Illinois Health and Hospital Association

May 26, 2017

Diana Knaebe
Director, Division of Mental Health
Illinois Department of Human Services
600 East Ash Street, Building 500
Springfield, Illinois 62703

Dear Director Knaebe:

Thank you again for your interest in hospital and health system feedback on the recent Medicaid Rule 132 and Rule 140 proposed revisions. On behalf of the Illinois Health and Hospital Association's (IHA's) more than 200 hospitals and nearly 50 health systems, I am writing to provide more formal recommendations that would improve access to Medicaid services delivered by community mental health providers, seek clarification on the proposed changes, and offer our assistance as your staff moves forward reducing administrative barriers to implementation and expansion of these critical services. Overall, 93 IHA members offer behavioral health services through hospital-based inpatient and outpatient services, nine of which are dedicated, freestanding psychiatric hospitals. Your prioritization of mental healthcare across Illinois is recognized and we truly appreciated discussing potential reforms in upcoming *1115 Waiver Advisory Council: Rule 132 Subcommittee* meetings.

The Rule 132 and Rule 140 proposed revisions have great potential to improve access to and coordination between community mental health service providers and other healthcare providers along the care continuum if implemented appropriately. Currently, there are over 300 community mental health centers (CMHCs) in Illinois, many of which are not formally affiliated with a larger system of care. The proposed behavioral health clinic (BHC) model in the drafted Rule 140 revisions affords an avenue for providers like hospital-based organized clinics, rural health clinics and maternal and child health centers to provide community mental health services. In turn, this new reimbursement mechanism would allow these settings to create a delivery system that integrates physical and mental healthcare under a Medicaid payment structure that has more alignment than ever before. As health systems often have integrated electronic health records and enhanced administrative mechanisms for follow-up care, this would only strengthen our state's healthcare delivery system.

There are several components I would like to highlight as important to the hospital community, as well as some questions and comments. In particular, IHA supports:

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1) Ensuring reimbursement rates for the same community mental health services in BHC and CMHC settings are equal. Reducing already underfunded CMHC rates in a BHC setting would create an unnecessary disincentive for this integrated delivery model. In addition, these are both outpatient settings with the identical practitioner qualification and licensure standards for each service, so varied reimbursement would be unjustified.
2) Confirming that future grants and requests for proposals are not limited to CMHCs, but also remain open to qualified networks of providers with psychiatric resources like a coalition of hospitals, BHCs and federally qualified health centers.
3) Safeguarding the currently proposed services that BHCs would be eligible to provide, which already require additional layers of certification for specific specialty services and prohibit delivering some services that CMHCS provide like Assertive Community Treatment (ACT) and Psychosocial Rehabilitation. Limiting BHC service delivery more will only create additional barriers to accessing these services in different types of integrated settings. In addition, clarification is needed around which four services cannot be delivered in a BHC, as this was indicated as an item for follow-up at the last Subcommittee meeting.
4) Reducing prescriptive language in each rule, to ensure CMHC and BHC goals are not confused with requirements. For instance, the various new reporting requirements are burdensome, and the descriptive format suggests these will likely not be shared back with providers in the state's delivery system so they are aware of the community mental health resources available. One example is the requirement under Rule 132 of an access plan describing geographic boundaries, or service area, that detail where and when the organization will operate programs and provide services to clients, with several additional descriptive details required.
5) Creating greater flexibility around fidelity requirements so they can be customized to the communities served, especially for team-based services. In particular, current ACT requirements can be burdensome in certain situations due to workforce shortages and the needs that exist within a community. The prescriptive nature of psychiatrist requirements to spend a minimum of 10 hours each week with the ACT team, in addition to the threshold enforced on the amount of time an advanced practice nurse can substitute for the psychiatrist's time on the team creates unnecessary clinical practice barriers. Instead of requiring all fidelity requirements at all times, exceptions should be made when only a majority of the requirements must be met. For example, an ACT psychiatric resource should be available if needed, but requirements for their physical presence should be reduced to only reflect immediate availability. The Rule 140 revision that more generally states the ACT team must be supported by a psychiatrist demonstrates much needed flexibility, although greater clarity would be helpful to ensure older, but more specific requirements are not enforced upon audit.
6) Clarifying language in each rule to ensure providers know when deemed status would be sufficient for all certifications, audits, annual surveys and the mediating impact of accreditation. In addition, with a statewide shift to Medicaid managed care further clarification may be necessary for how audit processes may be altered or streamlined.

Again, thank you for your interest in reducing administrative barriers to implementation and expansion of Medicaid services delivered by community mental health providers. 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
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