HEARTLAND ALLIANCE
ENDING POVERTY

October 1, 2016

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Illinois Department of Healthcare and Family Services
Division of Medical Programs
Bureau of Program and Policy Coordination
201 South Grand Avenue East
Springfield, Illinois 62794

RE: Illinois' Behavioral Health Transformation Section 1115 Medicaid Demonstration Waiver

Heartland Alliance for Human Needs & Human Rights welcomes the opportunity to provide comments on the state's proposed behavioral health transformation Section 1115 Medicaid waiver. Many of our participants face behavioral health challenges that impede their ability to thrive. We agree that Illinois's behavioral health system is in dire need of improvement and investment and are appreciative that the state is focusing attention on these needs. Inadequate treatment of behavioral health disorders costs the state billions of dollars and results in millions of Illinoisans to suffering unnecessary hardship and lost potential.

We commend the Administration for outlining a proposed plan and feel it can serve as an effective framework to transform our behavioral health system. While many details are omitted, the reforms as proposed should improve the system from where it is today and could make dramatic improvements with proper implementation and stakeholder input. We look forward to continuing to work in partnership with the Administration and other community members to implement this vision and improve the lives of those struggling with behavioral health disorders throughout Illinois.

As the behavioral health transformation depends on both the waiver benefits themselves as well as proposed State Plan Amendments (SPA) and administrative rules changes, we would like to provide comments on each.

I. 1115 Medicaid Demonstration Waiver

Section 1.3.5 – Designated State Health Programs (DSHPs)

It is unclear based on the waiver proposal whether Illinois is just seeking Federal Financial Participation to help fund the DSHPs listed or if the state intends to require the organizations who deliver services under these programs to become Medicaid certified providers. Most states who have sought DSHP funding through Medicaid waiver have not required DSHP providers to become

Medicaid certified. The state should make clear that it intends to follow the lead of other states who have sought federal funding for DSHPs and that these programs and their participants will not need to be enrolled in the Medicaid program.

Section 1.4 – Demonstration hypothesis and evaluation

For the evaluation component of the waiver, we recommend that Administration include feedback from the provider community regarding the implementation of the waiver as part of the evaluation. This feedback is essential to properly assess the success of the waiver and should be included in its analysis and submissions to the Centers for Medicare and Medicaid Services (CMS). Regular updates on the evaluation component of the waiver should be made public and reviewed by the Medicaid Advisory Committee and in other venues. We also recommend seeking more in-depth and qualitative responses from impacted Medicaid beneficiaries beyond the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Section 3.1.1 – Supportive housing services

Heartland Alliance has long advocated for a Medicaid supportive housing services benefit and wholeheartedly supports the inclusion pre-tenancy and tenancy supports in the waiver proposal. While this coverage is an important step forward in improving stability and lower overall costs for the most complex and vulnerable members of our community, we recommend expanded eligibility for this benefit to include those who:

- Are currently eligible for rule 132 services or have a substance use disorder.
- Meet a broadly defined level of serious mental illness based not only specific diagnostic criteria but also level of functioning and need. Acceptable diagnoses should not be limited to psychotic disorders but should also include mood disorders, anxiety disorders, personality disorders, and co-occurring disorders mental health and substance use disorders.
- Meet a broad definition of homelessness or risk of homelessness. Pre-tenancy and tenancy supports can benefit all Medicaid beneficiaries facing housing instability – these benefits should not be limited to those who have faced lengthy or chronic homelessness.
- Are currently in an institutional setting or at-risk of entering an institutional setting without supportive housing services. Institutional settings include but are not limited to nursing homes, intermediate care facilities, institutes of mental disease, state psychiatric hospitals, and correctional facilities.
- Are current supportive housing tenants in programs that receive state grant funding for supportive housing services.
- Both individuals and families at risk of homelessness.

The state will benefit from a broad definition of eligibility. These benefits and supports can help prevent individuals and families from entering the cycle of homelessness that is so costly to our communities and the state. Intervening immediately when a family or individual experiences a housing crisis prevents further disruption in their lives and numerous long-term negative impacts on children and families. The state should leverage Medicaid financing to support the use of this model

to the greatest extent possible and broad eligibility requirements are essential to fully capitalize on its promise.

In addition to expanded eligibility, Heartland Alliance strongly recommends that the state include the following provisions within the waiver and during implementation of the new benefit:

- Establish a per diem rate structure instead of a fee for service structure, creating a streamlined process across all managed care organizations (MCO) and the state fee for service system for pre-tenancy and tenancy services. A per diem rate will move the state closer to its goal of a system grounded in value based payment.
- Ensure continuity of housing tenancy supports. Innovative MCO contracting arrangements should be made so that residents in permanent supportive housing do not have their housing supports determined by which MCO they are enrolled with or what contracts their supportive housing provider has with MCOs. The Massachusetts Behavioral Health Partnership has established an alternative to each supportive housing provider needing to contract with each MCO and could serve as a model.[1]
- Reinvest system savings into a flexible rental subsidy pool in order to increase supportive housing capacity. Supportive housing has been found to decrease crisis system costs and investing these savings in additional supportive housing units will realize even greater savings for the state. Illinois does not have enough affordable or permanent supportive housing in order to meet current needs. A rental subsidy pool must be created with enough flexibility to be accessible to managed care organizations, hospital systems, and local regions or counties.
- Support supportive housing providers in acquiring needed Medicaid and MCO infrastructure, training and technical assistance.
- Provide increased rates for difficult to serve populations. For example, persons experiencing chronic homelessness or leaving long term incarceration may need specialized support services that need to be considered in rate development.

Section 3.1.2 – Supported employment services

We strongly support the inclusion of supported employment Individualized Placement and Supports (IPS) services in the waiver proposal and urge the Administration to design program requirements to adhere closely to the evidence-based Dartmouth Psychiatric Research Center IPS model. Fidelity to the IPS model is critical to the success of the new benefit and we encourage the state to work with existing IPS providers in the state, as well as other stakeholders, to develop the criteria and processes needed to certify IPS programs for the purposes of this benefit.

In addition, supported employment providers will need assistance in learning to work within the Medicaid and MCO systems, as well potentially needing support in adhering to the IPS model. The state must facilitate this support financially and through ongoing training and technical assistance.

[1] U.S. Department of Health and Human Services. (February 2015). State Strategies for Improving Provider Collaboration and Care Coordination for Medicaid Beneficiaries with Behavioral Health Conditions. Available at https://aspe.hhs.gov/basic-report/state-strategies-improving-provider-collaboration-and-care-coordination-medicaid-beneficiaries-behavioral-health-conditions

Lastly, the rate methodology as currently drafted provides funding based in part on job acquisition and retention. This may serve as a disincentive to provide supported employment services to those with significant barriers to employment such as a criminal record. The state should develop a rate structure that properly compensates supported employment providers for working with Medicaid beneficiaries who face significant barriers to employment, possibly through incentive payments for working with these populations.

Section 3.1.3 – Services to ensure successful transitions from Illinois Department of Corrections (DOC) and Cook County Jail (CCJ) incarceration

We commend the Administration for the inclusion of these services in the waiver proposal. The following additions and revisions to the waiver will further strengthen the proposal:

- DOC/CCJ staff should work directly with community based providers to arrange for proper referrals and post-release care. It is not realistic to think MCO staff will go into DOC facilities to link the inmate with a provider immediately upon release, and such linkages are not likely to succeed with a simple referral by phone. We recommend allowing providers to connect with the inmate pre-release for those who will be in FFS or in managed care post-release. If the state is determined to delegate this task to MCOs, then the state must develop a metric for MCOs to be incentivized to ensure this population successfully transitions back to the community post-incarceration.
- DOC/CCJ staff must improve their working relationship with community-based providers to ensure the success of these new benefits. Collaboration on release plans, efforts to discharge returning citizens during provider business hours, sharing of accurate release dates, and assisting community providers to meet returning citizens upon their release are necessary to prevent those discharged from falling through the cracks and continuing the cycle of recidivism. These relationships have not always been as collaborative as needed in the past and the state must endeavor to improve these connections and processes.
- Pre-release services should be available for 60 days to facilitate needed connections with community based providers. The proposed 30 days are insufficient to make the needed connections, such as identifying appropriate post-release housing, applying for Supplemental Security Income and arranging a treatment plan with community providers.
- CCJ waiver benefits should be made available to other jails that indicate an interest in arranging these needed services. These services are just as critical in other parts of the state. The state should enter into intergovernmental agreements with interested counties to allow their financial participation in paying for Medicaid financed pre-release services, similar to the arrangement with Cook County.
- Pre-release services should be made available to the juvenile justice population. Ensuring proper referrals and treatment plans prior to release are essential for juveniles as they are for adult populations. To facilitate this, the state should waive parental income in determining

eligibility for Medicaid services for the DJJ population similar to Washington State.[2] This will ensure health coverage and access to treatment for this vulnerable population.

- Pre-release medication assisted treatment for drug and alcohol dependence should be evidenced-based and use the most effective methods available. Buprenorphine is more effective than naltrexone and treatment efficacy should take precedence over concerns around diversion of buprenorphine.[3] Buprenorphine is generally safe and not likely to cause overdose, so the risks of health complications due to diversion are low.[4] Increasing the likelihood that those leaving correctional facilities are able to address their substance use disorders and enter into recovery should be the top priority. In addition, it is crucial that this pilot program is targeted to returning citizens who are interested in this treatment and who consent to the administration of these medications.

Section 3.1.4 – Redesign of substance use disorder service continuum

The waiver proposes a number of important steps forward in substance use disorder service, particularly the inclusion of Medicaid financing for up to 30 days of intensive inpatient treatment in substance use disorder treatment facilities considered Institutes of Mental Disease (IMD). We are concerned, however, about how each new service will be piloted and targeted. Services such as substance use disorder case management, withdrawal management, and recovery coaching can benefit many beneficiaries and should be not arbitrarily restricted. In the event that these services are piloted, the targeting of the services should be done in consultation with community stakeholders.

In addition, we urge the state to design these new services with innovation in mind. Currently, substance use disorder services are reimbursed based on the type of physical location where they are delivered but little to no reimbursement is provided for services delivered during outreach or in other non-traditional settings. The state should redesign its substance abuse service rules to allow for substance use disorder interventions at critical times such as before a beneficiary has decided to enter a treatment facility and may still be in the community or unstably housed. Furthermore, substance use disorder evaluation metrics must measure a wider range of outcomes beyond simply abstinence from drug or alcohol use and treatment completion. Harm reduction models of care are more effective for many populations than abstinence-only models, but alternative metrics need to be developed to properly evaluate their effectiveness. The occurrence of relapse is not necessarily an indication of failed treatment. The state should use evidence-based models in designing all aspects of its substance use disorder continuum.

Section 3.1.5 – Optimization of the mental health service continuum

These new services fill important gaps in our current mental health service continuum, but we caution the state to make sure strict and consistent monitoring protocols for entry and exits from

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[2] Washington State Health Care Authority. (2013). Medicaid administrative claiming cost allocation plan for King County Superior Court Juvenile Probation Services (KCSCJPS). Available at: http://www.hca.wa.gov/sites/default/files/billers-and-providers/KCSCJPS_CAP.pdf

[3] American Society for Addiction Medicine. (June 2015). National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. Available at: http://www.asam.org/quality-practice/guidelines-and-consensus-documents/npg.

[4] Ibid.

short-term IMD stays are included in the benefit design. The state must not inhibit its efforts to move away from institutional care and increase community capacity. We recognize that some individuals require institutional levels of care for a short period in order to stabilize after a crisis, but the length of stay should be limited to only what is clinically necessary. Crisis beds should also be integrated into the community to the greatest extent possible.

Section 3.1.6 – Additional benefits for children and youth with behavioral health conditions and/or serious emotional disturbance

The inclusion of these services in the waiver proposal is an important step forward for the state but we urge the state to define what constitutes a crisis requiring in-home services broadly. A psychiatric hospitalization should not be the only prerequisite for authorization of intensive in-home services.

We are also concerned about the lack of services for transition-age foster youth. The continued Medicaid eligibility of foster care youth through the age of 26 offers a critical opportunity to support these vulnerable individuals as they transition to adulthood but the waiver is silent on targeted services for this population. Illinois should craft a specific benefit for these youth that focuses on trauma, behavioral health services, employment, and education.

Section 3.2 – Cost sharing requirements

We appreciate that the Administration did not include any cost sharing requirements for waiver benefits. Cost sharing only serves to discourage beneficiaries from accessing needed services and provides little to no financial benefit to the state.

Section 4.1 – Behavioral and physical health integration activities

We strongly support including behavioral health and physical health integration activities as an initiative within the waiver proposal. In line with our recommendations overall, we recommend that the Administration explore improving integration more broadly including and integrating services beyond Integrated Health Home (IHH) benefits.

Section 4.2 – Infant/early childhood mental health consultation

Heartland Alliance supports the inclusion of this initiative in the waiver proposal and implores the state to take full advantage of the waiver in order to expand treatment services for both mother and child.

Section 4.3 – Workforce initiatives

A lack of workforce capacity is among the largest challenges facing the Illinois behavioral health system. We appreciate that the Administration has included some provisions in the waiver proposal that seek to address this challenge, but unfortunately these efforts are not nearly up to the task. The provider community welcomes loan repayment programs, increased graduate medical education investments, telemedicine, and training resources, but these are mostly long-term investments that will only address our workforce and infrastructure deficits modestly and over time. Direct financial support from the state either through more adequate reimbursement rates or direct support for

making the investments required by the behavioral health transformation are the only way for the state to achieve the ambitious goals set forth in the Administration's plan.

First and foremost is Illinois's shortage of behavioral health providers. Medicaid beneficiaries regularly struggle to identify needed treatment with waiting lists of several months all too common. We are heartened by the state's recent announcement of increased mental health rates, but these will only serve to counteract the defunding of previously existing psychiatry capacity grants. The state desperately needs an infusion of qualified providers and the waiver does not include a viable plan to address this. The state must allocate additional financial resources to our workforce, either through the waiver or through regular state budgeting.

Furthermore, many of the providers that will make this transformation a success have never been funded thought the Medicaid system. As a result, these organizations will be required to devote time and resources to develop the systems needed to comply with Medicaid and MCO rules, such as having proper IT security protocols, electronic billing systems, and other compliance protocols. Such demands would be difficult at any time, but Illinois's budget crisis has devastated the financial well-being of the Illinois provider community. The state must provide financial support specifically targeted to assisting providers become ready to access Medicaid reimbursement.

Similarly, the state has an important role in providing training and technical assistance to providers seeking to become certified Medicaid providers. We commend the state for recognizing that providing training and learning collaboratives to smaller community providers within the waiver initiatives and hope the state plans on facilitating extensive and ongoing support to providers as a part of this transition. This support includes assistance with the certification process, identifying and understanding needed system and staff investments, contracting with MCOs, and maintaining ongoing compliance with both the state and MCOs regulations. The state should also encourage MCOs to streamline and simplify their requirements for smaller community providers and explore innovative contracting arrangements.

One additional role the state should play is to help facilitate partnerships between larger providers with more experience with accessing Medicaid financing and smaller providers. Heartland Health Outreach has developed such a model, known as *Health Neighborhoods*, but developing the needed contracting arrangements has taken over a year and significant staff time. Overall, the state should expect providers to need substantial amounts of time to make this transition and should provide the financial and logistical support needed for a successful transition without disruptions of care.

In terms of telemedicine, the state has thus far mostly focused on how the technology can help rural behavioral health professional shortage areas. This is an important gap to address, but the state should consider ways to leverage telemedicine for individuals who are hard to serve and see in a clinic setting due to their severe behavioral health conditions.

Section 4.4 – First episode psychosis
We strongly support the inclusion of First Episode Psychosis (FEP) programs in the waiver and urge the state to include the complement of services included in the National Institute for Mental Health study on the treatment model.

We do have some concerns, however, about how the new initiative will be targeted. The waiver proposal indicates that the state's FEP program will be targeted to only individuals living with Schizophrenia Spectrum Disorder. We believe the waiver should include a broad definition for FEP, including all illnesses that cause psychosis or are pre-psychosis such as bipolar disorder. The cost savings and opportunities to avoid lifelong disability apply to all youth experiencing FEP and should not be limited by narrow diagnostic criteria.

Authorization of waiver services
The process for authorizing these new benefits underpins the success of the waiver proposal. Beneficiaries must be able to receive the right services at the right time and in the right setting, but cumbersome and inconsistent authorization processes will prevent realizing the Administration's vision of behavioral health transformation. We urge the state to take this opportunity to institute new streamlined and standardized processes so that the encouraging slate of new benefits can be easily accessed in a timely manner by those who need them. Such a process should include clear criteria that the state and each MCO require for authorization of services and should set threshold criteria low enough that a broad range of those experiencing behavioral health challenges can benefit from these services prior to suffering unnecessary deterioration in functioning.

Value-based contracting
The move to value-based contracting is one of the most promising yet technical goals laid out by the transformation plan. Heartland Alliance is supportive and we have already begun exploring such arrangements with MCOs and health care stakeholders. These arrangements can have serious pitfalls, however, so the state must use caution to ensure these payment arrangements are properly designed. Providers must be equal partners in negotiating value-based payment arrangements and have much to offer in thinking through how to ensure the incentives and metrics are appropriate for the population served. For example, providers know how difficult it can be to engage an individual experiencing a behavioral health crisis, often taking many months without any improvement in quantitative metrics like health status indicators or health utilization behavior. A proper metric for the first six months of service might simply be whether a beneficiary continues to engage, but the state and MCOs may not recognize this without provider input. We look forward to working with the state and other stakeholders to ensure new payment methodologies are well designed to drive improvements in quality across the system.

II. State Plan Amendments and Administrative Rule Changes

While it is unfortunate that the state has yet to share many details regarding the SPAs it intends to submit to CMS, we understand that the self-imposed timeline for submission of both the SPAs and the waiver make a formal input process difficult. The SPAs are critical to the functioning of the

waiver and the overall behavioral health transformation, however, and the state should provide at least a general overview of the SPAs as soon as is feasible.

Considering the lack of written details to respond to, we strongly recommend that the state draft these SPAs to allow the following provisions during implementation, and that the state continue to work closely with the provider community and other stakeholders after the SPAs are submitted and presumably approved by CMS to ensure these new initiatives are implemented smoothly and do not result in disruptions in care.

Integrated Health Homes (IHH)

Establishing IHHs for individuals facing severe behavioral health challenges, as well as potentially other Medicaid populations, is an ambitious undertaking that has caused many other states difficulties. It is essential that the state provide adequate support and ample time for providers to make this transition and to develop proper protocols, linkages, payment methods, and expectations for all involved. We urge the state to ensure the following

- Provider organizations should be lead IHH entities, such as community mental health centers and federally qualified health centers. MCOs have an important role to play, but a successful IHH will require direct knowledge regarding the actual delivery of care in order to provide the intensive care coordination needed for those with severe behavioral health diagnoses to succeed in treatment. MCOs are simply too far removed for this role.
- Medicaid beneficiaries with either a mental health diagnosis or substance use disorder diagnosis should be eligible for IHH services. These services should not be restricted to those with severe and persistent mental illness.
- Beneficiaries found to need IHH services should be categorized by severity of need and different rates should be paid to properly compensate providers caring for the hardest to serve. Diagnostic criteria alone should not determine the severity of need for an IHH member and social determinants of health must also be considered.
- Per-member-per-month payment rates should be developed to reimburse IHH entities rather than reimbursement for each individual service. This will further the state's efforts to move towards value-based payment and will give providers the flexibility needed to deliver services based on the unique needs of the IHH member.
- Individuals with severe behavioral health needs often may struggle to come into a clinic or keep an appointment. It is critical that IHH design allow for the delivery of services in the community.
- Outreach and engagement should be incentivized, as this is often the most difficult phase in the treatment process. Without financial support for outreach and engagement, many of the hardest to serve will continue to remain unstable and out of care, cycling through hospitals and criminal justice facilities. Such incentivizes could be designed through bonus payments to providers who identify and engage eligible participants.
- Care team requirements should be clearly defined and should include peer support staff. Heartland Alliance has found peer specialists to be incredibly helpful in engaging hard-to-serve populations in effective treatment.

- Rates must reflect the investments needed to develop the systems required by the IHH model, as well as the care team requirements developed by the state and community partners.

Uniform assessment

We appreciate that the state has provided some detail on its intended SPA regarding the uniform assessment. Heartland Alliance has found the Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA) tools to be comprehensive and well-designed and we believe they can serve as an effective foundation for Illinois's assessment tool. We are particularly appreciative that they generally include a wide range of dimensions for assessment including past trauma history, criminal involvement, material needs, and other non-clinical dimensions that are critical to properly assessing the needs of an individual. The emphasis on member strengths is also encouraging.

That said, many important details are still unclear, such as exactly how the state plans to use the assessment, which specific metrics will be included in Illinois's version of the tool, what the threshold scores will be to authorize various levels of care, and who will administer the assessment. We urge the state to work in collaboration with community stakeholders to define this tool, to ensure it is not duplicative with MCO or other required assessments, and that it can be used to authorize services in a streamlined way.

Crisis stabilization and mobile crisis response

We are encouraged that the state is seeking this SPA, but again, the public needs to know more details. How this SPA will be integrated with other existing and waiver services within the crisis response continuum is unclear. The process for emergency responders and other community stakeholders to access these services is also unknown. The state should design and implement this benefit to maximize timely access to these services and should seek consultation from the provider community as it is implemented.

Administrative rule reform

Heartland Alliance is encouraged that the state intends to reform Rule 132, 2060, and 2090 and agrees that changes are desperately needed. The rules are cumbersome, impede the integration of care, delay needed treatment, and restrict providers from crafting and delivering the tailored services that each Medicaid beneficiary requires. We urge the state to collaborate with stakeholders in the drafting of these reforms and to seek input prior to submitting any change to the Joint Commission on Administrative Rules.

Some principles that will ensure any rule reforms address the current barriers imposed by our existing administrative rules include:

- Provide flexibility to providers in terms of staffing composition, treatment setting, and service provision. This will allow providers to craft services based on their clients' needs rather than the requirements of Illinois administrative rules.

- Simplify and streamline documentation, assessment, and prior authorization requirements.
- Limit the frequency of reassessments and treatment plan reviews.
- Promote the integration of mental health and substance use disorder treatment, as well as the integration of behavioral health and primary care.
- Reflect the new managed care environment and allow value-based payment models.
- Incentivize treatment for the hardest to serve such as those diagnosed with severe and persistent mental illnesses, who are experiencing homelessness or who have criminal justice backgrounds.
- Consider all opportunities under the Medicaid Rehabilitation Option to design and deliver services needed by the diverse population served under this benefit.
- Allow all licensed mental health providers including but not limited to social workers, licensed counselors, psychologists, and psychiatrists to bill for behavioral health services and make this billing process as straightforward and timely as possible.
- Allow for same day billing and for certain populations such as those receiving ACT team services to engage in other helpful treatment options, such as psychosocial rehabilitation.

In closing, we commend the state for seeking the opportunities contained in this proposal but must also remind our state leaders that this transformation plan alone will not solve all of the problems facing the behavioral health system. As the administration moves forward with this plan, it is key that everyone in the state recognize that while Medicaid does provide flexibility to expanding our behavioral health system, these changes will not replace the need for grant funded services. Indeed, if we don't also invest in non-Medicaid services, the success of this transformation will be hindered.

Not all individuals in need of services are Medicaid eligible or are willing and able – given their mental or behavioral health challenges – to enroll. Nor can all services needed to support individuals in recovering from behavioral health conditions be included in the waiver. Grant funds for community mental health treatment, substance use disorder treatment, supportive housing services, prevention programs and many other critical programs must be allocated so that providers can successfully transition to Medicaid reimbursement and those who are not enrolled in Medicaid can receive needed services. Otherwise, a significant proportion of Illinoisans will continue accessing expensive, crisis services due to a lack of community programming and many others will struggle to meet the basic needs on which good behavioral health depends.

We again appreciate the opportunity to comment and look forward to continuing to work in partnership with the state and other stakeholders as this vision is implemented.

Sincerely,

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