the terms of participation to be signed by each person admitted to a DUC.	Brenda Hampton Dan Wasmer	September 30, 2018
18. Furnish properties, hire and train staff.	Awarded agencies	November 30, 2018
19. Open DUC to receive referrals.	Awarded agencies	November 30, 2018

PASRR System

The State agencies are aware of concerns regarding the PASRR system and DHS/DMH and HFS are working on a major redesign of the State's MH PASRR program and the PASRR data system, so that it more effectively and efficiently handles the screening and assessment of individuals with serious mental illness. However, PASRR is a vast system that has implications beyond the *Williams* and *Colbert* Consent

[4] In the event that the NOFO responses do not provide sufficient coverage, we will need to re-NOFO and the timeframe will extend.

Decrees. In the State's efforts to pursue a redesign of PASRR and ensure that it meets the full expectations of Federal CMS, the State has requested and will receive technical assistance from the PASRR Technical Assistance Center (PTAC). Ultimately, this will become the basis for procurement of a vendor or vendors that can maintain a conflict-free operation and provide a PASRR data system. As such, updates to the redesign progress will be reported to the Parties based on the following anticipated schedule:

Reports	Lead	Due Date
1. Overview of Re-Design Issues, strategies and process	HFS and DMH	August 2018 (parties' meeting)
2. OBRA 1 and Level I: Process, Tools, Reporting, Tracking/Follow-up	HFS and DMH	September 2018 (parties' meeting)
3. Level II: Process, Tools, LOC Determination, Setting and Service Recommendations, Reporting	HFS and DMH	October 2018 (parties' meeting
4. Pre-Admission Specialized Reviews – Supportive Living Programs		
5. SMHRFs – where do the four SMHRF levels fit in the continuum; how do they fit in the continuum, defining the populations, needed rule changes, strategies for change.	Data collection and clinical analyses required to explore feasibility and/or capacity need. High level administrative feedback required.	
6. Resident Reviews Triggers, Process, Tools, Reporting	HFS and DMH	November/December 2018 (parties' meeting)
7. Specialized Services: Definition and Service Provisions: New Options	HFS and DMH	
8. Secure Governor's Office, DHS, HFS leadership high level sign-off and authorization to proceed		January 2019
9. Process Enhancements in Partnership with MCOs	HFS and DMH	Date contingent of administrative approval
10. PASRR Data System – General Specifications	HFS and DMH	"
11. PASRR Data System - procurement initiated.	HFS and DMH	"
12. MH PASRR Assessment entity(ies) – procurement initiated	HFS and DMH	"
13. Development of MH PASRR system implementation timelines.	HFS and DMH	"

Training Institute

Since 2016, DMH and the Department on Aging have jointly funded a Williams and Colbert Training Institute. The Institute is housed within the University of Illinois at Chicago College of Nursing, under the guidance of Dr. Cheryl Schraeder. Trainers are national academic leaders, content experts and

experienced facilitators. The Institute conducted an environmental scan utilizing literature reviews of best practices for safe transitions, including review of inter-professional standards of care and best practices for transitional care. An internal needs assessment was also conducted and consisted of current program analysis, including an inventory of training materials and approaches; identification of organizational drivers and a review of data associated with negative client outcomes.

The mission of the Institute is to provide ongoing additional staff development support to *Williams* and *Colbert* providers, including community mental health centers' direct care and supervisory staff, Housing Locators, Manage Care Organizations, Resident Review entities, Outreach Workers and other contractors who work with and on behalf of Class Members. The Institute is contracted to hold quarterly in-person trainings as well as a series of webinar trainings in concert with recommendations provided by IDoA, DMH and from participants' surveys.

The FY19 training schedule, topics and venues are still in development. Included in the final curriculum will be training focused on substance use, best practices in treating polysubstance users, state of the art medication administration and therapies for those with co-occurring serious mental illness and substance use.

Multi-Agency Guiding Coalition

The State recognizes that cooperation and coordination between various State agencies is necessary in order for there to be long-term, systemic change to the long-term care system in Illinois. As such, the State is in the process of creating a multi-agency "Guiding Coalition," which will be comprised of high level staff from IDoA, DHS, HFS and DPH. This Coalition will generate ideas for programs and solutions to the service delivery systems involved, and will include the proposal of and validation of models that have the potential to effectuate change to the long-term care system in Illinois, which will, in turn, generate positive changes for *Williams* Class Members as well. This work will focus on the service delivery system from beginning to end: outreach, referral, assessment, evaluation and planning and implementation.

In addition to the Coalition, there is also the potential for there to be an "Advisory Council," which will be comprised of a number of stakeholders from outside groups affected by these issues, including representatives in the areas of primary care, behavioral health, residential/housing, hospitals, managed care organizations and advocates. The Coalition will share its various ideas, models and small piloted outcomes with the Council to elicit feedback and the Council will also be able to provide additional ideas and potential problem-solving mechanisms to the Coalition. This cooperation between the State and stakeholders will help ensure that any changes and recommendations from the Coalition will be able to be successfully replicated on a larger scale to truly effectuate change.

Updates on the status of the Guiding Coalition and Advisory Council will be provided to the Parties and Monitor as more detail becomes available.

Impact of the 1115 Waiver

The Illinois Behavioral Health Transformation 1115 Waiver was approved on May 7, 2018 for the period of July 1, 2018 through June 30, 2023. Under the Waiver demonstration, ten limited pilot projects will be implemented with start dates over the course of the first three years. While there are pilots with some potential impact on *Williams* Class Members, it is important to recognize that *Williams* Class Members represent a limited segment of the total Medicaid population and present with significant and serious behavioral health needs. The *Williams* Settlement also has a dedicated implementation budget. Not all of the pilots have direct relevance to *Williams* Class Members, but are targeted at other populations for whom transformation of service delivery is also critical. It is important to note that pilots are limited by enrollment, qualifying provider, or other criteria.

CMS did not approve the inclusion of the proposed pilot for coverage of short term services in IMD/SMHRFs; therefore, Medicaid coverage of any approved SMHRF Crisis Stabilization Unit would have to be under Federal MCO Regulations allowing coverage of services in an IMD "In lieu of" covered inpatient hospital or crisis residential stabilization. The length of stay must be fifteen days or less.

The 1115 Waiver includes several Substance Use Disorders (SUD) pilots, including one for SUD services in appropriately licensed SUD IMDs, for persons with a primary diagnosis of SUD or OUD. These pilots might offer potential alternatives for individuals with primary SUD diagnoses who are sometimes admitted to NFs and, in the past, to SMHRFs. In year one, the Crisis Intervention services pilot for persons aged 6 - 64 will also begin. There may be opportunities for inclusion of crisis services available to Williams Class Members in pilot programs located in acute care community hospitals or community mental health crisis residential services under 16 beds.

In year two, two limited pilots with relevance to potential *Williams* Class Members will begin. The Assistance in Community Integration Services pilot targets individuals meeting specific health and housing criteria and are focused on pre-tenancy and tenancy-sustaining services. The health criteria target high utilizers of emergency departments and those with two or more chronic conditions. The housing criteria target those facing homelessness upon release from settings specified in 24 CFR 578.3 (not including correctional or IMD facilities) or who are at imminent risk of institutional placement. The second potentially relevant pilot covers Supported Employment for individuals 14 years or older who have serious and persistent mental health or SUD needs and specific risk factors. At this point, the State does not consider Consent Decree populations under *Williams* or *Colbert* priority populations for these pilots due to the dedicated funding streams already available to support Class Member needs in these areas.

Impact of the Managed Care Organization Reboot

With the inception of Health Choice Illinois on January 1, 2018, HFS began the process of transitioning 2.7 million Medicaid members to a statewide mandatory managed care model emphasizing whole-person care. When the transition is complete later this year, it is estimated that 80% of the Illinois

Medicaid population will have their care managed by one of five statewide health plans, with two additional plans specifically located in Cook County. *Williams* Class Members have been enrolled in managed care since its original inception, though with the addition of previously uncovered counties to the program, more Class Members may be covered.