July 17, 2018

Patricia Bellock
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763-0001

Dear Director Bellock:

On behalf of the Illinois Health and Hospital Association’s (IHA) more than 200 member hospitals and nearly 50 health systems, I am writing to provide comments on the Better Care Illinois Behavioral Health Initiative, focusing on the Behavioral Health Clinic designation, Integrated Health Homes and recent updates on the community mental health service array. Overall, 112 IHA members provide inpatient and outpatient mental health treatment; 85 provide inpatient and/or residential services; and 10 are dedicated, freestanding psychiatric hospitals. Approximately 80 hospitals provide outpatient mental health treatment, including flexible partial hospitalization services.

The reimbursement of Behavioral Health Clinics and Integrated Health Homes have great potential to create more flexible access to mental health service providers in a timely manner, while ensuring patients are able to receive physical and behavioral health services in a more streamlined and integrated manner. The updates to the community mental health service array may provide greater coordination between providers across the care continuum and state-sponsored programs for Medicaid beneficiaries. Although these initiatives could be promising for the healthcare delivery system as a whole in Illinois, there are several components that would benefit from further clarification in order to best serve the field.

Behavioral Health Clinics
The Department of Healthcare and Family Services (HFS) Notice of Adopted Amendments for 89 Ill. Adm. Code 140 in the July 6, 2018 Illinois Register stated in Section 140.460(c) that clinics receiving reimbursement on an encounter rate basis are prohibited from receiving reimbursement from the Department in any other form than their established encounter rate. The July 12, 2018 Provider Notice on New Provider Type – Behavioral Health Clinics (BHCs) did not address this language. It would be helpful to clarify that hospital-based organized clinics may be reimbursed for the provision of services in Section 140.453 beyond their encounter rate, fee-for-service or otherwise, as long as they do not bill encounter-based services and FFS services on the same day for similar services. This would incentivize hospital-
based organized clinics to participate in behavioral health clinics, as well as provide crucial wrap-around services like case management for high-need Medicaid beneficiaries. For example, a Medicaid beneficiary experiencing a mental health crisis and a co-morbid physical chronic disease may be medically stabilized in the emergency room, provided a psychiatric assessment, and admitted for inpatient psychiatric hospitalization. After a period of days this beneficiary may be transitioned to an intensive outpatient program at the same hospital for day treatment and then have follow-up therapy as determined by a behavioral health provider within that health system. The Behavioral Health Clinic designation provides an opportunity for the health system to be reimbursed for case management following a hospitalization or intensive outpatient program as the patient continues to receive outpatient services like therapy, allowing true integration of physical and behavioral health services. However, as written, payment for case management would be denied for existing, highly-qualified providers attempting to integrate physical and behavioral health services across the care continuum. IHA would not support the final Rule 140 provisions if hospital-based organized clinics were effectively excluded from community-based mental health reimbursement, but expected to certify Behavioral Health Clinics to competitively qualify for participation in programs like Integrated Health Homes or grants.

**Integrated Health Homes**

On June 14, HFS released a public notice highlighting the proposed changes to implement Integrated Health Homes, describing the reimbursement as a non-specified per-member, per-month care management fee with an outcomes-based payment model that rewards measurable, positive outcomes associated with integrated care. As requested at a recent 1115 Waiver meeting, we are seeking clarification on several Integrated Health Home issues, including:

- How hospitals should prepare for discharge planning changes, potentially interfacing with seven Managed Care Organizations (MCOs) and multiple Integrated Health Homes for care coordination and various service authorization approvals;
- The role of MCOs;
  - Whether they will have the option of contracting only with preferred Integrated Health Homes, akin to “preferred provider” networks;
  - Whether specific care coordination activities will be delegated to Integrated Health Homes and what activities MCOs will be responsible for;
- Patient flexibility to switch Integrated Health Homes, or remain with their existing primary care provider in an assigned Integrated Health Home;
- Any outcome measures that will be tied to care quality and potential incentives;
- The various criteria, including operational requirements, staffing ratios and staff education or licensure requirements to be certified as an Integrated Health Home;
- The per-member, per-month care management fee for each of the four patient tiers; and
- How direct care providers like primary care and emergency room physicians will be notified of patient assignments to different Integrated Health Homes for care coordination.
IHA requests that the Department release a model contract for Integrated Health Homes to use with other providers and MCOs, similar to existing model contracts for managed care that provide guidance on suggested provisions.

Update to Community Mental Health Service Array
The July 11 Provider Notice summarizing updates to the community mental health service array indicates that referrals to the state’s centralized crisis intake line, Crisis and Referral Entry Service (CARES), and Mobile Crisis Response services will be extended from the child and adolescent population to also require adult referrals processed through CARES and Mobile Crisis Response in order to authorize level of care changes (e.g., admission to an inpatient mental health unit for an adult from an emergency department). The provider notice indicates this transition will take place August 1. However, IHA recommends direct guidance be provided to hospitals on this service expansion and whether it is a requirement that hospitals use the CARES intake line and Mobile Crisis Response for adult inpatient mental health admission authorization, in addition to existing hospital assessments. There is some concern that a new requirement for Mobile Crisis Response authorization for adult admissions may increase delays in the emergency department or care transition “bottlenecks”, although increased coordination with community-based service providers is welcome to ensure patients access the right care in the right setting. For example, after an assessment is done in the emergency room, a patient may wait 30 to 40 minutes for a second assessment by a Mobile Crisis Response team, and although this varies, if the patient is still admitted to the inpatient unit, he/she may then receive a third assessment. The duplication of services and delay in care may be exacerbated in rural areas or those underserved by Mobile Crisis Response providers.

Again, thank you for your interest in reducing administrative barriers to implementation, expanding Medicaid services delivered by community mental health providers and further integrating medical and behavioral healthcare. If you have any questions or comments, please contact me at pgallagher@team-iha.org or 630-276-5496, or Lia Daniels at ldaniels@team-iha.org or 630-276-5461.

Sincerely,

Patrick Gallagher
Senior Vice President, Health Policy and Finance

cc: Teresa Hursey, HFS
    Lia Daniels, IHA