Exhibit E

“IWG Statement of Determination”

Implementation Work Group Statement of Determination
In the Matter of Jeff D. v. Little

Submitted October 2, 2024, via e-mail by *Jeff D.* Class Counsel, pursuant to the Implementation Assurance Plan, Objective B, paragraph 3.e.iii.

A. Jeff D. Background: the Settlement Agreement and Implementation Plan

Jeff D. v. Little is a long-running Federal lawsuit brought to provide access to behavioral health services for Idaho children who have a diagnosis, or would be diagnosed if assessed, of serious emotional disturbance (SED). The Defendants include the Governor, the Director of the Department of Health and Welfare ("Department"), including the Class Members in the Child Welfare Division, the Department of Juvenile Corrections, and the State Department of Education. The Department's experts have determined that, at any point in time, more than twenty thousand Idaho children may be diagnosed with SED and, therefore, are likely *Jeff D.* Class Members.

Over the course decades of litigation the Department has entered into Consent Decrees and Settlement Agreements requiring mental health services and treatment be provided Class Members so they may remain in their homes and communities and not suffer crises that result in hospitalizations and residential treatment. The Department promised to end the all-too-common expedients of advising parents to have their children arrested and incarcerated in the juvenile justice system, or having the Department remove children from their parents' custody under the Child Protection Act, in order to access services and treatment.

In 2011, the Federal Court of Appeals for the Ninth Circuit remanded the case back to the Idaho Federal District Court to implement the prior Consent Decrees and Settlement Agreements. Rather than litigate the failure to implement a System of Care, the parties agreed to negotiate a new Settlement Agreement to ensure that the obligations and purposes of earlier Consent Decrees entered by the District Court in 1983, 1990, and 1998, would be met, to wit: "to provide adequate and appropriate treatment and educational programs in the least restrictive environment . . ." *Jeff D. v C.L. "Butch" Otter*, No. 4:80-CV-04091-BLW, JOINT MOTION AND STIPULATION FOR APPROVAL OF SETTLEMENT AGREEMENT AND PROPOSED ORDERS, at p. 2 (June 12, 2015).

The 2015 Settlement reached by the parties further elaborated on the expected results of the Agreement:

> The purpose of this Agreement is to direct and govern the development and implementation of a sustainable, accessible, comprehensive, and coordinated service delivery system for publicly-funded community-based mental health services to children and youth with serious emotional disturbances ("SED") in Idaho. The specific objective of this Agreement is the development and successful implementation of a service array and practice model that are consistently and sustainably provided to Class Members statewide, in the

> manner prescribed herein. As a result of this Agreement, Class Members will receive individualized, medically necessary services in their own communities, to the extent possible, and in the least restrictive environment appropriate to their needs.
> *Jeff D. v C.L. "Butch" Otter*, No. 4:80-CV-04091-BLW, Settlement Agreement, ¶ 1 (June 29, 2015) (footnote omitted) ("Settlement Agreement").

The Settlement Agreement required the parties to develop an Implementation Plan within nine months with the assistance of an Implementation Work Group (IWG). The IWG was to be:

> comprised of Plaintiffs' counsel, Defendants' counsel, and children's mental health stakeholders with knowledge relevant to system beneficiaries, services and processes. The IWG is intended to help facilitate successful implementation planning as prescribed by this Agreement.
> Settlement Agreement, ¶¶ 59-60.

Defendants were to submit the plan to the Court for approval, and "timely comply with the Implementation Plan approved by the District Court." Settlement Agreement, ¶ 64.

The Settlement Agreement further provided that:

> After approval of the Implementation Plan by the District Court, the IWG will continue to meet at a minimum of twice yearly, but more frequently if needed. During the implementation period, the IWG is intended to foster communication between the Parties by providing a forum to discuss progress on and problem-solve issues related to the Implementation Plan and Defendants' performance under this Agreement.
> Settlement Agreement, ¶ 66.

The Settlement Agreement was grounded on seven key components, including:

A. Services Provided to Class Members
B. Principles of Care and the Practice Model
C. Access to Care
D. Workforce Training and Development
E. Due Process
F. Governance and Interagency Collaboration
G. Quality Management, Improvement and Accountability

Components A and C, which encompass the essential design features of Idaho's System of Care to deliver behavioral health services and supports to Class Members under the Settlement Agreement, are the issues relevant to this Statement. In brief, *Section A. Services Provided to Class Members*, details the healthcare treatment the Department agreed to provide to Class Members under the Agreement; and *Section C. Access to Care,* maps out how children and their families enter and move through the System of Care from identifying and assessing their behavioral health needs, planning treatment and coordinating care, to transitioning out of care.

The promises made in these components serve the dual functions of (1) describing what are the procedural rights and responsibilities of the parties, and (2) establishing what system-wide behavioral healthcare results for youths and their families must be achieved to satisfy the Settlement Agreement and bring Idaho's children's mental health system reforms, and this case, to a successful conclusion.

B. Missed Deadlines: Amending the Implementation Plan

Using the IWG collaborative structure, the parties and stakeholders, including parents of Class Members and service providers who have struggled to access services for Idaho's children with serious mental health needs, jointly drafted the Implementation Plan which described in detail how the Settlement Agreement would be operationalized. Considerable progress implementing the plan was made from 2016 through 2019. By 2020, however, forward progress had slowed, and the Department missed its deadline for completing implementation as set by the Settlement Agreement.

The parties engaged an expert to assist in getting the Department back on track. After more than a year of negotiations, the parties agreed to amend the Implementation Plan with their Implementation Assurance Plan ("IAP"), filed January 11, 2022.

> The parties developed the IAP because 1) some elements of the Implementation Plan (IP) have been completed even as key deadlines have been missed; 2) the State has initiated the process of seeking bids for the statewide Idaho Behavioral Health Plan (IBHP) contract to maximize the Medicaid program and other funding sources to implement mental health services for the *Jeff D* class members; 3) the ongoing COVID crisis has impeded collaboration, diverted resources, impacted service delivery, and delayed compliance with the Settlement Agreement (SA) and IP; 4) the IAP will better align focus and action with current challenges and opportunities; and 5) increased oversight or accountability will be needed to achieve full implementation of the SA agreed to by the parties and approved by the Court.
> IAP, p. 1.

As its title indicates, the IAP's purpose was to get the Settlement Agreement fully implemented by refocusing the Department's efforts with updated and prioritized deliverables, with direct integration of a new and expanded behavioral health plan and Managed Care Organization ("MCO"), and greater accountability for deadlines and deliverables.

Additionally, the parties were much more specific about how to complete the essential blueprints for successful implementation, calling for five authoritative documents or manuals, including a) Services and Supports Crosswalk; b) an updated Practice Manual; c) Access Pathways Map; d) Due Process Protocol; and e) an updated Quality Management, Improvement, and Accountability ("QMIA") Plan. The Director's Report that is the subject of this Statement is required because the Department has not timely completed the Services and

Supports Crosswalk and the Access Pathways Map. *See* IAP, Objective B, paragraph 3.e.iii. Additionally, because these authoritative documents were not timely completed, an updated Practice Manual is also overdue.

The parties understood when they reached a Settlement Agreement in 2015, and completed drafting an Implementation Plan in 2016, that the blueprints described in the IAP as "authoritative documents" were necessary to describe and document the basic design of the Youth Empowerment Services ("YES") System of Care. Absent these documents, and the program plans or designs needed to complete them, the YES System of Care cannot achieve its intended purpose, and many hundreds of children and youth in Idaho will not receive the mental health services and supports they need and are entitled to under the Court approved and ordered 2015 Settlement Agreement. The result is needless or avoidable untreated child depression, anxiety, and fear, damaged families, out-of-home placements, failure in school, delinquency and detention, self-harm, and suicides.

The Department claims it has provided the IWG with sufficient final drafts of the Services and Supports Crosswalk and Access Pathways Map. The IWG has notified the Department that neither document meets the content requirements set forth in IAP. Moreover, the IWG has repeatedly provided the Department with additional time and detailed input on how to bring Services and Supports Crosswalk and Access Pathways Map into compliance. Inexplicably, the Department has refused to amend the authoritative documents to meet the IAP requirements.

C. What is required to Complete the Services and Supports Crosswalk?

The IAP spells out what is required of the Department to complete the Services and Supports Crosswalk in detail. See, IAP, Objective A.

> OBJECTIVE A: Services and Supports
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> The Idaho Department of Health and Welfare (hereinafter "IDHW") will complete a Services and Supports Crosswalk that provides authoritative guidance on services and supports and Appendix C[1] to all YES Providers and stakeholders.
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> The Services and Supports Crosswalk will describe the scope and parameters of each medically necessary service and support as generally set forth in the Appendix C of the Jeff D. Settlement Agreement (hereinafter "Agreement") and as further explained below. YES Services and Supports will be delivered to YES Class Members and their families substantially consistent with the Services and Supports Crosswalk and other YES Authoritative Documents.

[1] The Appendices to the 2015 Settlement Agreement provide added detail around several major components included in the Agreement. Appendix C. broadly lists all of the "services and supports [that] must be available and accessible to every Class Member as needed or clinically appropriate on a statewide basis . . ." 2015 Settlement Agreement, Appendix C, p. C-1.

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1. YES Defendant Agencies will complete and maintain an authoritative Services and Supports Crosswalk document that describes the Services and Supports outlined in Appendix C. YES Services and Supports will be offered and delivered to YES Class Members and their families substantially consistent with the Services and Supports Crosswalk. IDHW will consult with the IWG, subject to procurement restrictions, as IDHW develops the Crosswalk. The Services and Supports Crosswalk will be completed and provided to the IWG within the following timelines:

a. Final Draft completed by the Execution of the IBHP Contract [June 16, 2023]

b. Final authoritative document will be negotiated with the Idaho Behavioral Health Plan (hereinafter "IBHP") Contractor and will be completed by the Service Start Date [July, 1, 2024] of the IBHP Contract.

2. Services and Supports descriptions in the Crosswalk shall include: pre-approval requirements; service descriptions; scope, intensity and duration constraints; service delivery methods and timelines; financial and categorical eligibility; eligible service location and accessibility; provider qualifications (licensing, certification, supervision, training, etc.); other policies or rules that impact access to care, service delivery agency or agencies; funding source(s); and statutory or regulatory authority for the foregoing, for each YES Class Member discrete population served including Class Members with more intensive needs, dual diagnosis youth (including those with Serious Emotional Disturbance (SED) and Developmental Disabilit(ies) (DD)), juvenile justice-involved youth, child welfare-involved youth, special education youth, youth in families over 300% FPL, 1915(i) eligible youth, youths needing out-of-home placement, and any other group(s) with substantively different benefits or eligibility criteria relating to receipt of YES Services and Supports.

a. Federal and State Medicaid coverage, restrictions and services and eligibility opportunities shall be assessed and may be incorporated into the Services and Supports descriptions, such that "Defendants will implement and administer Idaho's Medicaid program to provide services to the fullest extent allowable under the Medicaid Act", as required by Paragraph 36 of the Agreement.

b. Telehealth services will be incorporated into the Crosswalk as a distinct item, and employed as clinically, programmatically, and administratively appropriate.

c. The YES Defendant Agencies will establish and maintain intensity and duration standards based on national standards of care for core YES Services, with statewide and regional average minimums for hours per month and months per client by the Service Start Date of the new IBHP contract. Prior to completing the final draft of the Services and Supports Crosswalk, IDHW will consult with the

> IWG when determining the core services requiring minimum standards under this paragraph.
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> * * *
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> 5. The services and supports descriptions in the Crosswalk will compare services and supports as described in (2) above with services and supports actually received by class members for each IDHW Region, including any differences between urban and rural areas, documenting discrepancies in each of the following: clinical details; medical necessity; pre-approval requirements; scope, intensity and duration minimums or limits; financial and categorical eligibility; eligible service location and service hours; provider qualifications (licensing, certification, supervision, training, etc.); and other policies or rules that impact access to care. IDHW, through the IBHP contractor, will ensure that YES services and supports are delivered substantially consistent with the Services and Supports Crosswalk, and the Appendix C requirements.
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> 6. The YES Defendant Agencies will complete a Services and Supports Crosswalk for all of the discrete populations of YES Class Members served by YES Providers. IDHW will combine all Defendant Agency contributions into one document using consistent formatting, terms, definitions, and descriptions. * * *

On September 6th, 2024, the IWG advised the Department that its latest version of the Services and Supports Crosswalk did not meet the IAP requirements.

> Class Counsel and the Implementation Work Group (IWG) Stakeholders have reviewed the Crosswalk document the Department submitted to the IWG on June 28, 2024. The Department submitted its latest version without comment or explanation. No effort was made by the Department to highlight the changes that were made from the previous "final" version of the Crosswalk that was shared a year ago on August 24, 2023. Neither was there any response regarding the extensive Crosswalk materials/feedback that was provided by Class Counsel and the IWG Stakeholders to the Department on April 9, 2024.
>
> Having carefully examined the Department's latest version of the Crosswalk it is evident that little was changed in this version from the last, dated August 24, 202[3]. All of the discussions and substantive input provided by the Stakeholders and Class Counsel over the last year have amounted to almost no improvement over several previous drafts shared last year.
>
> The bright spots in this latest version include updating some service descriptions informed by Magellan's Services and Supports descriptions from its Provider Manual. In addition, the narrowly-focused citations to authority are an important resource for understanding the rules and regulations that govern

access to care, and the global cites may provide context for Idaho's children's behavioral health programs.

The shortcomings in the Crosswalk, unfortunately, are far more notable. What is more, most of the problems are long-standing, and have been repeatedly raised by Class Counsel, the IWG stakeholders, and/or several private consultants. They include:

1. "Authorization Requirements" are much too narrowly construed and often fail completely to provide basic program eligibility or clinical guidance about the listed services and supports. We examined the text in the Crosswalk along with related information from Magellan's Provider Manual. See the attached spreadsheet. Even with Magellan's additional information (that was not incorporated in the Department's Crosswalk), twenty (of 38) services do not provide sufficient information to determine who is eligible or appropriate for the listed service. Ten descriptions are marginal and need to be improved. Eight services have adequate eligibility descriptions, although the information that is provided may be unduly restrictive or otherwise at odds with providing the service consistent with the Jeff D. Principles and Practice Model.

2. There is very limited information regarding discrete populations of Class Members as required. Two categories are missing altogether: Class Members with more intensive needs, and dual diagnosis youth with mental health and Substance Use Disorder (SUD). See IAP Obj. A, ¶6. The information that is included in the column labeled 'Additional Information for Discrete Populations' falls well short of sufficient.

For example, Child-welfare-involved youth has boiler plate language asserting that: "A Child Welfare case manager needs to be involved in the coordination of services" and "Child Welfare case management is not considered a duplication of YES Case Management, TCC or ICC." Guidance for residential care is more extensive, providing that "provisions of IDAPA 16.06.01 related to alternate care plans and Title IV-E Eligibility must be addressed, including requirements for a Qualified Residential Treatment Facility, and necessary judicial determinations under the Child Protective Act (Idaho Code sections 16-1622, 16-1619A). A permanency hearing may be held for youth in ACP no later than 12 months after the date of placement and every 12 months thereafter, while the youth is in RTC." TFC provides additional information on clinical eligibility, although it does so by reserving entirely to DHW discretion who is eligible "based on their significant emotional and/or behavioral needs." That's the sum total of guidance for the hundreds of youths in need of YES services and supports who are involved with the child welfare system or needing out-of-home placement.

The information provided for juvenile justice-involved, special education, and dual diagnosis (mental health & Developmental Disability (DD)) youths, are

equally or less informative. The information for youth in families over 300% FPG is one sentence: For Non-Emergency Medical Transportation (NEMT), "DBH may also support transportation needs with flexible funds via the IBHP."

The information that should be presented in the Crosswalk for discrete populations includes:

a. Services and supports that are required or voluntarily provided to youth and families to identify, screen, assess and link Class Members to YES services and supports.

b. YES and/or behavioral health services that are mandated or offered by the agency that bears program responsibility for the discrete population. These services and supports should be listed in the Column labeled "Service Descriptions" with all of the relevant information detailed across the rest of the Crosswalk columns. The information must include a full description of the clinical eligibility or appropriateness for each service.

c. The provider, clinician, agency representative, or beneficiary who has responsibility for decision-making when jurisdictions and/or programs overlap must be detailed, along with the basis on which responsibility is determined, and decisions are made.

d. Describe how YES services and supports vary (may be expanded or restricted) for specific discreet populations.

e. Detail how complaints and appeals procedures vary depending on the discrete population or the responsible agency.

In addition, the Department needs to define which children are included in each of these different groups. For instance, the Crosswalk should provide clarity on who is included in the juvenile justice-involved and the child-welfare-involved populations. Similar guidance would be appropriate for special education and SUD populations. For instance, as presented, it appears that only youth already receiving special education services are included in the special education population category. It should include all Class Members who may benefit from education-related services.

3. Another critical weakness in the Crosswalk is the lack of clarity on services involving treatment planning and case management/care coordination. These are fundamental building blocks for the System of Care and the lack of clarity and guidance on these services undermines the entire service delivery system. Instead of providing a description of treatment planning, the Crosswalk describes one planning process—Child and Family Teams (CFT). While that is necessary, it does not provide guidance for the thousands of youths who do not have either a formal or informal CFT. Other treatment planning guidance is hinted at elsewhere, but taken together the materials fall well short of a description of treatment planning, which is a required precursor to most treatment services.

Case management and care coordination are essential services for SED youths who have complex needs and are multi-system involved. The Crosswalk

has many paragraphs of descriptive text relating to case management and care coordination, but it is often duplicative, overlapping, and confusing. Distinctions among Case Management, Targeted Care Coordination (TCC), Intensive Care Coordination, and Wraparound are unclear. Which Class Members are eligible for each, and why, is a mystery. Moreover, TCC is being phased out this year and it's unclear from the Crosswalk what service(s)—if any—will replace it. In addition, there are references in the Crosswalk to Level of Care (LOC) criteria that affects which services are available to Class Members. As such, information describing how the LOC assignment process works should be included in the Crosswalk Service Descriptions or Authorization Requirements.

4. Also missing altogether from the Crosswalk are the front-end services of identification, screening, referral, assessment (save for Comprehensive Diagnostic Assessments (CDA)), and service linking. Class Counsel has repeatedly reminded Defendants that these are required services under the Settlement Agreement and must be included in the Crosswalk. Failing to describe the front-end of the System of Care likely indicates a fundamental misunderstanding of its importance, or an avoidance of Defendants' responsibility to ensure that all youths in Idaho are aware of YES, are screened for strengths and needs, and are linked to appropriate assessments and/or services as needed.

5. The Crosswalk feature that compares what is required under the Settlement Agreement against what is actually provided, and the programmatic steps in between, has been removed. We have previously reminded the Department about the purpose of the Crosswalk:
"…[T]he Crosswalk is intended to take the language from the Settlement Agreement's Appendix C and translate it through intermediary management organizations or systems (e.g., Medicaid, FACS, DD, MCO, Provider) into practice instructions for clinicians delivering care so as to ensure that each class member gets all of the medically necessary services and supports included in the YES SOC as promised in the SA, and Appendix C. To do that, there needs to be appropriate guidance for each level of the system that positively contributes to delivering the promised services and supports." P. Gardner email to IWG, January 9, 2023.

As presented, the Crosswalk fails to do this, including failing to describe what services are actually provided to Class Members at the clinical level. Done properly, the Crosswalk would list service descriptions or authorization requirements for each level of the system as we demonstrated in our template provided to the Department and the IWG on April 12, 2024. This input was requested by the Department and, apparently, ignored.

Although not explicitly required to be included in the Crosswalk, "[p]rior to completing the final draft of the Services and Supports Crosswalk, IDHW will consult with the IWG when determining the core services requiring minimum standards under this paragraph." See IAP Objective A, 2c. The consultation is

intended to assist the YES Defendant Agencies to "establish and maintain intensity and duration standards based on national standards of care for core YES Services, with statewide and regional average minimums for hours per month and months per client by the Service Start Date [July 1, 2024] of the new IBHP contract." Id. The timing in the IAP text suggests that these standards would properly be included in the Crosswalk as elements of what Class Members are eligible to receive. Defendants have not determined the standards as required.

It is important to point out that the June 28, 2024, version of the Crosswalk comes more than six and half years after the first version of the Crosswalk was shared by the Department's workgroup tasked with completing it, on December 7, 2017. That group was discontinued by the Department, setting the process back until efforts began again in earnest in mid-2019, culminating in a collaborative draft completed at the end of the year. The Department did a formal review and comment and issued its responses in mid-February 2020. Further reviews and negotiations followed that failed to result in an updated version from the Department until well after the IAP was filed with the Court in January 2022.

Although the IAP agreement was specifically intended to kick-start the completion of the Crosswalk and other Authoritative Documents, two and a half years later the Crosswalk shared with the IWG has not appreciably improved. In several ways it has gone backwards from the Department's December 2019 version, including dropping its "crosswalk" aspects. That there has been very little change from the previous version shared a year ago, on August 24, 2023, is especially discouraging.

The fundamental shortcomings in this latest version of the Crosswalk render it largely inoperable. As such, the Department has not complied with the IAP requirement to "complete a Services and Supports Crosswalk that provides authoritative guidance on services and supports and Appendix C to all YES providers and stakeholders." IAP Obj. A.

Based on the foregoing, Class Counsel and the IWG Stakeholders must conclude that the Department will not or cannot produce a compliant Crosswalk despite the hundreds of hours of research and investigation, dozens of drafts and critiques, weeks of negotiations, three outside consultants, a Court-ordered Settlement Agreement and two Court-approved Implementation Plans. Accordingly, Class Counsel and the IWG Stakeholders have no choice but to invoke at our upcoming IWG meeting the accountability provisions of the IAP that require the Director of IDHW to "draft a report within thirty (30) days detailing the reasons for delay and the corrective steps needed to resolve the

> delay. Plaintiffs may agree to accept the report as proposed to resolve the matter, or to collaborate on appropriate corrective action." IAP, Obj. B. 3.e.iii.
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> We believe this is the only way to gain accountability for delivering on the long-overdue description of the services and supports that constitute Idaho's YES System of Care.
> Email from P. Gardner to IWG dated September, 6, 2024.

D. What is required to Complete the Access Pathways Map?

The IAP details what is required of the Department in completing the Access Pathways Map:

> OBJECTIVE C: Access Model
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> * * *
> An Access Pathways Map will be completed to provide authoritative guidance on the YES Access Model and Appendix A[2] requirements to all YES Providers and stakeholders.
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> The Access Pathways Map will comprehensively detail planned service pathways through the YES SoC from identification through transition, consistent with the YES Authoritative Documents.
>
> Guided by the Access Pathways Map, Defendant agencies will complete development of the YES SoC, and deliver services and supports to scale statewide to all YES Class Members.
>
> 1. Defendant Agencies will complete an authoritative Access Pathways Map that details how discrete YES populations described in Objective A are intended or expected to move into, through, and out of the YES SoC. Consistent with the Agreement and Appendix A, the Access Pathways Map will detail the rules, policies, and procedures that influence or determine access to care for YES Class Members for each discrete population described in Objective A who may be eligible to receive YES services and supports. IDHW will consult with the IWG, subject to procurement restrictions, as IDHW develops the Access Pathways Map. The Access Pathways Map will be completed within the following timelines:
> a. Final Draft completed by December 31, 2022.
> b. Final authoritative document will be negotiated with the new IBHP Contractor in compliance with the timelines specified below.

[2] 2015 Settlement Agreement Appendix A provides guidance on the Access Model, which "describes the process by which Defendants will interact with Class Members and thereby afford them access to the full array of services and supports provided under this Agreement." 2015 Settlement Agreement, Appendix A. p. A-1.

> 2. The Access Pathways Map pathway descriptions shall set forth every limitation, opportunity, condition, requirement, and decision that may influence or determine access to care relating to: identification; informing; engagement; screening; assessment; diagnosis or functional impairment; risk factors; referral; teaming; treatment, case or care planning or management; care coordination; service authorization; service delivery; level of care; service scope, intensity, and duration; services or treatment plan modification; choice of provider; funding source; timing or timeliness; and transition. The authoritative Access Pathways Map will include each discrete YES service provider pathway for every YES service and support included in the Services and Supports Crosswalk.
>
> 3. The completed Access Pathways Map will be reviewed and approved by the parties, no later than the Service Start Date [July 1, 2024] of the new IBHP Contract. * * *
> IAP, Objective C.

As with the Services and Supports Cross walk, the latest version of the Access Pathways Map submitted to the IWG on May 30, 2024, failed to pass muster. The Department's message accompanying their Map left in doubt whether what was submitted was the required "final" Draft.

> Dear IWG Members: Attached please find the Access Pathways Maps draft that the Department has finalized after consideration of the materials recently provided by Patrick. Please note that the Department anticipates further work will be done on these Maps that will enhance the screening requirements and that will address other areas that need either improved descriptions or improved service delivery measures; however, with the exception of some minor edits this version of the Maps has been provided to Magellan to incorporate into its planning efforts. As I noted earlier these Maps reflect how the Department thinks the system will/should work and not how it works today.
>
> The Department is amenable to the proposal to have smaller meetings specific to resolving questions that remain about the Maps, with the results of those meetings coming back to IWG for ratification.
> Email from A. Foutz to IWG dated May 30, 2024.

Subsequent communications confirmed that the May 30th draft was intended to be the Department's Final Draft required by the IAP. Class counsel advised the Department that It did not meet minimal requirements. The Department was also reminded that the Access Pathways Map must be "reviewed and approved by the parties." IAP, Objective C, ¶ 3.

Rather than provide the Department with extensive line-by-line comments and concerns, Class counsel offered to present an IWG version of a complete Access Pathways Map that could be

the basis for negotiating a Final Draft. The Department declined the offer, asserting that Class counsel's proposal was "directed at only the outstanding disagreements about the APM," and "the Department is not inclined to accept your proposal given the numerous rounds of feedback and edits that have already occurred." Email from A. Foutz to Class counsel, dated July 2, 2024.

The IWG concerns with the latest version of the Department's Access Pathways Map include:

1. The detail presented by the Map is insufficient to describe how youths and their families are identified and move through the System of Care as required. The entire schematic representation for service delivery that encompasses more than 40 services and supports for 20,000 or more Class Members is rendered in just two pages (pps. 4 & 5). Inexplicably, the Department has produced hundreds of pages of information in the past that could have been used to fill out necessary details, but are absent in this version.

2. Many gaps occur in the flow charts. There is no information provided relating to identification, outreach, and how the Department will ensure that at-risk youth will be screened for need and Class eligibility. Many of the details are simply assertions that things will get done, or high-level generalizations, without detailing the procedures that describe how services are accessed, as required. Virtually no "rules or policies" are included as is also required. (There is a long list of References that are not linked to any of the material in the Maps and is thereby rendered virtually useless for the purposes of understanding system performance.)

3. Information is, at times, in conflict with the Settlement Agreement requirements. Also, requirements stated in the Settlement Agreement are often missing. Some required Settlement Agreement provisions are noted as a "required element to be developed."

4. Critical aspects of the system are either confused or absent. For example, making connections for youths who are screened positive for mental health needs are left to the youths or their families to find an assessment or treatment, notwithstanding that the Settlement Agreement places the responsibility for linking youth and their families to services on the Department. Treatment planning is confused about when it happens and who performs the service.

5. The Map section depicting the fundamental services for high-needs children of intensive care coordination (ICC) and Wraparound, and their correlated service of Child and Family Teams (CFT), conveys almost no information about how these scarce resources will be deployed, why a youth in the same Level of Care would be approved for one or the other, or how a CFT is actually arranged or developed.

6. The one page of flow charts detailing 'other agencies' (p. 7) do not identify adequately who is included in these populations. They also fail to adequately identify services and supports offered by other agencies that meet *Jeff D*. requirements, and how youths and their

families may access those services. The term "refer" is used repeatedly as a placeholder instead of describing rules and procedures on how to move to the next step in the System of Care, as is required. Although as many as 5,000 youth are involved with the county and State probation and detention systems, and prevalence data indicate that 50-70% of these children may be eligible Class Members, the map sections presented by the Department convey virtually none of the information that is required under IAP Objective C.

7. The Maps ostensibly identify decisions that are appealable (set off in red outlines). Although most of the boxes that are indicated as appealable seem to be correctly identified, many more decisions that are also appealable are not identified as such. By implication, parents and youths may be denied their right to challenge these decisions if they use this Map as guidance that does not accurately indicate when a decision may be appealed.

In short, the Access Pathways Map submitted to the IWG on May 30th does not adequately describe how children and families can access service and supports and move through the YES System of Care, and demonstrably does not "detail the rules, policies, and procedures that influence or determine access to care for YES Class Members for each discrete population described in Objective A who may be eligible to receive YES services and supports." IAP, Objective C, ¶ 1.

E. Summary

The many shortcomings of the Services and Supports Crosswalk and Access Pathways Map, after years of delays, make it necessary to escalate this challenge to the Director. We note that the identified challenges for these two authoritative documents share much in common. Thus, the inability to describe the front-end of the system (identification, screening, assessment, and linking to services), the confusion surrounding treatment planning and care coordination, and the absence of adequate contributions from agencies other than Medicaid and Behavioral Health are present in both documents. As such, the IWG's concern is that the years of delay may not be an intentional disregard of the Department's agreements and the Court's Orders, but may demonstrate a lack of a clear vision and coordinated plan on how to operationalize the YES System of Care consistent with the Settlement Agreement.

In the event that the Department and its sister agencies cannot produce an adequate Services and Supports Crosswalk and Access Pathways Map within a matter of a few months, the IWG stakeholders and Class counsel will be obliged to do so. That would effectively cede the Department's authority for the design of the YES System of Care. While it has always been the goal of the parties for the Department to design and implement the YES System of Care, sustaining that goal is dependent upon the Department fulfilling its responsibility to comply with the Settlement Agreement and Implementation plans. Our hope is to sustain the Department's role by having the Director of the Idaho Department of Health and Welfare review and provide corrective action for the YES System of Care blueprints: the Services and Supports Crosswalk and the Access Pathways Map. The Director's coordinating authority may be needed to finalize the design and planning of the YES system of Care.

F. What the Director's Report Needs to Do

The IWG views the Director's Report as an opportunity to get the parties back on track and restore confidence in the Department's role and commitment in this effort. While the IAP calls for "detailing the reasons for delay" in producing the Services and Supports Crosswalk and the Access Pathways Map, what is most important to the IWG is setting forth "the corrective steps needed to resolve the delay." IAP, Objective B 3.e.iii. Also critical is establishing who is responsible for completing these authoritative documents, and setting (and assuring) a prompt compliance deadline. Medicaid's Director clearly should be in charge and held responsible for timely completing this deliverable. However, as pointed out above, agencies other than Medicaid, including Developmental Disabilities, Children, Youth and Family Services, Department of Juvenile Corrections, and the State Department of Education have responsibilities that have not been met. The IWG has repeatedly been advised by the Medicaid Director that Medicaid's authority does not extend to these agencies. We hope the Director will use his authority and influence to help get the job done.

Appendix A

YES Services	Included "Pre-approved requirements" & "other policies or rules that impact access to care"	Magellan App C add	Status
Identification and Screening			
Identification & Referral	None		Absent
Screening & Referral	None		Absent
Engagement	None		Absent
ASSESSMENT AND TREATMENT PLANNING			
Early childhood assessment	None		Absent
Functional Assessment	None		Absent
Health Behavior Assessment & Intervention	None		Absent
Comprehensive Diagnostic Assessment (CDA)	None		Absent
Child and Adolescent Needs and Strengths (CANS) assessment	D. The CANS is required prior to a youth receiving any outpatient behavioral health services except those services that do not address a functional need (e.g., Health Behavior Assessment and Interventions, Neuro/Psychological Testing, Medication Management, and Crisis Services) F. The CANS is required prior to a youth receiving any outpatient behavioral health services except those services that do not address a functional need. A CANS must be updated at least every 90 days or more frequently as necessary based on the youth's needs, the request of the family, or whenever there is a change in condition.	The initial CANS is completed as a result of a Comprehensive Diagnostic Assessment… All treatment plans that address a functional need (i.e., Psychotherapy) must be based on the CANS.	Does not establish what is required, or who is eligible, to get a CANS
Psychological Testing	D. Generally, psychological testing solely for purposes of education or school evaluations, learning disorders, legal and/or administrative requirements is not covered. H.To be provided as a school-based service it must be written in the youth's Individualized Education Program (IEP), transitional Individualized Family Service Plan (IFSP), or Services Plan (SP).		Does not establish what is required, or who is eligible, to get psych testing
Neuropsychological Testing	D. Generally, neuropsychological testing solely for purposes of education or school evaluations, learning disorders, legal and/or administrative requirements is not covered. E. Prior Authorization is required after threshold of 14 units per member per calendar year.		Does not establish what is required, or who is eligible, to get neuropsych testing
Care Planning through Child and Family Team (CFT)/ CFT Interdisciplinary Team Meeting	D. All youth involved in the Youth Empowerment Services (YES) system of care should have access to a CFT. CFTs may operate differently based on the needs of the youth. Teams may be facilitated by the primary mental health provider, an Intensive Care Coordinator with Magellan, or a Wraparound Intensive Services (WInS) Coordinator. The frequency of team meetings and intensity of work depends on the needs of the youth and family. H. Dually diagnosed youth in the Medicaid's 1915(i) DD Program require a DD case manager complete their DD Plan of Care. If they are also in the Medicaid's 1915(i) YES Program, they are required to have a Person-Centered Service Plan (PCSP) as well.		Good

Other Tx Planning (e.g., Individual skills building treatment plan, CBRS team-building, monitoring and adapting, crisis planning, transition planning)	None		Absent
CASE MANAGEMENT AND INTENSIVE CARE COORDINATION			
Case Management (CM)	D. address a youth's CANS assessed needs and strengths. Case Management is provided to youth with a behavioral health, SUD, or co-occurring diagnosis who need help navigating the system or coordinating care. Case Management can be provided up to 180 days prior to discharge for youth transitioning out of an inpatient or residential facility. E. Authorization is only required when services exceed a threshold of 240 units (60 hrs) per youth, per calendar year and additional service hours are needed. F. Case Management can be provided up to 180 days prior to discharge.	Case Management services cannot be duplicative of any services or activities that the member is already getting from any hospital or residential discharge coordinators. Case Management services can be provided to members receiving Intensive Care Coordination through Magellan Intensive Care Coordinators or Wraparound Coordinators.	Description is too broad--could be considered to include every Classs Member.
Targeted Care Coordination (TCC)	D. TCC can be provided up to 180 days prior to discharge for youth transitioning out of an inpatient or residential facility. Targeted Care Coordinators are not to provide other direct services to the youth. Youth who are engaged in Targeted Care Coordination shall not receive duplicative services, such as case management or WInS. TCC may be appropriate for youth with intensive needs, including one or more of the following criteria: • Is at substantial risk of out-of-home placement due to mental health needs; • Has experienced 3+ foster care placements within 24 months for reasons related to mental health needs • Is involved with multiple child-serving systems related to their mental health needs • Is under age 12 and has been hospitalized for reasons related to mental health needs within the last 6 months • Is under age 12, has been detained within the 6 months, and has unmet mental health needs • Has experienced more than 1 hospitalization for mental health needs within the 12 months • Is currently in an out-of-home placement due to mental health needs and could be discharged safely to their home or community within 90 days with appropriate services and supports in place. H. Targeted Care Coordination services cannot be duplicative of any services or activities that the youth is already getting from any hospital or residential discharge coordinators	Providers will be able to continue to serve existing members receiving TCC services and bill for TCC services through Dec. 31, 2024. Starting July 1, 2024, new members needing this care will begin services with ICC or Idaho WInS rather than TCC.	This service is being phased out, so it may not matter whether the text is adequate or not. It does provide a better example of how to describe a service to meet the Crosswalk requirements.

Intensive Care Coordination (ICC)	D. for youth with serious emotional disturbance (SED) and need a higher level of care, or who are transitioning from an out-of-home placement such as therapeutic foster care, an acute psychiatric hospital, or a psychiatric residential treatment facility (PRTF) and when intervention is needed to keep a child from being moved to an out-of-home placement or involved in multiple child-serving systems related to their mental health needs. E. ICC may be appropriate for youth with intensive needs, including one or more of the following criteria: • Is at substantial risk of out-of-home placement due to mental health needs • Has experienced 3+ foster care placements within 24 months for reasons related to mental health needs • Is involved with multiple child-serving systems related to their mental health needs • Is under age 12 and has been hospitalized for reasons related to mental health needs within the last 6 months • Is under age 12, has been detained within the 6 months, and has unmet mental health needs • Has experienced more than 1 hospitalization for mental health needs within the 12 months • Is currently in an out-of-home placement due to mental health needs and could be discharged safely to their home or community within 90 days with appropriate services and supports in place		This is good, except that it is more narrowly defined than allowed under the SA.
Wraparound Intensive Services (WInS)	D. is intended to assist youth and families who may be experiencing high levels of need or are at risk of requiring more intensive services, including out-of-home placement. Youth who are engaged in WInS cannot receive duplicative services, such as Intensive Care Coordination or Targeted Case Coordination (TCC). E. WInS may be appropriate for youth with intensive needs, including one or more of the following criteria: • Has qualifying CANS score. • Is at substantial risk of out-of-home placement due to mental health needs. • Has experienced three or more foster care placements within 24 months for reasons related to mental health needs. • Is involved with multiple child-serving systems related to their mental health needs. • Is under age 12 and has been hospitalized for reasons related to mental health needs within the last six months. • Is under age 12, has been detained within the last six months, and has unmet mental health needs. • Has experienced more than one hospitalization for mental health needs within the last 12 months. • Is currently in an out-of-home placement due to mental health needs and could be discharged safely to their home or community within 90 days with appropriate services and supports in place.	Case Management services can be provided to members receiving Wraparound Intensive Services.	Good
TREATMENT SERVICES & SUPPORT SERVICES (DIRECT SERVICES)			

Medication Management	D. to determine the need for psychotropic medications and monitoring of the medications… Medication management is a required component of Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP) services, and an optional component for Day Treatment.		Should not be limited to "psychotropic" meds
Individual Psychotherapy	H. To be provided as a school-based service it must be written in the youth's Individualized Education Program (IEP), transitional Individualized Family Service Plan (IFSP), or Services Plan (SP).		Absent
Family Psychotherapy	H. To be provided as a school-based service it must be written in the youth's Individualized Education Program (IEP), transitional Individualized Family Service Plan (IFSP), or Services Plan (SP).		Absent
Group Psychotherapy	None		Absent
Skills Building/Community-Based Rehabilitation Services (CBRS)	E. Authorization is only required when services exceed a threshold of 308 units (77 hrs) per youth, per calendar year and additional service hours are needed. An Individualized Skills Building Treatment Plan created using the teaming approach prior to the provision of services is required. F. The Skills Building/CBRS treatment plan must be developed prior to starting services		Absent
Skills Training and Development (STAD)	E. for youth whose functioning is sufficiently disrupted to the extent that it interferes with their daily life as identified by a comprehensive diagnostic assessment	…and a functional assessment tool.	"sufficiently disruptive" alone is an indequate description of what is required, or who is eligible, to get STAD
Behavior Modification and Consultation (BMC)	D. The youth shall not also be actively engaged in Skills Building/Community Based Rehabilitative Services (CBRS). Youth may also receive Child Habilitation Intervention Services (CHIS) and Behavior Modification and Consultation (BMC) services through Medicaid's Children's Developmental Disabilities Program if the goals are unique and there is coordination between providers E. Authorization is required for a BMC assessment, treatment review, and continued stay reviews. For the assessment, the following must be submitted for review: • A completed CDA indicating the service is medically necessary • Justification for referral for a functional behavioral assessment		Does not establish what is required, or who is eligible, to get BMC

Day Treatment	D. ...to youth exhibiting severe needs that can be addressed and managed in a level of care that is less intensive than inpatient psychiatric hospitalization, partial hospitalization or residential treatment, but requires a higher level of care than intensive or routine outpatient services. When a youth is participating in Day Treatment, only the following services can be received outside of the program: • Separate Case Management or TCC/CFT • Respite • Youth Support or Family Support • Recovery Coaching • Psych/Neuropsychological Testing • Psychiatric Evaluation • Medication Management E. Authorization is required for admission to and continued care in Day Treatment. The request for services shall show a need for services at this level of intensity as described in the service description.		Relies exclusively on external LOC determination. Does not establish what is required, or who is eligible, to get BMC
Intensive Outpatient Program (IOP)	D. adolescents who are recovering from mental health (MH) including eating disorders and/or substance use disorders (SUDs), experiencing moderate behavioral health symptoms that can be addressed and managed in a level of care that is less intensive than partial hospitalization but that require a higher level of care. ... also be provided for Eating Disorder IOP services. ...a step-down program from psychiatric hospitalization, partial hospitalization, or residential treatment. It may also be used to prevent or minimize the need for a more intensive level of treatment. IOP is appropriate for individuals who live in the community without the restrictions of a 24 hour supervised treatment setting during non-program hours. When a youth is participating in IOP, only the following services can be received outside of the program: • Separate Case Management • Child and Family Teams (CFT) • Wraparound Intensive Services (WInS), Intensive Care Coordination, or Targeted Care Coordination (through Dec. 31, 2024) • Respite • Peer Support, Youth Support or Family Support • Recovery Coaching • Psych/Neuropsychological Testing F. If a youth no longer is meeting the minimum 6 hours per week of treatment but does not meet medical necessity to transition to outpatient therapy yet, a transitional step down may be considered for 1 to 2 weeks prior to the planned discharge.		Somewhat better than above, but again, relies exclusively on external LOC determination. Does not establish what is required, or who is eligible, to get BMC

Partial Hospitalization Program (PHP)	D. used to treat mental health conditions, including eating disorders, or substance use disorders, or both; i.e., co-occurring conditions. for members whose symptoms result in severe personal distress and/or significant psychosocial and environmental issues and whose symptoms can be addressed and managed in a level of care that is less intensive than psychiatric hospitalization but who require a higher level of care than routine outpatient or other intensive services. When a youth is participating in PHP, only the following services can be received outside of the program: • Separate Case Management • Child and Family Teams (CFT) • Wraparound Intensive Services (WInS), Intensive Care Coordination, or Targeted Care Coordination (through Dec. 31, 2024) • Respite • Youth Support, Peer Support, or Family Support • Recovery Coaching • Psychological Testing/Neuropsychological Testing E. Authorization is required for admission to and continued care in PHP. The request for services shall show a need for services at this level of intensity as described in the service description.		Somewhat better than Day Tx, but again, relies exclusively on external LOC determination. Does not establish what is required, or who is eligible, to get BMC
Intensive Home and Community-Based Services (IHCBS)	D. provided to youth who are experiencing social, emotional, and behavioral difficulties and need more intensive services to increase stability across settings and help prevent out-of-home placement. **FFT**--for youth who have demonstrated a range of maladaptive, acting out behaviors and related syndromes. The youth would be age 11-18, and have ongoing trouble regulating their emotions/behavior as a result of trauma. **MDFT**-- The youth would be age 6-17. **MST**--to reduce multiple causes of serious behavioral health needs of youth ages 12-17 who are chronic or violent juvenile offenders, at risk of out-of-home placement or transitioning from an out-of-home setting, have ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems, have externalizing behavior symptomology resulting in a DSM diagnosis of Conduct Disorder, ODD, Behavior Disorder NOS, etc., and for who less intensive treatment has been ineffective or is inappropriate. **TBS**--for youth with serious emotional disturbances and is age 5-18 years old. **Family Program**--youth who are at risk of out of home placement, severe behavioral challenges, and those returning from residential placement from ages 4 to 18. address behavior challenges in the home in order to help parents create safety in the home while addressing aggressive behaviors, family problems and emotional issues. E. Authorization required and criteria varies based on the modality requested. The request for services shall show a need for services at this level of intensity as described in the service description.	...should be provided to, among others, youth at risk of out-of-home placement, including a residential program or psychiatric hospital, youth transitioning from an out-of-home placement back to their families or other community setting, and youth with significant behavioral health needs.	Mixed--the overarching definition is too vague to establish what is required, or who is eligible, to get IHCBS. Some of the individual services do better, others are absent.

Applied Bahavioral Analysis (ABA)	None		Absent
Therapeutic after-school and summer programs (TASSP)	D. ...assist youth in developing social, communication, behavior, and basic living skills, as well as psychosocial and problem- solving skills.		Description is too broad--could be considered to include most Classs Member.
Integrated SUDS	None		Absent
Residential-Based Treatment Services			
Treatment Foster Care (TFC)	D. based on the documented needs of the youth, the inability of less restrictive settings to meet the youth's needs, and the clinical judgment of the DHW. E. based on the documented needs of the youth, the inability of less restrictive settings to meet the youth's needs, and the clinical judgment of the DHW. F. Pre-placement documentation, including a placement agreement, must be signed by the parent/guardian(s) before or on the date of placement H. A Child Welfare case manager needs to be involved in the coordination of services. Service timelines and service plan development must follow IDAPA 16.06.01 and 16.06.02 rules, and Title IV-E Eligibility must be addressed, including necessary judicial determinations under the Child Protective Act. the worker may request an emergency placement when the youth's functioning indicates they will most likely be diagnosed with SED or they may already have a diagnosis, but the documentation is not yet available.		This is far too vague and discretionary to establish who is entitled, and what is required, to get TFC.

Psychiatric Residential Treatment Facility (PRTF)	E. Prior authorization and continued stay reviews are required. • Documentation of a qualifying diagnosis and corresponding functional impairment (serious emotional disturbance or SED). o Examples of qualifying diagnoses, when diagnosed as a major mental health disorders that are currently causing debilitating symptoms, are: Anxiety Disorders, Depressive Disorders, Bipolar Disorders, and Psychotic Disorders o Less debilitating diagnoses are not solely sufficient for a qualifying diagnosis. Examples include: Adjustment Disorder, Dysthymic Disorder, and Cyclothymic Disorder. • Evidence that available local resources and treatment in less restrictive levels of care have failed to address one or more of the following situations: o Danger to self, danger to others, and/or serious dysfunction in daily living. • Evidence that behaviors or conditions require continuous monitoring and intensive treatment, including 24/7 medical supervision, and there is risk of admission into an acute psychiatric hospital without PRTF services. • Written recommendation from the treating outpatient provider that includes at minimum: o The need/reason for this level of care o The reason(s) lower level of care is not appropriate or has not yet produced the desired results o The provider's anticipated post-discharge plan F. Approval of PRTF services does not guarantee acceptance and/or admission to a PRTF. If a PRTF placement is not found within 90 days, the approval will be re-reviewed to ensure medical necessity continues to be met. If updated records are not received for the re-review within 10 business days of Magellan's request, a denial will be issued and a new Prior Authorization request will need to be submitted. A tentative discharge plan and master treatment plan must be submitted at the time of	…[for] youth [who] need treatment apart from their usual environment due to the complexity of their clinical needs and/or they need a highly structured and therapeutic setting. Intensive Care Coordination is provided by Magellan when a member is placed in residential care... The Individualized Treatment Plan will address the transition out of residential care and family involvement while the member is in the residential care facility. Any youth placed in a residential facility in another state must have an Interstate Compact completed upon admission to the facility. A tentative discharge plan and master treatment plan must be submitted at the time of admission.	Without determining if these are the right considerations, this appears to be an adequate description of considerations/ requirements for PRTF.

Residential Treatment Center (RTC)	D. ...for participants who have multiple significant behavioral health symptoms and needs that impair their ability to safely function in the home, school, and/or community setting. The treatment facility provides therapeutic services that are appropriate for participants whose psychiatric, behavioral, or cognitive problems are so severe that they cannot be treated in a lower level of care. E. Prior authorization and continued stay reviews are required. Examples of qualifying diagnoses, when diagnosed as a major mental health disorders that are currently causing debilitating symptoms, are: anxiety disorders, depressive disorders, bipolar disorders, and psychotic disorders o Less debilitating diagnoses are not solely sufficient for a qualifying diagnosis. Examples include: adjustment disorder, dysthymic disorder, and cyclothymic disorder. • Evidence that available local resources and treatment in less restrictive levels of care have failed to address one or more of the following situations: o Danger to self, danger to others, and/or serious dysfunction in daily living setting and there is risk of admission into an acute psychiatric hospital without RTC services. • Written recommendation from the treating outpatient provider that includes at minimum: o The need/reason for this level of care o The reason(s) lower level of care is not appropriate or has not yet produced the desired result o The provider's anticipated post-discharge plan F. Approval of Residential Treatment Center (RTC) services does not guarantee acceptance and/or admission to an RTC. If an RTC placement is not found within 90 days, the approval will be re-reviewed to ensure medical necessity continues to be met. If updated records are not received for the re-review within 10 business days of Magellan's request, a denial will be issued and a new Prior	Intensive Care Coordination is provided by Magellan when a member is placed in residential care. Any youth placed in a residential facility in another state must have an Interstate Compact completed upon admission to the facility. A tentative discharge plan and master treatment plan must be submitted at the time of admission.	Without determining if these are the right considerations, this appears to be an adequate description of considerations/ requirements for RTC.
SUPPORT SERVICES *Settlement Agreement Appendix C, C.3*			
Medicaid Respite	D. provides relief for parent/guardian(s) and that is aimed at de-escalation of stressful situations. Other Medicaid services cannot be provided at the same time as respite services. Respite cannot be provided on a continuous, long-term basis as a daily service to enable an unpaid parent/guardian(s) to work. Medicaid Respite is only available to Medicaid's 1915(i) YES Program youth E. Services cannot exceed a maximum of 300 hours total in a 12 month calendar period. Services cannot exceed 72 hours of consecutive care (when not delivered in a community location) or 10 hours of consecutive care (when delivered in a community location) F. to continue receiving it, Respite must be documented on the youth's approved person-centered service plan (which must be completed within 90 days of becoming eligible). H. ...and this benefit must be used at least 1x per year.	...for youth with serious emotional disturbance (SED) intended to relieve a stressful situation, de-escalate a potential crisis situation, or provide a therapeutic outlet for a youth's emotional problems. ...to prevent disruption of the youth's placement by providing rest and relief to caregivers and youth while helping the youth to function as independently as possible. Respite may be accessed immediately upon enrollment in the program...	Description may be too broad--could be considered to include all Classs Members.

Vouchered Respite	D. available to parent/guardian(s) of youth with serious emotional disturbance (SED) to provide short-term or temporary respite care by friends, family, or other individuals in the family's support system. E. Authorization is required. To be eligible for vouchered respite, a youth must: • Be under the age of 18 • Be a resident of Idaho • Have been assessed by a master's-level licensed clinician with credentials to diagnose • Have been determined to have a serious emotional disturbance (SED) • Have had respite services identified on the child/youth's person-centered service plan or treatment plan F. Families are authorized 2 vouchers in a rolling year. An authorization will be valid up to 6 months and shall not exceed $600.00 per qualified youth.		Although it appears to be more more "prescriptive" than above, this description may also be too broad--could be considered to include all Classs Members.
Non-Emergency Medical Transportation (NEMT)	NEMT services are not covered for respite or for Child and Family Team meetings. available for the youth and up to one (1) medically necessary attendant when healthcare service requires an overnight stay and/or appointment is more than 101 one way miles from the youth's home. E. Prior authorization is required. To receive NEMT, the following requirements must be met: • Youth who have a medical appointment but do not own or cannot operate a car, or do not have a friend or family member who can take them, can request services through Medicaid's NEMT contractor • If a youth has a vehicle to transport their self, or friends, or family members who can take them to their appointments, they can request mileage reimbursement from Medicaid's NEMT contractor • The contractor will review requests and decide if Medicaid will pay for transportation. Services are authorized based on the least expensive transportation available and the closest available Medicaid provider • If a youth has been referred for medical care outside their community, a referral from their doctor may be needed before they will schedule transportation F. The request for transportation or gas mileage reimbursement must be made at least 2 business days prior to the date of the appointment. For long distance trips, which include flights, the request must be made at least 5 business days prior to the appointment or date of travel, whichever is earlier. If a trip is urgent, a request may be expedited. H. When a Child Welfare case manager is involved FACS will coordinate transportation. Transportation services are available as a school-based service, however, they are a separate service from NEMT.		Unclear what the contractor is determining about the requests for service, other than whether youths do not own or cannot operate a car, or do not have a friend or family member who can take them. It seems there are other matters in play that are not stated. If so, the description does not establish what is required, or who is eligible, to get NEMT
Family Psychoeducation (FPE)	D. ...specialized sessions (joining sessions and an educational workshop) should be completed before beginning ongoing sessions.		Absent

Family Support	D. for youth who have been identified as having a serious emotional disturbance (SED) or co-occurring disorder and assist the entire family in their own recovery. to help the family feel less isolated, more empowered throughout the recovery process and engaged in the community Family support builds upon strengths in the family unit. E. Authorization is required after reaching the threshold of 416 units (104 hrs) per youth, per calendar year and additional service hours are needed.	Member eligibility: A licensed professional has determined that family support will assist in the parent/caregiver's social, interpersonal, familial, and/or personal wellness. • The parent/caregiver has demonstrated a need for support in building hope, empowerment, and resilience, advocating for their needs, and developing a support system.	Making SED the operative determination is overbroad and could be considered to include all Classs Members. Additional elements are highly discretionary.
Youth Support	D. intended for youth who have the capacity and ability to understand their diagnosis, needs, strengths, behaviors, and symptoms to be an active participant in making decisions for their individualized care.	These services support members aged 12-17 who have a diagnosis of SED, a mental health condition, or co-occurring conditions. Youth Support Services may be initiated when there is a reasonable likelihood that such services will support the youth member in working toward self-directed recovery, building hope, empowerment, and resilience, and natural supports in the community of their choice. Member eligibility: A licensed professional has determined that youth peer support will assist in the member's social, interpersonal, familial, and/or personal wellness. • The member is not at imminent risk to self, others, or property. • The member has demonstrated a need for support in self-directed recovery/wellness, building resilience, and living successfully in their community	Similar problem as above--too vague and discretionary to determine who is entitled, and what is required, to get Youth Support.
Case Consultation	None.		Absent
Flexible Funds (also called "Flex Funds")	D. Services must be included in the treatment plan. E. Authorization for flex funds is required. Flex funds must be related to the youth's strengths and needs, and addressed in the youth's treatment plan	Flexible Funds may be available to meet the unique needs not otherwise paid for in an Individualized Treatment Plan. Examples of flex funds include, but are not limited to, family supports such as limited rental payments, utilities, automobile repair, and individual supports such as therapeu□c behavioral incentives.	Absent
CRISIS RESPONSE SERVICES			

Crisis Respite & Youth Crisis Centers (YCC)	D. those experiencing a behavioral health crisis. A behavioral health crisis is a situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress due to psychiatric symptoms associated with mental illness or substance use disorder(s).	...provide services to those experiencing a behavioral health crisis for no more than 23 hours and 59 minutes per single episode of care.	Good
Crisis Response Services	D. Provided when a youth is experiencing an acute crisis, is not at imminent risk of harm to self or others, and crisis response is appropriate for providing rapid and time-limited assessment and stabilization to determine the most appropriate response to a crisis situation.		Somewhat problematic use of circular reasoning. [This is approriate when it's appropriate.]
Crisis psychotherapy	None		Absent
Crisis Intervention Services	H. Receiving crisis intervention services via Children's Habilitation Intervention Services (CHIS) does not prevent youth from receiving any YES Crisis Services.	...experiencing an acute crisis, is not at imminent risk of harm to self or others, and crisis intervention is appropriate for providing rapid and time-limited assessment and stabilization. ...identifies and assesses immediate strengths and needs to ensure that appropriate services are provided to de-escalate the current crisis and prevent future crises. Services shall be provided consistent with an existing crisis plan using formal and informal supports, in partnership with the family. ...intended to stabilize the member during a behavioral health crisis.	Good
Mobile Response Team (MRT)	D. due to the parcipant's escalating behaviors that may be creating disruption to the participant's functioning and stability. F. Service is limited to varying days and times as it is rolled out.		Absent
Inpatient Hospitalization			

Inpatient--Community Hospital	D. ...for individuals with substantial impairment in thought, mood, perception, or behavior and are an imminent risk of danger to self or others. E. Medical necessity must be demonstrated for admission or extended stay by meeting the severity of illness and intensity of service criteria outlined in IDAPA 16.03.09.701: Severity of illness criteria – the youth must meet 1 of the following: • Currently dangerous to self as indicated by at least 1 of the following: o An attempt to take their own life in the last 72 hours; demonstrated self-mutilative behavior within the past 72 hours; a clear plan to seriously harm themself, suicidal intent, and lethal means available to follow the plan; and/or a current plan, specific intent, or recurrent thoughts to seriously harm themself or others, and is at significant risk of making an attempt without immediate intervention • Actively violent or aggressive and exhibits homicidal ideation or other symptoms that indicate they are a probable danger to others as indicated by 1 of the following: o Engaged in, or threatened, behavior harmful or potentially harmful to others or caused serious damage to property that would pose a serious threat of injury or harm to others within the past 24 hours; Made threats to kill or seriously injure others or to cause serious damage to property that would pose a threat of injury or harm to others and has effective means to carry out the threats; and/or a mental health professional has information from the youth or a reliable source that they have a current plan, specific intent, or recurrent thoughts to seriously harm others or property and is at significant risk of making the attempt without immediate intervention • Gravely impaired as indicated by at least 1 of the following criteria: o Has such limited functioning that their physical safety and wellbeing are in jeopardy due to their inability for basic self-care, judgment, and decision making; The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered them unmanageable and unable to cooperate in non-hospital treatment; There is a need for	...for members who have a diagnosis from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) with substantial impairment in thought, mood, perception, or behavior. Both severity of illness and intensity of services criteria must be met for admission. A Notfication of Admission (NOA) is required.	Without determining if these are the right considerations, this appears to be an adequate description of considerations/ requirements for inpatient care.
State Hospitals (e.g., State Hospital West/SHW)	D. for youth ages 12-17 years to receive more intensive comprehensive behavioral health services than they could receive in a community hospital environment, 24 hours a day, 365 days a year. Younger youth may be considered for admission depending on their milieu.		Absent