Community Behavioral Healthcare Association of Illinois

Marvin Lindsey, MSW, CADC
Chief Executive Officer
3085 Stevenson Drive, Suite 203
Springfield, Illinois 62703
Phone: 217/585-1600
Fax: 217/585-1601
www.cbha.net

CBHA Comments on Illinois' Behavioral Health Transformation Section 1115 Demonstration Waiver Application October 1, 2016

The Community Behavioral Healthcare Association of Illinois welcomes the opportunity to submit our comments on Illinois' 1115 Demonstration Waiver. CBHA, a membership association of community mental health and substance use providers across the state, is eager to work with the state in its efforts to "transform" or improve the Illinois community behavioral health system, a system as the Waiver points "demonstrate clear room for improvement."

CBHA believes the Waiver has the potential to dramatically change and possibly improve the community behavioral health care system in Illinois if done with stakeholder input, careful planning and a phased in approach. We are also glad to see that some of the proposed Waiver services and initiatives are services that our association has advocated for over many years. We believe these services, the initiatives and the State Plan Amendments present the opportunity for individuals with mental illnesses and substance use disorders to receive the most appropriate, efficient and effective care they deserve. Whether we take advantage of this opportunity and are able to fully leverage the Waiver is dependent on a number of to-be-made decisions.

If the Waiver is approved, the state must understand, we cannot build a system in haste and around acute care. The state must not be in a haste to totally dismantle proven services that are crucial for some, such as in the case of residential care for children. The transformation must be a public health approach that will go beyond cost reductions, disease management to health promotion and a full continuum of care in order to make real differences in the lives of people in Illinois.

With this mind, we would like to offer our comments and recommendations on what we believe will help to achieve the goals listed in the Waiver and result in an improved community behavioral health care system.

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Demonstration Financing and Budget Neutrality

Populations with complex mental health and substance use disorders have not fared well within the Illinois Human Services financing system for behavioral health care services. The fragility of the financing and delivery system for individuals needing services for mental and substance use disorders are exacerbated by disproportionate cuts to community treatment and services. The current system has been woefully underfunded and the current rates have been frozen for many years. We offer the following recommendations, questions and comments:

1. **CBHA urge a rate review and restructuring to guarantee the outcomes elucidated in the document**. **Current rates for community behavioral health services need to be restructured in order to improve and sustain current infrastructure and ensure sufficient access to care.** In a study conducted 10 years ago by the University of Illinois at Chicago[1], the results showed Medicaid rates for community mental health services cover 75% of actual costs to provide the services. . That was 10 years ago and there still has not been a rate increase. The current Medicaid rate ($122.11) for a psychiatrist only covers half of their cost ($225.00) and the Medicaid rates have NOT been restructured since 1996, according to the Illinois Psychiatric Society.

2. This year, the state is proposing a rate add-on for certain behavioral health services rendered by licensed community mental health centers for one year (July 2016-June 2017). **While this is an excellent step forward, we recommend the add-on be expanded to other services and made permanent.** The rate restructuring is necessary for achieving the goals of the Waiver. **We recommend the state take a portion of the savings from the Waiver to phase-in rate increases for community behavioral health providers over the five year life of the Waiver.**

3. The proposed services that are in the Waiver must include reasonable reimbursement rates and that take into account provider's total cost for providing the services. **Again, we urge a rate review and restructuring to guarantee the outcomes elucidated in the document.**

4. The Waiver mentions several times that the $1.2 billion in savings from the Waiver will be invested back into the behavioral health system. It is not clear what is considered the "behavioral health system**". Given the overall goal to move away from volume based care to value based structures, we recommend investments be made to rebuild community BH infrastructures and supports to keep people healthy in their home environments and reduce avoidable urgent and inpatient care.**

5. We understand that the Waiver covers Medicaid services, however there are still a significant number of individuals who are uninsured or underinsured who access community behavioral health services. There are supports services that are necessary components of a continuum of care that are not covered by Medicaid. **We strongly urge that funding for these services be retained as the state moves to implement the Waiver and State Plan Amendments**.

[1] State Funding of Community Agencies for Services Provided to Illinois Residents with Mental Illness and/or Developmental Disabilities. http://www.ancor.org/sites/default/files/pdf/U_of_I_Final_Rate_Study.pdf

6. The Waiver is requesting resources to support an infrastructure to develop a robust behavioral health and physical health network. Without the necessary CEHRTs (Certified Electronic Health Record Technology) and ability to access real-time data like ADT Alerts, integration remains an unrealistic theory. **We recommend that expenditures to support the IT infrastructure of community behavioral health providers be included.**

Demonstration Eligibility

1. Medical necessity, especially related to trauma may need to be clarified here, including the difference between what this means for children versus adults.

Demonstration Services/Benefits

CBHA supports an array and scope of services that go beyond traditional interventions such as the current acute care residential, long term care or outpatient services. Consistent with federal CMS, CBHA recommends that the Waiver services be a "person-driven long-term support system in which people with disabilities and chronic conditions have choice, control and access to a full array of quality services that assure optimal outcomes, such as independence, health and quality of life." [2]

- Pages 28: Data is not being shared in current demonstration pilots, like Choices, in part because there was no quality base-line data. We need more evidence re: the benefits, sustainability of costs, etc. This might be said for MCO's in general.

- Pages 28-29: Services discussed in GOHIT and SOC transformation in the four county areas. Will Mobile Crisis Response and crisis stabilization (support services?) be updated in 132?

Supportive Housing Services

1. Listed in the Waiver are some proposed supportive housing services, **we recommend that transportation services also be included.** Providers who currently provide supportive housing services point out that transportation cost for individuals to get to and from appointments or training sessions that help people maintain housing and skills required for autonomous living, is essential in both rural and urban areas.

2. The Waiver states that the supportive housing services will be authorized by both the Health Plans and the State. **In FFS regions of the state, who will be authorizing the services? We also recommend that the authorization criteria be clear and readily available to providers?**

3. The definition of eligible members for supportive housing services includes "Individuals with serious mental illness (SMI) who are either at risk of inappropriate institutionalization or homelessness or currently reside in an institution or permanent supportive housing." **We recommend that the definition also include those with SMI**

[2] Retrieved from Medicaid.gov: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Long-Term-Services-and-Support.html

and substance use disorders and those with chronic substance use disorders. Those individuals in substance use recovery homes and half-way houses should be able to benefit from these services.

4. Currently, the system does pay for services (although not as specific as those proposed) and that a significant issue remains investment in capital, development of housing and leasing costs. The transformation plan does not seem to address the real issue, which is lack of housing and supportive financial resources**. What is the plan for increasing the actual units of supportive housing?**

5. **This service will need stronger considerations for youth in transition to adult services with ICG youth and DCFS youth in care**.

Supported Employment Services

1. On page 35 of this section, the Waiver states that supported employment services will only be for those within Integrated Health Homes (IHHs). However, it also states on page 36 that those eligible for services will be individuals with SMI, SUD or SED and express a desire to be employed. **We recommend that all individuals with SMI, SUD or SED be eligible for this service.**

2. Providers who are currently providing these services urge the state to reconsider the 20 hour of service per month limit. **The 20 hour limit is unrealistic for most members with SMI and will create additional administrative work. We recommend the hours be increased to 30 hours per month with the ability to request additional hours.**

3. The Waiver states that providers will receive outcome based rates per participant that will be determined by 5 milestones that are listed. **Please clarify methodology and if providers have to reach all 5 milestones in order to receive the outcome based rate? We also recommend that the outcome based rate be tiered to factor in those participants who are harder to place due to their illnesses and additional supports required.**

4. On page 36, "*Ensuring accurate information about how employment will affect incomes and disability supports."* **Is the formula for return to work changing?**

5. Need to consider whether the current exclusionary criteria for IPS contract criteria limits the intent of 1115's use of SEP

6. Clarification needed on whether Supported Employment will only be accessible through the use of the IPS model with the current 51 IPS teams. Perhaps the state would consider a graduated model of the 5 year period to allow current SEP providers who are not yet implementing the model to access the waiver while beginning the IPS implementation and fidelity process with the expectation of full implementation by a certain year. That year based on the average length of time current providers have taken to meet acceptable fidelity

Services to ensure successful transitions from Illinois Department of Corrections (IDOC) and Cook County Jail (CCJ) incarceration

1. We understand that the MAT for IDOC Justice Involved Populations will only be offered to 200 individual statewide. **We recommend that the pilot include an equal percentage of women. We also recommend including how the program will be evaluated and if successful, how it will be expanded to cover more people.**

2. IDOC Justice Involved Individuals, who are chosen for the pilot and decide to withdraw once they are released, should be given the option of other MATs (methadone and buprenorphine) while continuing in the pilot.

3. **Are the individuals eligible for CCJ Waiver services, individuals who are completing their jail sentence (60 days, 6 months, 1 year)?**

4. Great to see the IDOC and CCI section. Should there be a special section for juveniles and DCFS youth in care, including parents of youth? Pages 20 & 28 also refer to IDOC & CCI (as do later sections) – but do not address DJJ populations – the transition for young people back to their communities seemingly should be included here as it seems this is challenging for DJJ.

5. In general, while there are some sections that are specific to children in the waiver – it does feel like a bit of an add-on rather than a true integration of the age continuum…

6. Consideration should be made to the qualifications and workforce development of recovery coaches. The current availability of recovery coaches is sparse when utilizing the CRSS model especially in more rural areas.

Redesign of substance use disorder service continuum

1. The Waiver discusses incentivizing providers to care for individuals with SUDs at the "*right time in the lowest acuity setting*." In order for the current system to do this, 1) capacity will need to be increased to make sure individuals seeking care are able to access services in a timely manner rather than sit on waiting lists, 2) **the state must increase substance use treatment support services which have been proven to reduce costs and improve outcomes, 3) there is an over abundance of research that show certain populations with SUDs have better outcomes when place in appropriate settings. Cost cannot be the ONLY factor when considering what the best treatment for Medicaid individuals is.**

2. CBHA applauds the state for adding recovery coaching, case management and ASAM level III.5 residential treatment services with more than 16 beds as Waiver services. The increase of residential beds will help to increase much needed access.

    - **Numerous studies support the effectiveness of theses services. A pilot is not necessary. We recommend that case management and recovery coaching be extended to all individuals receiving SUD services.**

- **If the state includes case management just for a targeted population on a pilot basis, the state will be leaving federal dollars on the table because substance use case management will continue to be paid through General Revenue Funding as part of DASA service package. Will the state continue to offer case management as GFR funded service during the life of the Waiver?**

- Why is recovery coaching and case management only for a targeted populations and a pilot? There is evidence that support the effectiveness of theses services.[3] **A pilot is not necessary. We recommend that case management and recovery coaching be available to all individuals receiving SUD services. These services should also be allowed to be practiced in the community and not only in a residential or an outpatient setting.**

- **If the state requires case management only for a targeted population on a pilot basis, the state will be leaving federal dollars on the table because substance use case management services will continue to be paid through General Revenue Funding as part of DASA service package. Will the state continue to offer case management as a GFR funded service during the life of the Waiver?**

3. **CBHA supports the SUD IMD, Recovery Coaching and Case Management service that is being proposed in the Waiver. We also recommend that all Medicaid eligible individuals seeking SUD treatment be eligible for the services.**

4. These types of Rule 2060 case management activities that are proposed for SUD are not currently billable under the MH Rule 132. Internal staffings, record reviews, letters, & outreach activities are not considered billable for Rule 132. **If the goal is to eliminate silos and collapse Rules 132 and 2060/90, then the activities billable as case management services should be the same for MH clients and well as SUD clients**.

5. Again, we recommend "Withdrawal Management" services be expanded to all Medicaid participants seeking services.

6. Page 50, *In addition, to ensure the added services are utilized in an appropriate manner, Illinois will implement an independent third party pre-authorization service for SUD assessment, level of care, and length of stay recommendations. This third party will pre-authorize services and perform chart audits and random site visits, among other functions, to ensure fidelity.*
    - Any preauthorization service would need to accommodate intakes at 24/7 facilities
    - Needs clarity on the role of this authorization entity for MCO clients. The registration of MCO clients with Illinois MH Collaborative and DARTS adds extra burden for agencies, needing to complete lengthy registration processes for MCO clients We strongly encourage developing a utilization management

[3] Manual for Recovery Coaching and Personal Recovery Plan Development
http://www.bhrm.org/media/pdf/guidelines/RC_Manual_DASA_edition_7-22-05.pdf
Recovery Management and ROSC: Scientic Rationale and Promising Practices
http://www.naadac.org/assets/1959/whitewl2008_recovery_management_and_recovery-oriented_systems_of_care.pdf

process, reduces duplication of work and does not increase administrative burdens.

- Random site visits and chart audits in addition to the annual DASA post-payment review and BALC review is audit heavy for providers.
- **The Third Party pre-authorization process should be transparent and a record of authorizations and denials should be posted by HFS on a monthly basis**.
- **CBHA recommends there be a RPF and RFI process for the third party pre-authorization entity in FFS regions.**

7. *DASA will conduct post-payment audits annually for each Medicaid-certified provider, based upon a subset of licensure rules.*
    - **Please identify the subset of licensure rules or when will they be made available for viewing.**

8. *DASA will enhance its licensing and credentialing requirements….providers will be required to undergo annual trainings*
    - **CBHA recommend that there be stakeholder input prior to the development of the enhancement of the *licensing and credentialing requirements*.**

Optimization of the mental health service continuum

1. **CBHA believes the use of MH IMDs must be carefully monitored. On one hand, there is the past history of IMDs that is detailed in the Williams Consent decree.** Since the implementation of the William's consent decree, the state has created SMHRFs, which are IMDs. One feature of the SMHRFs are short term crisis stabilization services. After the creation of SMHRFs, the state developed a set of rules to govern SMHRFs. The state has not implemented the Rule nor have they evaluated the program. According to the Williams Consent Decree Court Monitor's January 2016 Report, "structural changes should be made as it relates to the State oversight and management of IMDs."

   On the other hand, there is the issue of inadequate acute crisis stabilization services in communities across Illinois. The result has been a reliance on local jails or emergency rooms for "boarding" individuals with mental health or substance use disorder conditions which are an indication of the need for additional service capacity. A central question is: Can MH IMDs provide effective and safe short term acute mental health crisis stabilization services in communities they are located? And will the state provide the oversight to monitor the service?

CBHA recommends:

- **That state resources also be used to develop acute crisis stabilization services within community based mental health centers so that consumers will be afforded choice.** Patient choice is of paramount importance in every stage of recovery, including when provision of temporary crisis intervention and/or acute stabilization services becomes necessary. Existing legislative precedent – encapsulated in the Williams and Colbert Consent Decrees – recognizes that individuals should always be provided a choice between admission to a nursing home or IMD and a community based

alternative. **If members enrolled in fee-for-service are provided with a funded option to stay in an IMD for up to 30 days, they should also be provided with a funded, equivalent community-based option.**

- **The state to follow the Williams Court Monitor's recommendations of developing an effective way to provide oversight and management of the MH IMDS.** CBHA recommends a quarterly report should be made public and include:
  - The number of person served
  - Average length of stays
  - Number of Referrals to Community Providers
  - Number of Referrals to Long term care
  - Number and Kind of Critical Incidents Filed

- **The State should fully implement the rules that will provide oversight to the SMHRF's**. The Court Monitor has called for "structural changes should be made as it relates to the State oversight and management of IMD's", the rules to provide that oversight are not in place. We need to implement, evaluate and modify the MH system based on the reality of the law/rule the State passed.

- **The state must increase the amount of mental health supportive housing. One of the reasons for the continued existence of IMDs' long term care programs or nursing homes is because there is a lack of permanent supportive housing across the state. In many cases, nursing homes and IMDs are the only choice.**

- Also, in areas of the state where there are no MH IMDs, the Waiver does not address who will be providing the crisis stabilization services. **CBHA recommends that the state develop mental health community provider's capacity to provide acute mental health crisis stabilization services in other areas of the state.**

Crisis beds

1. **CBHA recommend at the the maximum length of stay for this service be 90 days.**

2. **Currently, GRF covers the staffing cost for 24 hour coverage for mental health crisis care. CBHA recommends funding for this service include the 24 hour coverage cost as part of the Medicaid rate for these services.**

3. **We recommend piloting's** the Comprehensive Intervention Services Model (CISM) in conjunction with the crisis beds requested in the 1115 Waiver. CISM is a behavioral health crisis care model that provides a full continuum of crisis intervention services which broadens accessibility and capacity to reduce the reliance on emergency department services and psychiatric hospitalizations. This model offers immediate access to treatment and supports to individuals experiencing a behavioral health crisis and is designed to:

   - provide relief through the reduction from symptoms.
   - support individuals with treatment options that may prevent conditions from worsening,
   - assist consumers while in crises

- provide continuous support and treatment services while the consumer resumes his/her the road to recovery
- promote keeping people in their communities around their natural support systems while providing a cost effective community care alternative for individuals experiencing mental health or co-occurring (mental health and substance use) crises

The basic service components of the CISM are:

- 24 hour phone and face to face behavioral health crisis intervention
- Integrated Crisis Assessment (includes assessment of co-occurring disorders [mental and substance use disorders])
- **Crisis beds d**etermined by community need (includes a regional crisis home that is shared by several counties)
  - Acute stabilization (preventing unnecessary hospitalizations)
  - Step-down
  - Transitional
  - Length of stay up to 30 days
- Individual Crisis Counseling and peer support
- Stabilization groups, including peer led crisis recovery and support groups when available
- Medication Monitoring
- Care Management
  - Referral
  - Linkage
  - Provide Transportation to appointments
  - Discharge Planning
- Length of total services up to 90 days

4. Expectation for crisis beds to have access to 24/7 psychiatric consultation will be challenging with the current lack of access to psychiatry services and likely the rate structure for this service. Recommend allowing this to be met by an APN or establishing regional/statewide consulting psychiatrist due to the intermittent nature/scalability of the need for consultation.

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

1. **Section 3.16.1 and 3.1.6.2: Intensive in-home and Respite Care**

   CBHA is pleased to see intensive in-home services and respite care for children and adolescents ages 5-21. Coordinated integration of in-home care and respite care services is a humane and cost-effective means to provide a continuum of care in the least restrictive environment, preventing unnecessary outof- home placement.

CBHA recommends the service menu for the intensive in-home service and respite care package be flexible and meaningful to meet the multiple needs for children and their

families. For youth who have experienced trauma a broader services array is necessary to meet the needs of evidenced informed practices. The proposed individual and family therapy and skills training will not be sufficient to address the needs of youth suffering from untreated trauma histories in the proposed service menu.

To often Illinois has utilized costly institutional care either in a psychiatric hospitals or residential placement to reclaim children suffering from a mental, emotional, social, and behavioral disorder. Keeping children in their home and community in the least restrictive setting has been proven to be more effective and efficacious and results in better health outcomes.

2. **Intensive in-home services** – We assume Medicaid must always serve the identified client – but in the case of a child – and particularly in this type of service – it seems like you need to gear services toward the family system (and maybe that is just really about how you document the service). There should be some recognition that intensive in-home services may include clinical services to other members of the family system that are "impacting" the mental health of the child. These other members may or may not be independently Medicaid eligible at this level of care, but these services would ideally be provides as part of the whole family treatment plan. **We also recommend that this is not tied to PracticeWise as it is currently in the Choices demonstration project until further information regarding implementation of PW is gathered.**

Other Waiver Initiatives

1. **Section 4.2: Infant/Early Childhood Mental Health Consultation**

CBHA is pleased to see supports for inclusion of infant/early childhood mental health interventions. Strategies to teach professions who have frequent and early contact with the developing child to improve their social-emotional and behavioral health and development of at-risk-children children is encouraging.

CBHA would recommend a core component of this initiative would be the early identification of trauma in the screening and assessment of this process. The repeated stress of violence, abuse, neglect, and negative social determinants all have tangible effects on the development of the brain of a child. A child who experience four or more adverse childhood experiences and is left untreated can reduce their life expectancy by nineteen years. The loss of social capital for these children is devastating.

2. **Section 4.4: First Episode of Psychosis**

CBHA is pleased to see programs that address individuals in the initial onset of a Schizophrenia Spectrum Disorder, aimed at avoiding the usual trajectory into a disability.

Because the onset of behavioral disorders begin in adolescents by age fourteen, CBHA would recommend the administration to continue to initiate prevention and early intervention programs that promote early identification of mental, emotional, social

and behavioral disorders in children and adolescents. The best prescription for bending the cost of health care is to identify issues early.

3. Great to see prevention with infant and early childhood: trauma-informed care needs to be highlight here.

4. Need to be very careful about overregulating and excessive monitoring. That usually drives up rates at the state AND provider levels.

Integrated Behavioral Health and Physical Health Delivery System/Health Homes

- The Waiver proposes a planning process to create IHH. The Waiver fails to describe a model or process to achieve an actual IHH. More importantly, it appears that the creation and defining of the IHH is the responsibility of the state and health plans only. CBHA recommends that:
    1. **Community Behavioral Health Organizations and other stakeholders are included in the planning and design of the proposed Integrated Behavioral Health and Physical Health Delivery System or IHH.**

    2. **The proposed Integrated Behavioral Health and Physical Health Delivery System or IHH must be designed to include a truly integrated rate structure that is risk adjusted and with its own regulatory program.** Rate structure needs to adequately support the inputs required to provide integrated, community-based services (e.g., technology, transportation), the increased costs of workforce development (e.g., recruitment, training, support and salaries competitive with industries to which behavioral health workforce migrates), and the staff costs in the effort to utilize "providers to practice at the tops of their licenses."

    3. **The state must invest in technology that connects community behavioral health providers, hospital, FQHCs and other providers. Easily accessible medical and behavioral health information is essential to providing effective client and patient treatment.** In many cases, providing optimal client care requires the electronic exchange of data with other providers or participation in a Health Information Exchange (HIE), often referred to as interoperability. **Behavioral Health IT services and interoperability has the potential to produce substantial savings to the health care system by reducing adverse drug-to-drug interactions and emergency room use and to fully integrate community providers into this nation's healthcare continuum.**

    4. **We recommend that the state develop IHH pilots across the state that includes Behavioral Health Homes operated by Community Based Behavioral Health organizations.**

- On Page 72, there is a description of disease specific pilot in regards to Integrated Behavioral Health and Physical Health Delivery Systems. **Please provide examples.**

Workforce-strengthening

CBHA supports the state's goal of strengthening the behavioral health workforce.

- We support the loan repayment program that is listed however, the state must consider that currently some areas of the state are listed as workforce shortage areas and receive Public Service Loan Forgiveness funds for loan repayment. These are usually rural areas of the state where it is even more difficult to recruit and retain credentialed professionals. **We recommend that the state offer a loan repayment differential for behavioral health professionals willing to work in rural communities.**
- CBHA also supports the workforce optimization initiative that will fund the infrastructure required for the provision of virtual care via telemedicine. **We also recommend funding to enhance the current low rates that makes it very difficult for community behavioral health providers to offer this services.**

- Workforce is a real and critical component related to rates, repurposing and implementation of the details in 1115. Peer support and family support specialists, bring in ways to increase MHP credentialing (curriculum/course),etc.

Data Integation/Information Technology

The ability of the state to develop fully functioning integrated health homes in Illinois will largely depend on the information technology information infrastructure and the exchange of health information among behavioral health and medical care providers to achieve better care and reach the state's goals in the Waiver.

CBHA Recommends:

- The state includes financial resources to assist community based behavioral health organizations in acquiring; installing or enhancing needed electronic health records and billing systems that are capable of exchanging data with other systems. The Waiver is requesting expenditures to support an infrastructure to develop a robust behavioral health and physical health network

  Information technology systems are a prerequisite for integration and performance. In order for IHHs, to be effective, they will need to get data in real time or as close to real time as possible. Illinois doctors and hospitals have received over $500,000,000 as part of the HITECH Act to adopt EHRs and for meaningful use payments. Community Behavioral health providers were not included in the HITECH Act and have not received any federal funds for IT. **We urge the state to use current resources and/or savings from the 1115 Waiver to invest in needed community behavioral health IT infrastructure**. Without the necessary EHRs and connectivity to access real-time data, integration remains a theory. **We recommend that expenditures to support the IT infrastructure of community behavioral health providers be included.**

- **The state must invest in technology that connects community behavioral health providers, hospital, FQHCs and other providers**. Easily accessible medical and behavioral health information is essential to providing effective client and patient

treatment. In many cases, providing optimal client care requires the electronic exchange of data with other providers or participation in a Health Information Exchange (HIE), often referred to as interoperability. **Behavioral Health IT services and interoperability has the potential to produce substantial savings to the health care system by reducing adverse drug-to-drug interactions and emergency room use and to fully integrate community providers into this nation's healthcare continuum.**

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General Comments

- We agree that the administrative rule changes are needed to "ease *the burden on providers and break down barriers to the integration of behavioral and physical health"* however; **we recommend that there be stakeholder input at the beginning of the process.**

- Throughout the Waiver, the term" community behavioral health providers" is used. Who does this include? **Please define "community behavioral health providers".**

- *"Because the State only achieved a stop-gap budget on the last day of the 2016 fiscal year (June 30, 2016), the healthcare ecosystem faces uncertainty for the months ahead."* How will this uncertain future impact the proposed work of the 1115 Waiver or is there a chance that only some of the proposed services can be implemented if the waiver is approved and the state experiences budget problems similar to this year?

- One of the "pain points listed is: "*Insufficient community behavioral health services capacity".* During the last fiscal year, a survey taken among community behavioral health providers demonstrated that 76% of community behavioral health providers had reduced or eliminated behavioral health services and 75% had to lay off or reduced staff hours over the last fiscal year. We recommended that the state survey the behavioral health treatment system to get an accurate account of the capacity needs of the field. **We also recommend that the state develop a phased in approach to increase behavioral health service capacity.**

- As stated on Page 9, "*Wait times for new psychiatrist appointments can be as long as 3 months".* The number one issue for the lack of psychiatrists is the exceptionally low Medicaid payment rates for psychiatric services. **We recommend that the state's 1115 Waiver factor in a way to review and restructure psychiatric rates.**

- The stated vision of a sustainable payment model to support integrated behavioral and physical health homes is welcomed by our association; as well as the state's plan to include "significant stakeholder input". However, on page 10, it mentions "Integrated Health Homes" while also speaking about "integrated behavioral and physical health homes". **What is the difference between the two?**

- On Page 12, it states that the state plans to use "uniform screening and assessment tools" for earlier diagnosis". Currently, there is a statue, PA 97-1061 that has lain dormant since 2012. The law calls for a "uniform behavioral health care screening and when warranted an assessment and evaluation process" in three statues:
  - Public Aid Code (305 ILCS 5/5-5) (from Ch. 23. par. 5-5) Medical services
  - The Alcoholism and Other Drug Abuse and Dependency Act (20 ILCS 301/10)

- The Community Services Act (405 ILCS 30/2) (from Ch. 91 1/2 , par.902)
- **We recommend that the state develop rules to carry out the intent of the law.**

- On page 15-16, the section on Data Interoperability and transparency mentions these two features as being critical to implementing full integration of physical and behavioral health. CBHA agrees with this assessment but there was no mention of how the state plans to address the regulatory barriers that currently exist in the exchange of health information among behavioral health and medical care providers. The Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Director (SMD) letter outlining new service delivery opportunities for individuals with a substance use disorder (SUD). The letter highlights a new opportunity for states to use Section 1115 waivers to test Medicaid coverage of a full continuum of addiction treatment settings, including settings that would otherwise be prohibited under the Institutions for Mental Disease (IMD) exclusion. CBHA is pleased to see that the State has included the SUD IMD exclusion in the waiver. The letter also includes **health IT adoption as an example of a desired practice reform to support SUD delivery system transformation.** CMS encourages states to support electronic health information exchange among providers, including through the use of certified electronic health records, in ways consistent with federal health privacy and confidentiality requirements outlined in 42 CFR Part 2. **CBHA recommends that the state review recommendations from the CMS letter and the Office of the National Coordinator and the State's 2012 Behavioral Health Integration Project (BHIP) that included a legal and operational framework necessary to protect confidentiality while helping to facilitate data exchange.**

- The Waver does not seem to be very applicable for children's mental health needs, especially with the connection to the NB Settlement. **Very weak on integrating Trauma evidence informed concepts, especially for children. Hope to see more in the 132 changes.**

- **Consider incorporating school-based services now or in the 132 changes**. This is a national trend to assure Illinois is seriously considering and planning for now.

- **We urge transparency on how the state will hold managed care organization accountable to their outcomes**.

- **Does the Waiver factor in a DCFS system MCO carve-in?**

- **There needs to be careful oversight of pilot projects (Choices) already in place or in the future that fully evaluate cost analysis, long-term sustainability, etc**.

- Page 6: The definition of residential care in IL is misunderstood. Many states with PRTFs are not in the residential care count. Residential care settings are lumped into psychiatric hospital numbers. **We recommend that the state clearly distinguish residential settings from PRTFs.**

- Page 8: Care coordination—be careful in using "conflict free" case management as it oftentimes eliminates providers who know the systems and community needs.

- Page 8: Network Adequacy.- MCO's are tasked with increasing capacity/provider networks including creative services, but we don't always see the accountability from the state to ensure this responsibility is met. It cannot just be left to the local system of care. **We urge the state to set clear guidelines around network adequacy for MCOs and enforce them.**

- Page 9: Duplication/gaps in behavioral health services. Contractual and regulatory requirements make collaborative member-centric service provision challenging. **Contract and regulatory requirements between systems at all levels need to be more flexible for clients to move across systems and programs to work with the needs of clients regardless of the door they come in. (This is referenced somewhat on page 16 but the need to get rid of the red tape hindering the ability to provided integrated service provision can't be overstated).**

- Page 14: Caution only including tele-psychiatry as an example. The need for increased psychiatry and providers attempts to get smart on the use of telepsychiatry is a high priority. But other telehealth provisions should be made available and financially supported (e.g., nursing, behavioral health therapies and case management).

- Page 14: **Workforce strategies around expanding psychiatric services should include strategies around expanding the approved use of Advanced Practice Nurses.**

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"*Further, the state appreciated that different providers are at different stages in their evolution toward becoming integrated health homes. Therefore, the model will likely follow a phased approach under which all providers are encouraged to make progress. This approach will also create greater incentives for providers that are able to move quickly towards a higher degree of integration."*

- This incentive approach will favor BH providers who have the least distance to travel in reforming their service approach over providers that need more help to make the transformation. **A more equitable incentive approach could help the system grow.**

- **It also favors large medical systems who are well-financed to advance behavioral health without partnering with community MH/SA providers, with the potential to carve MH/SA providers out of local systems.**

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"Illinois intends to build a system of integrated health homes to manage members with complex behavioral health needs (e.g. serious mental illness, substance use disorder) and hold providers accountable for outcomes.

Illinois will submit an updated SPA for these IHHs, which will align financial incentives around a comprehensive approach to behavioral and physical health services, uniform assessment, evidenced-based practices, and wellness promotion.

- **Needs further clarification for how providers will be held accountable, toward what performance measures or benchmarks.**

- Uniform assessment is a good move in theory, but current behavioral health assessment requirements already are 12+ pages of client information under Rule 132. **We recommend a hybrid assessment that is brief, relies on baseline and reassessment measures, leverages HEDIS recognized measures, and facilitates getting people served at the right level of care – opportunity to move away from Rule 132 and toward an efficient system that is not reliant on excessive documentation and antiquated processes.**

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"*Illinois also seeks to fund DSHPs through this waiver demonstration. These DSHPs include state health services provided by a variety of agencies, including the Department of Juvenile Justice, The Division of Alcohol and Substance Abuse, and the Illinois State Board of Education."*

  - **State Designated Health Programs-DASA listed here as well as included in the formation of IHHs… but DMH not included in the plan for SDHPs?**
  - **Why is there a need for separate DSHP system?** The DSHP seems to perpetuate the "silo" problem and does not integrate services, as written.

- **Testing new ideas are great, but the state need to evaluate the true impact and lasting/long-term sustainability vs focus on the demonstration period only, especially with managed care organizations' involvement, care coordination entities', and with the DCFS youth in care.**

- **The Waiver need to consider the DD population through several sections – particularly those with ASD – who are not currently considered "behavioral health" within Medicaid.**

- Staff credentials/qualification issues – State does not uniformly use RSAs under the Medicaid Rule (i.e., DCFS excludes) and yet there seems to be a place for those staff in these services. In addition (noted later) – **we do need programs that can assist folks with the MHP credential – the DHS approved certification program could be made much broader.**

- Data deficiencies – it's not just that the State agencies cannot communicate with each other or providers – there is a larger issue (at least within DCFS) where the data doesn't get shared well internally…nor are the system efficient/non-duplicative, helpful, etc.

- Goal 1: **Need to have some measure to capture potential population that may be deflected from inpatient yet not successfully connected to community mental health utilization. Perhaps homeless population data.**

- Goal 4: **Need to make the connection to reduction in physical health diagnoses as well as MH and SUD.**

- Goal 5: **Need to ensure that supported services can bridge across inpatient and residential treatment settings so that supportive work is begins/continues across**

an inpatient/residential stay increasing the likelihood that community-based supports are in place/maintained for successful re-entry. Also could add a measure of employment status while in residential treatment