Oral Testimony of Nora Collins-Mandeville
Director of Systems Reform Policy
Before the House Human Services Appropriations Committee
Subject Matter: DCFS Managed Care
April 5, 2018

To Chair Harris, Spokesperson Bellock, and members of the House Human Services Appropriations Committee,

We appreciate the opportunity to speak with you today to express grave concerns about the lack of planning for the implementation of managed care for children in Illinois Department of Children and Family Services (DCFS) care. My name is Nora Collins-Mandeville. I'm the Director of Systems Reform Policy at the ACLU of Illinois where I advocate in tandem with legal counsel for fundamental system change for children in DCFS care.

I am here before you this morning to plead for legislative action to prevent youth in foster care from being harmed by the proposed transition to managed care without appropriate planning. Medical and behavioral healthcare for foster care youth is complex. DCFS is ill-prepared to transition young people in foster care to a managed care organization without thoughtful, deliberate, inclusive, and transparent planning. All of these crucial elements are currently lacking. Moreover, DCFS continues to be plagued by insufficient services and placements for youth already in its care, is unable or unwilling to disclose data necessary to systematically address the resource gaps in a meaningful way, and fails to demonstrate progress in remedying such monumental challenges.

Our concerns are rooted in our experience with DCFS' approach and level of commitment in addressing underlying deficiencies that necessitate litigation like the *B.H. v. Walker*[1] consent decree. Recognizing that this committee is familiar with the *B.H.* class action lawsuit against DCFS, I will only speak briefly about the recent activities which are immediately relevant to today's subject matter. In 2014, we advised DCFS of reports about severe shortages of mental

[1] ACLU, along with pro bono co-counsel from Schiff Hardin and Riley, Safer, Holmes & Cancila, filed the *B.H.* lawsuit against DCFS in 1988 alleging that the level of care being provided to children in substitute care was constitutionally inadequate. See *B.H. et al. v. Johnson*, No. 88-cv-5599 (N.D. Ill 1989).

health services and substandard conditions at various residential treatment centers housing our clients. With hundreds of youth languishing in shelters, detention centers, juvenile prisons, psychiatric hospitals and other settings waiting for the services and placements they needed, we asked[2] the Court to intervene to address DCFS' violation of the *B.H.* consent decree as an emergency. Court-appointed experts issued their report[3] finding systemic problems within DCFS, including the lack of adequate home and community based mental health resources and long waits for less restrictive placements for children languishing in intensive residential treatment centers and group home settings. Based on these findings, DCFS submitted an Implementation Plan to the Court in February 2016.[4] DCFS' progress to date in remedying services and placement resources is woefully inadequate and it should not instill the legislature's confidence that DCFS will abide by its commitments without being held accountable.

The *B.H.* Implementation Plan is a binding court order; however, this Administration flouts its obligation to provide information about programming initiatives, share reliable and timely data, and work in a collaborative manner with the independent, court-appointed experts or counsel representing youth in care.[5] Its approach to managed care is no different, which is all the more concerning when DCFS moves forward without being able to answer some basic questions about how the transition to managed care will work. Rather than discuss plans for the transition of the plaintiff class to managed care, DCFS has asserted that the Department of Healthcare and Family Services is handling managed care, claimed it could not discuss the contract, and most recently, informed us that we could attend "public meetings" to find out information. In February, the

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[2] *B.H.* at 466. *Plaintiffs' Emergency Order to Enforce Consent Decree.*

[3] Testa, M.F., Naylor, M.W., Vincent, P., & White, M. (2015). *Report of the Expert Panel: B.H. vs. Sheldon Consent Decree*. This report was issued pursuant to the April 10, 2015 Court appointment of experts to assess and recommend how to improve placements and services. In addition to placement and service recommendations, the experts also called for fundamental changes to leadership structure, training, and monitoring within DCFS.

[4] On October 20, 2015, DCFS was ordered to develop an enforceable implementation plan that identifies the tasks, responsibilities, and timeframes necessary to accomplish the objectives of the Consent Decree as addressed in the expert panel's findings and recommendations. The Court provided the experts' assistance to DCFS. DCFS submitted its' *B.H. Implementation Plan* to the Court on February 23, 2016 and the final amended and revised Implementation Plan was submitted to the Court on September 28, 2016.

[5] *B.H.* supra at 4383*. Plaintiffs' Submission Addressing the Fourth Triannual Interim Status Report on the B.H. Implementation Plan*. (Emphasis added):

> The Department's leadership appears determined not to change its course back to full support of the Implementation Plan and its initiatives. In many cases, ***the Department does not communicate information to the Experts and Plaintiffs that is critical to measuring the progress*** of the initiatives under the Implementation Plan and making course corrections where necessary…While the Implementation Plan anticipated that the parties would periodically review the progress made toward reform and negotiate appropriate revisions once actionable evidence became available, the ***Department has prevented that process***. After several months, by failing to respond to Plaintiffs' and the Experts' requests for information, the ***Department effectively refuses to discuss or present alternatives to failing initiatives,*** instead letting them wane while the ***need for service development to help of hundreds of youth in care goes unmet***. This impedes—and essentially makes impossible—the achievement of the goals of the Implementation Plan.

Federal Court had to explain to DCFS that we should not have to guess why information is not being shared regarding the MCO contract. The Court advised DCFS to explain why information could not be shared; but it has failed to explain or communicate. Only yesterday, after months of radio silence about the managed care transition, did we receive a handful of documents from the Department which they indicate relate to the transition. We are in the process of reviewing those documents now and will be requesting to meet with the Department to discuss their content and plans.

Beyond DCFS' failure in addressing these needs, youth in foster care have disproportionately high healthcare needs. DCFS itself acknowledged one aspect of this complexity in its FY18 report to the Federal Government:

> Among the challenges of implementing Medicaid managed care for foster children, ***setting an appropriate rate is among the most difficult.*** For various reasons, health care utilization on the part of foster children differs from other Medicaid populations. Establishing an appropriate rate and then aligning the rate with needs of foster children is especially important.[6]

If DCFS has conducted this rate setting analysis, it should be available for public review. DCFS must collaboratively and transparently plan any MCO transition with stakeholders who actually treat and care for DCFS youth. DCFS is obligated to ensure MCO contract outcomes align with federal child welfare goals to promote child safety, permanency, and well-being. DCFS is accountable for service delivery, which means it is responsible for managing and monitoring MCO performance, as well as delineating roles and responsibilities for decision-making.

This committee has held a series of hearings related to the rollout of managed care, quality and transparency of outcomes, and network adequacy. The issues raised throughout those hearings are serious and unresolved. We implore you to intervene on behalf of the young people in Illinois' struggling child welfare system; do not permit this MCO rollout in the absence of sufficient planning and accountability.

I am happy to answer any questions and thank the committee for listening to our concerns.

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[6] In accordance with federal funding requirements, each state's child welfare entity submits a "Child and Family Services Plan" to outline its goals and activities for the upcoming five years and each year the agencies provide updates regarding this plan. See U.S. Department of Health & Human Services, Administration for Children and Families (ACF) Children's Bureau. DCFS describes considerations and its activities needed for managed care:

This work would include: 1) developing 'per placement month' spending trajectories that illustrate how the cost of healthcare varies over the developmental life course of children in out-of-home care; 2) developing diagnosis-specific health trajectories that characterize the most common diagnoses by placement month; and, 3) using the above analyses, provide recommendations for how to organize healthcare for foster children. See Illinois Department of Children and Family Services. Annual Progress & Services Report FY18. DCFS has provided no known follow up on those action items.