**Section 140.TABLE N Program Approval for Specified Behavioral Health Services**

a) Purpose. Services requiring program approval, as required in Section 140.453, shall be approved based upon the criteria outlined in this Section. For the purposes of this Section, Department shall mean the Department of Healthcare and Family Services (HFS) or its agent.

b) Process

1) Initial Program Approval

A) Enrolled providers, and providers seeking enrollment with HFS pursuant to Section 140.452, to provide one or more of the services detailed in Section 140.453 that require program approval, must identify their intention to provide those services with the HFS Provider Participation Unit through the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) portal.

B) The Department shall process the provider's enrollment application, or updated materials, pursuant to Subpart B.

C) Following the provider's enrollment, or updated enrollment status, the Department will perform program approval of the provider's service program within 90 days.

D) The program approval process shall include:

i) The annual submission of an attestation detailing the provider's adherence with Section 140.453 and this Table N, for each service for which the provider is seeking program approval.

ii) The review of provider program plans, policies, procedures, staffing materials, and other documents required by the Department to determine compliance with Section 140.453 and this Table N, for each service for which the provider is seeking program approval.

iii) Program approval of PSR and IO service programs shall require an on-site visit prior to approval.

iv) The Department may, at its sole discretion, elect to perform on-site program approval activities for any and all services detailed in this Table N.

E) The Department will notify the provider of the date and format of its program approval activities in writing. For program approval activities that are subject to on-site review, the Department will notify the provider at least 10 days prior to the scheduled review. The Provider must:

i) Make the physical plant and site locations available to the Department during clinical review;

ii) Make all administrative and clinical staff, required program plans, procedures manuals, and other necessary documentation required to complete the program approval review available to the Department during the review.

F) The Department shall utilize the program approval criteria detailed in subsection (c) of this Table N for each of the qualifying service program types to be reviewed.

G) Following the on-site review, the Department shall notify the provider in writing, within 10 business days, of its program approval findings.

i) Providers determined to be approved shall be enrolled for a period of 12 months for the service program specialty in IMPACT.

ii) Providers determined not to be approved:

• May request programmatic technical assistance from the Department. Throughout the period of receiving technical assistance, and at the sole discretion of the Department, the Department may work jointly with the provider to remedy outstanding issues and approve the provider's program.

• Providers determined not to be approved shall be notified of their rights to appeal pursuant to subsection (e), following the receipt of technical assistance from the Department.

2) Program Approval/Annual Re-Approval. Following successful completion of initial program approval, providers shall have their service programs reviewed and re-approved annually pursuant to subsection (b)(1)(D) through (G).

A) Providers determined to be re-approved shall continue to be enrolled for the service program specialty in IMPACT for an additional period of 12 months.

B) Providers failing to continue to meet the approval standards shall be issued a Notice of Deficiencies. The Notice of Deficiencies shall inform the provider that it is granted 30 a day period to remedy all identified deficiencies and that technical assistance is available from the Department.

i) Providers that remedy identified deficiencies shall be re-approved pursuant to subsection (b)(2)(A).

ii) Providers that fail to remedy identified deficiencies shall be provided Final Notice from the Department upon the close of the 30 day period established by the Notice of Deficiencies. Upon the date of issuance of Final Notice, the provider shall be informed of its right to appeal and the availability of technical assistance (see subsection (b)(1)(G)(ii)).

c) Services

1) Community Support Team (CST) Program Approval. The provider must attest annually to CST Services meeting the standards detailed in this subsection (c)(1). Additionally, the provider shall demonstrate compliance with the following requirements through policy, procedures, aggregated service detail and/or client record documentation.

A) Programming. The provider shall ensure CST Services are delivered consistently with the following:

i) Services. Individuals served in the CST program shall have access to the interventions detailed in Section 140.453(d)(2)(A) and (G).

ii) Service Delivery

• CST Services are to be provided in the individual's natural setting, with teams delivering no fewer than 60 percent of services in the home or community setting.

• CST Services shall be provided during times and at locations that reasonably accommodate individual's service and treatment needs.

iii) Staffing Ratio. CST Services are delivered with staffing ratios that ensure that no more than 18 individuals per each full time equivalent staff are attributed to CST.

B) Staffing Requirements. The provider shall ensure that the CST team is established consistently with the following:

i) A team lead (see Section 140.453(d)(4)(B)(i));

ii) A team member who is either a Certified Recovery Support Specialist (CRSS) or Certified Family Partnership Professional (CFPP), based upon the age of the individuals served by the team. A person with lived experience may be included on a team that does not have a CRSS or CFPP if he/she obtains certification within 18 month after his/her date of hire; and

iii) One other staff member meeting the credentials to provide one or more of the services detailed in in Section 140.453(d)(2)(A) and (G).

C) Targeted Population Profile. The provider shall ensure the predominant population of individuals receiving CST Services from their CST program will exhibit 3 or more of the following conditions:

i) At risk of institutionalization;

ii) Repeated utilization of crisis services or emergency services for an underlying behavioral health condition;

iii) Current, or history within the last three months of (including threats of):

• Suicidal ideation or gestures; or

• Harm to self or others;

iv) History of failed treatment compliance with elements of the individual's Treatment Plan, Crisis Safety Plan or prescribed medications impacting his/her behavioral health condition;

v) Frequent utilization of detoxification services;

vi) Behavioral health issues that have not shown improvement through participation in traditional outpatient behavioral health services; or

vii) Compounding treatment factors, such as:

• Medical complexity, including cognitive impairment, additional medical conditions, and/or medication resistance;

• Issues with social determinants, including chronic homelessness, repeat arrest, and/or incarceration; or

• Behavioral complexity, including inappropriate public behavior (e.g., public intoxication, indecency, disturbing the peace) or other behavioral problems.

D) Provider-based Utilization Management. The provider shall establish a CST Service review process that adheres to the following:

i) The team shall meet weekly to review all individuals participating in the CST program and their progress in services.

ii) The CST team lead shall review, with the referring LPHA, the Integrated Assessment and Treatment Plan and CST Services on a monthly basis to ensure ongoing necessity for service delivery.

iii) The LPHA shall:

• Review each individual's progress in service; and

• Identify any necessary changes in CST Services, including transition to less intensive services, consistent with the participating individual's Integrated Assessment and Treatment Plan.

2) IO Program Approval. The provider must attest annually to IO Services meeting the standards detailed in this subsection (c)(2). Additionally, the provider shall demonstrate compliance with the following requirements through policy, procedures, aggregated service detail, and/or client record documentation.

A) Programming. The provider shall ensure IO Services are delivered consistently with the following:

i) Active Treatment. The provider shall program IO Services to ensure participants are provided with active treatment, meaning that activities and therapies are not primarily recreational or diversionary. IO Services are provided in response to the participating individual's condition with a reasonable expectation to:

• Improve or maintain the individual's condition;

• Improve functional level; and

• Prevent institutionalization.

ii) IO programming provides a series of time-limited, structured, group interventions specific to the needs of the participating individuals, including psychoeducational, skills-development, crisis de-escalation, and other therapeutic interventions. IO programming shall be evidence-informed and delivered through the use of a standardized curriculum model, when available.

B) Staffing Requirements. The provider shall ensure that IO Service programs are established and include staffing ratios. IO Service staffing ratios for groups shall not exceed one full-time equivalent staff to 8 individuals for adults and one full-time equivalent staff to 4 individuals for youth.

C) Targeted Population Profile. The provider shall ensure the predominant population of individuals receiving IO Services from their IO program meet the criteria in this subsection (c)(2)(C):

i) Recognize their condition and seek to manage that condition through lower intensity community services;

ii) Are at risk of institutionalization; and

iii) Have sufficient cognitive ability to benefit from IO Services.

D) Provider-based Utilization Management. The provider shall establish an IO Service review process that adheres to the following:

i) The IO staff shall review, with the referring LPHA, the Integrated Assessment and Treatment Plan and IO Services on a weekly basis.

ii) The LPHA shall review each individual's diagnosis and identify targeted IO Service topics and goals to be addressed through the provider's IO Service program.

3) PSR Program Approval. The Provider must attest annually to PSR Services meeting the standards detailed in this subsection (c)(3). Additionally, the provider shall demonstrate compliance with the following requirements through policy, procedures, aggregated service detail, and/or client record documentation.

A) Programming. The provider shall ensure PSR Services are delivered consistently with the following:

i) Active Treatment. The provider shall develop PSR Services to ensure participants are provided with active treatment, meaning activities and therapies are not primarily recreational or diversionary. PSR Services are provided in response to the individual's condition, with a reasonable expectation to:

• Improve or maintain the individual's condition;

• Improve functional level; and

• Prevent institutionalization.

ii) Co-occurring Treatment. PSR programs shall have the ability to provide services and interventions to individuals with co-occurring psychiatric and substance use disorder conditions.

B) Staffing. The provider shall ensure that PSR Service programs are established consistently with the following:

i) PSR Program Director. The PSR program shall have a full-time Program Director that meets the requirements of a QMHP (see Section 140.453(b)(2)). The Program Director shall be consistently scheduled onsite, spending at least half of his/her time in the provision of PSR Services.

ii) All PSR program staff shall have direct access to the PSR Program Director, or other delegated QMHP, at all times during PSR Service delivery.

C) Targeted Population Profile. The provider will ensure the predominant population of individuals receiving PSR Services from their PSR program will meet the criteria in this subsection (c)(3)(C):

i) Require a minimum of 20 hours per week of therapeutic services as evidenced in the plan of care;

ii) Benefit from a coordinated program of services and require more than individual sessions of outpatient treatment;

iii) Are not eligible to receive similar services under a facility payment rate;

iv) Have an adequate support system while not actively engaged in the program;

v) Have a mental health diagnosis;

vi) Are determined not to be dangerous to self or others; and

vii) Have the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of PSR Services.

D) Provider-based Utilization Management. The provider shall establish a PSR Service review process that adheres to the following:

i) The PSR staff shall review, with the referring LPHA, the Integrated Assessment and Treatment Plan and PSR Services minimally on the following schedule:

• Within 14 days after admission to the PSR program; and

• Once every 30 days, following the initial 14 day period.

ii) The LPHA shall:

• Validate the individual's diagnosis, establish the PSR Service goals with the individual, and direct the type, amount, duration and frequency of intervention to be delivered during the individual's participation at the PSR program.

• Certify that the individual cannot otherwise be stabilized in the community without participating in PSR Services, placing the individual at risk of institutionalization.

4) Medicaid Rehabilitation Option (MRO) Crisis Services Approval. The provider must attest annually to meeting the standards detailed in this subsection (c)(4). Additionally, the provider shall demonstrate compliance with the following requirements through policy, procedures, employee records, and aggregated service detail and/or client record documentation.

A) Programming. The provider shall ensure crisis services are delivered consistently with the following:

i) Crisis Screening Instrument Certification.

• Each provider of MRO Crisis Services shall establish and maintain a staff member who is a certified Trainer of the Department's Crisis Screening Instrument; and

• All staff providing MRO Crisis Services shall maintain active certification in the usage of the Department's crisis screening instrument.

ii) Providers that maintain a service area designation in the HFS IMPACT system shall accept all individuals referred by the HFS Crisis and Referral Entry Service (CARES) Line, on a no decline basis, 24 hours a day, 365 days a year and respond to the location of crisis within 90 minutes.

iii) Training Requirements. All staff providing MRO Crisis Services shall receive annual training on the following topics:

• Crisis Safety Planning, as directed by the Department; and

• Crisis de-escalation.

iv) Service Availability. Certified providers of MRO Crisis Services must be available to provide crisis services 24 hours a day, 365 days a year.

v) Service Delivery

• Providers of MCR shall provide all services in a face-to-face capacity, ensuring that the family is provided with a crisis safety plan and access to follow up services.

• Providers of Crisis Stabilization services shall ensure staff is trained to identify crisis and understand how to access the crisis response network when consumers are de-escalating.

B) Staffing Requirements. An LPHA is required to approve the implementation of crisis stabilization supports following an MCR event via the review and authorization of the individual's crisis safety plan.

C) Targeted Population Profile. The provider shall ensure the predominant population of individuals receiving MRO Crisis Services from their MRO Crisis Services program will meet the criteria in this subsection (c)(4)(C):

i) Adult's experiencing a psychiatric crisis in danger of harming themselves, others, or property;

ii) Children experiencing a behavioral health crisis, inclusive of psychiatric crisis (harm to self, others, property), mental health crisis, and other destabilizing factors that impact the youth in one life domain or more.

D) Provider-based Utilization Management. The provider shall establish an MRO Crisis Services review process that adheres to the following:

i) Providers of Crisis Stabilization services shall meet weekly with the LPHA authorizing services via the crisis safety plan to review ongoing necessity for service delivery.

ii) The LPHA shall:

• Review each individual's progress in service; and

• Identify any necessary changes in Crisis Stabilization services, including change in intensity of services.

5) Violence Prevention Community Support Team (VP-CST) Program Approval. The provider must attest annually to VP-CST services meeting the standards detailed in this subsection (c)(5). Additionally, the provider must demonstrate compliance with the following requirements through policy, procedures, aggregated service detail and/or client record documentation.

A) Programming. The provider shall ensure VP-CST services are delivered consistently with the following:

i) Services. Individuals serving in the VP-CST program must have access to the following interventions and supports:

• Proactive service engagement and peer supports delivered by a Peer Support Worker (PSW);

• Individual, group, and family Therapy/Counseling, as detailed in Section 140.453(d)(2)(A), utilizing evidence-informed, trauma-specific interventions and techniques; and

• Individual and group Community Support services, as detailed in Section 140.453(d)(2)(G).

ii) Service Delivery.

• VP-CST services are to be provided following a culturally responsive, trauma-informed approach to care.

• Providers of VP-CST must provide VP-CST services during times and at locations that are convenient to the individual and their family, as applicable, and that accommodate the individual's service and treatment needs and preferences.

• Providers of VP-CST must establish processes to receive referrals from local organizations funded by the Illinois Department of Human Services' Office of Firearm Violence Prevention (OFVP) as well as local emergency departments treating individuals who have experienced firearm violence.

• Providers of VP-CST must establish a plan to collaborate with other local, community-based organizations delivering violence prevention or intervention services, such as street outreach programs.

• Staffing Ratio. VP-CST Services are delivered with staffing ratios that ensure that no more than 18 individuals per each full-time equivalent staff are attributed to VP-CST.

B) Staffing Requirements. All staff delivering VP-CST services must receive annual training as required by the Department's fidelity model outlined in the Department's provider handbook for community-based behavioral health and available on the Department's website. The provider shall ensure that the VP-CST team is established consistent with the following:

i) A team lead (see Section 140.453(d)(4)(B)(i));

ii) A Peer Support Worker with lived experience with firearm violence, either directly or through community exposure; and

iii) One other staff member that minimally meets the credentials to provide the services detailed in Section 140.453(d)(2)(A) and (G).

C) Targeted Population Profile. The provider shall ensure that individuals receiving VP-CST services meet the following criteria:

i) History of or recent direct exposure to firearm violence or repeated exposure to firearm violence in the community; and

ii) Mental health needs and conditions associated with chronic and ongoing trauma exposures.

D) Provider-based Utilization Management. The provider shall establish a VP-CST Service review process that adheres to the following:

i) The team shall meet weekly to review all individuals participating in the VP-CST program and their progress in services.

ii) The VP-CST team lead and authorizing LPHA shall review each individual's Integrated Assessment and Treatment Plan and VP-CST services on a quarterly basis to:

• Review each individual's progress in service; and

• Identify any necessary changes in VP-CST services, including transition to less intensive services, consistent with the individual's Integrated Assessment and Treatment Plan.

d) Transferability. Program approval is assignable or transferable consistent with the policies and procedures established by the HFS Provider Participation Unit related to the assignment and transferability of a provider's enrollment status with HFS.

e) Service Requirements for CMHCs Providing Assertive Community Treatment (ACT). The Department deems CMHCs certified to provide ACT services consistent with the requirements detailed in this subsection (e), though it reserves the right to review ACT Programs pursuant to the process explained in Table N(b)(2), as required.

1) Assertive Community Treatment (ACT) Program Requirements

A) Services. ACT services are comprised of the interventions detailed in Section 140.453(d)(1), (d)(2), (d)(3) and (f)(1), excluding Section 140.453(e)(2)(B) and (e)(2)(F).

B) Service Delivery

i) ACT services are to be available 24 hours a day, each day of the year, and shall minimally adhere to crisis response protocols and timeframes when delivering crisis response services as part of the ACT intervention.

ii) ACT services are to be provided in the individual's natural setting, with teams delivering no fewer than 75 percent of services in the home or community setting.

iii) Individuals receiving ACT services shall receive a minimum of 4 face-to-face contacts per month, with an understanding that most individuals participating in ACT will require multiple contacts on a weekly basis.

iv) Service Ratio. Service ratios of no more than 10 individuals served per each full time equivalent staff attributed to ACT are allowable.

C) Staffing Requirements

i) Administrative Support. ACT services shall have dedicated administrative support with teams of fewer than 12 maintaining the ratio of .25 FTE per every 3 ACT team members (e.g., teams of 4 would require .25 FTE, teams of 6 would require .5 FTE, teams of 9 would require .75 FTE, etc.).

ii) Psychiatric Resource. ACT services are directly supported by a treating psychiatrist and/or Advance Practice Nurse at a ratio of 10 hours per week for each 60 participating individuals. An ACT team must have access to at least 5 hours of dedicated treatment and consultation time from the participating psychiatrist on a weekly basis.

iii) Core Team. ACT Teams shall be comprised of more than three staff members meeting the following requirements:

• A team lead (see Section 140.453(d)(4)(A)(iv));

• A full-time RN who provides services and monitors the clinical status and response to treatment for all individuals participating in ACT;

• A team member who is either a Certified Recovery Support Specialist (CRSS) or Certified Family Partnership Professional (CFPP), based upon the age of the individuals served by the team. A person with lived experience may be included on a team that does not have a CRSS or CFPP, provided that the certification is obtained within 18 months after the date of hire; and

• One other staff member meeting the credentials to provide one or more of the services detailed in in Section 140.453(b)(3)(A) and (d)(2)(G).

D) Service Target Profile. ACT services are intended for individuals who require intensive services being delivered by a multi-disciplinary team to remain stabilized in the community, as evidenced by having a Serious Mental Illness (SMI) and meeting the following criteria:

i) One of the following:

• Behavioral health issues that have not shown improvement through participation in less intensive behavioral health services;

• A history of unsuccessful treatment compliance with elements of the individual's Treatment Plan, Crisis Safety Plan or prescribed medications impacting their behavioral health condition;

• Compounding treatment factors, such as: medical complexity, including cognitive impairment, additional medical conditions, and/or medication resistance; issues with social determinates, including chronic homelessness, repeat arrest, and/or incarceration; or behavioral complexity, including inappropriate public behavior (e.g., public intoxication, indecency, disturbing the peace) or other behavioral problems.

ii) One of the following:

• At risk of, or at risk of recidivism to, institutionalization;

• Repeated utilization of crisis services or emergency services for an underlying behavioral health condition;

• Current, or history within the last three months of (inclusive of threats of), suicidal ideation or gestures or harm to self or others; or

• Frequent utilization of detoxification services.

E) Provider-based Utilization Management

i) The team shall meet daily.

ii) The team shall review all active ACT individuals and determine progress in services, minimally on a weekly basis.

iii) The individual's Integrated Assessment, Treatment Plan, and ACT services are reviewed monthly by the ACT team lead, in consultation with the ACT Psychiatric Resource, ensuring that the ACT psychiatrist reviews each individual's participation at least once per calendar quarter, to ensure ongoing necessity for service delivery.

iv) The ACT Psychiatric Resource shall:

• Review the individual's progress in service; and

• Identify any necessary changes in ACT services or service intensity, including transition to less intensive services, documenting all changes in the individual's Integrated Assessment and Treatment Plan.

f) Appeals. For appeals regarding program approval, the following shall apply:

1) The HFS rules for Medical Vendor Hearings (89 Ill. Adm. Code 104.Subpart C) shall apply to all appeals under this Section, except that:

A) Informal review of any appealable issue must be completed by the Department's Bureau of Behavioral Health (BBH) pursuant to this Section before formal appeal of the issue may be requested to the Department's Bureau of Administrative Hearings (BAH); and

B) 89 Ill. Adm. Code 104.204, 104.205, 104.206, 104.207, 104.208, 104.210, 104.211, 104.213, 104.216, 104.217, 104.249, 104.260, 104.272, 104.273 and 104.274 shall not apply.

2) A provider may appeal the following actions detailed in this Part:

A) Refusal to issue program approval; or

B) Revocation of program approval resulting in disenrollment from participation for the specific clinical service in question.

3) Informal Review Process

A) The provider seeking to appeal any of the issues in subsection (e)(2) must first request informal review of the issue by BBH before the issue may be appealed to BAH.

i) Request for informal review must be submitted in writing to BBH within 10 days after the date of notice of the contested action and must clearly identify the issue or action for which informal review is sought.

ii) If the request for informal review is received by BBH prior to the Department's intended action taking effect, the action shall be stayed until completion of the informal review and, if applicable, expiration of the subsequent 10 day period to formally appeal the outcome of the informal review to BAH.

B) The BBH shall complete the informal review of the contested action within 30 days after receipt of the request and shall determine whether to maintain, reverse or modify the action or take other action as necessary.

i) BBH may request and review all materials pertaining to the informal review held by the Department's vendors, agents or providers.

ii) BBH shall notify the individual or authorized representative in writing of the result of the informal review. The written notification shall:

• State the result of the informal review, including action to be taken, if any;

• State the reason and policy basis for the action; and

• Provide notice of the right to appeal and instructions on how to proceed with formal appeal through BAH.

C) The provider may appeal the result of the informal review by filing a written request for appeal with BAH within 10 days after the date of the notice of the result of the informal review. If the request for appeal is received by BAH prior to Department's intended action taking effect, the action shall be stayed until the appeal is resolved through final administrative decision or withdrawal of the appeal.

D) The final administrative decision shall be issued to the interested parties within 90 days after the date the appeal is filed with BAH unless additional time is required for proper disposition of the appeal.

E) Appropriate action implementing the final administrative decision shall be taken within 30 days after the date the final administrative decision is issued.

(Source: Amended at 46 Ill. Reg. 16740, effective September 20, 2022)