

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

Comments on “Illinois’s Behavioral Health Transformation” 1115 Demonstration Waiver

Contact: Daniel M.O. Frey, Director of Government Relations, (312) 334-0927 or dfrey@aidschicago.org

Dear Director Norwood,

The mission of the AIDS Foundation of Chicago (AFC) is to mobilize communities to create equity and justice for people living with and vulnerable to HIV and related chronic diseases. Founded in 1985 by community activists and physicians, the AIDS Foundation of Chicago is a local and national leader in HIV/AIDS policy, dealing heavily in prevention and housing. We collaborate with community organizations to develop and improve HIV/AIDS services; fund and coordinate prevention, care, and advocacy projects; and champion effective, compassionate HIV/AIDS policy.

HIV infection can be managed as a chronic disease if people with HIV have access to high quality, culturally-competent medical care and supportive social services. Providing this optimal care leads to long- and short-term cost containment as well as improved quality of life and positive outcomes, aligned with the Triple Aim. There are an estimated 42,500 people living with HIV in Illinois, and about 1,760 people are newly reported as diagnosed with HIV each year in the state.¹ According to the Illinois Department of Healthcare and Family Services, 12,734 people with HIV were on Medicaid in 2011.² AFC estimates that, thanks to the Affordable Care Act Medicaid expansion, an additional 11,400 people will become newly enrolled in Medicaid in Illinois by 2017, raising the number of people with HIV on Medicaid to over 24,100. A report from the Illinois Department of Human Services (DHS) states that 38,036 Illinois residents were served in state-funded homeless shelters in FY 2014. Separately, in October 2015, the Illinois State Board of Education reported that public schools identified 54,638 homeless students during the 2014-2015 school year.

¹ AFC estimate based on Chung Eui Kim & Fangchao Ma, “Community Viral Load and Social Determinants,” Illinois Department of Public Health, presented at Illinois HIV Planning Group Meeting in Collinsville IL on September 14, 2012;

² 2 Illinois Department of Healthcare and Family Services, special data request, received 4/30/2013;

Today, HIV is unique because while it can be treated as a chronic disease, we cannot forget that it remains a communicable disease. This creates a public health imperative that also serves the taxpayer. Every person with HIV who is successfully treated has a dramatically lower risk of transmitting HIV in the community; in fact, new evidence released by the National Institute of Health (NIH) demonstrates that consistent adherence to HIV medications reduces the chance that HIV will be transmitted by 96%.³ This shows that access to HIV treatment has enormous public health benefits and cost savings. Each HIV case prevented saves a minimum of \$380,000 in lifetime treatment costs⁴, much of which will be paid by the state.

We are at a critical juncture for the AIDS epidemic. Over the past 30 years, the federal government invested an estimated \$1 billion or more in a specialized safety net for people with HIV in Illinois. This network, created by the Ryan White Care Act and enhanced by the state, provides culturally competent, high-quality care that integrates medical and social services to meet the needs of people with HIV. Although the system is not perfect and is in need of modernization, many in the field believe the Ryan White Program created the original medical home in 1990 after which all others should be patterned. As health reform is fully implemented, funding for the Ryan White Program will almost certainly decline. The state and federal government faces a choice: to harness and modernize this proven, expert infrastructure to improve care for people with HIV and fill the many gaps in the system, or simply watch it fade away.

Housing and services for the homeless or unstably housed living with HIV or AIDS increase significantly access to treatment, treatment adherence, and viral suppression. There is a major need for many more rental subsidies with housing services for the hundreds of homeless individuals who are still homeless and living with HIV or AIDS in Chicago and Cook County. AIDS housing units and services help prevent new infections, improve health outcomes, and reduce significantly unnecessary health care costs like hospital inpatient admissions and ER visits.

Comments

AFC supports the Administration's decision to focus on the behavioral health system in this waiver proposal. The broadly defined strategy and goals of the waiver will serve as an effective foundation for the transformation effort.

Tenancy Services

AFC believes that the definition of homelessness used within the waiver should be the HHS definition of homelessness to capture all those eligible for tenancy and pre-tenancy services. Using this definition would allow people currently in supportive housing programs to be eligible for those services. By

³ Cohen, Myron S., et al. Prevention of HIV-1 Infection with Early Antiretroviral Therapy. 2011 New England Journal of Medicine 493-505: V365, no 6, <http://www.nejm.org/doi/full/10.1056/NEJMoa11052>

⁴ HIV Cost Effectiveness, U.S. Centers for Disease Control and Prevention, January 5, 2012. Accessed 6/19/13 from www.cdc.gov/hiv/topics/preventionprograms/ce/index.htm

comparison, the Department of Housing and Urban Development (HUD) has an extremely restrictive definition of homelessness. The definition from HHS we suggest using is as follows:

A homeless individual is defined in section 330(h)(4)(A) as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing." A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. [Section 330 of the Public Health Service Act (42 U.S.C., 254b)]

Under this definition, an individual may be considered to be homeless if that person is "doubled up," a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or jail or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness. (HRSA/Bureau of Primary Health Care, Program Assistance Letter 1999-12, Health Care for the Homeless Principles of Practice)

Individuals with Substance Use Disorder (SUD) should also be eligible for supportive housing tenancy services. SUD is not treated with parity with Mental Health (MH). We would recommend that MH and SUD (not strictly Severe Mental Illness [SMI]) be eligible for the tenancy benefit as part of the pilot program. Addressing these other conditions, which are often associated with SMI, will serve as a preventative measure. It is not always clear throughout the waiver proposal that SUD is included at parity with MH; Pages 5 and 17 demonstrate equality; Pages 23/Goal 1 and 24/Goal 3 cites MH only; Page 28 Exhibit 12; 3.1.1 has SMI only; page 54 Section 3.1.6 – only MH is noted. AFC believes that more clarity is required. Finally, current supportive housing tenants in programs that receive state funding for populations described above should be eligible for the tenancy services benefit.

System savings should be reinvested into a flexible rental subsidy pool in order to increase supportive housing capacity. Supportive housing has been found to decrease crisis system costs; investing these savings in supportive housing will provide an ongoing source for supportive housing funding. Illinois does not have enough affordable or permanent supportive housing in order to meet current needs. A report from the Illinois Department of Human Services (DHS) states that 38,036 Illinois residents were served in state-funded homeless shelters in FY 2014⁵. Separately, in October 2015, the Illinois State Board of Education reported that public schools identified 54,638 homeless students during the 2014-2015 school year⁶. A rental subsidy pool must be created with enough flexibility to be accessible to managed care organizations, hospital systems, and local regions or counties.

⁵(2015). Retrieved September 26, 2016, from <http://www.dhs.state.il.us/page.aspx?item=81019>

⁶(2016, August). Retrieved September 26, 2016, from <http://www.isbe.net/homeless/pdf/eoy-homeldxx-counts-fy10-16.pdf>

Any certified agency should be able to access tenancy support dollars, regardless of their ability to bill.

Agencies that do not currently bill Medicaid for services provide the majority of supportive housing services. As such, expertise for this type of benefit lives with agencies that do not currently bill for Medicaid. CSH offers the Dimensions of Quality program, which could serve as a supportive housing certification program. This would create standardization for the types and quality of services provided. We believe Illinois should adopt this or a similar definition of “certified” and allow for its usage to allow a wider scope of billers. Alternatively, agencies that have had contracts with DHS for supportive housing services could be deemed eligible to bill for Medicaid.

We recommend a per diem rate structure for tenancy support. To meet the state’s goal of paying for value and outcomes, we recommend a per diem rate structure instead of a fee for service structure, creating a streamlined process across all MCOs 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 Purchasing.

MCOs should work with community organizations to ensure requirements for contracting with them for tenancy services are not overly burdensome. HFS must make clear through the 1115 Waiver and directives to the MCOs that MCOs should work with, and be flexible with, prospective community partners so as not to make contracting with them overly burdensome and ultimately too costly to provide these needed services. For example, to contract with one MCO in Illinois, AFC completed a 1,300 question survey about our information technology security capabilities, hired a consultant to try to hack into our network, and installed a 24-hour security camera in front of our server room door (which was already is located on the very secure 21st floor of a downtown high-rise with 24-hour security and key-card access). While we fully support the importance of IT security, many community-based organizations cannot afford to meet these requirements, which go beyond what a health care organization has to meet to contract with an MCO as a medical provider. The 1115 waiver and tenancy services will not be successful if only a few, large agencies can provide services. Specifically, we recommend that funding for infrastructure needs such as IT security systems and electronic medical records should be provided through this transition by the state. Training and technical supports is not enough to ensure success of partnerships between community organizations and managed care systems. MCOs must be required to implement simplified contracting methods.

AFC encourages HFS to take into account that value-based outcomes are difficult, and sometimes impossible, to demonstrate for case management at this point in time. SUD case management, which is a worthy goal, has no real existing baseline of data for outcomes. The waiver does reference DASA’s use of NSDUH data on page 43, section 3.1.4.2. For other care coordination and case management analysis, the data on outcomes is only just beginning across the country as each individual MCO does their utilization and claims analysis. We encourage you to take this into account when the state begins implementing value-based outcomes.

Continuity of housing tenancy supports is crucial. Innovative MCO contracting arrangements should be made so that residents in permanent supportive housing do not have their housing supports impacted by

which MCO they are enrolled with or what contracts their supportive housing provider has with MCOs. The Massachusetts CSPECH demonstration has a regional mental health authority serving as an intermediary between MCOs and PSH providers that could serve as a model.

The waiver must provide support for supportive housing providers to obtain needed infrastructure, training and TA. A strong partnership between MCOs needs to be actively developed and supported by the state.

General Comments

AFC also encourages the state to include other chronic conditions and not just SMI to fully apply the states concept of Whole Health. On page 59, Exhibit 24 there is a list of 14 chronic conditions related to behavioral health and Medicaid members. We believe that all chronic conditions should be included so as to better reflect the model of Whole Health.

Rates for providers and Managed Care Organizations must support costs associated with innovation and high-quality healthcare. Asking MCOs and providers to meet standards without adequate funding from the state is simply setting up the system for failure. The success of the waiver will depend on the state providing adequate rates to community providers so that the community capacity needed to serve those experiencing behavioral health conditions can be properly treated in the community. Targeted rate increases for the services proposed in the waiver alone will not adequately address the capacity issues we currently face.

Planned State Plan Amendments (SPAs) for Integrated Health Homes (IHH), crisis recovery beds, and the uniform assessment, as well as any other SPAs or administrative rule changes, should be made public. These changes are integral to how the waiver will be implemented as well as the timing.

State grants must be continued and any transition from grant-based reimbursement to Medicaid financing should be gradual to maximize success. Many Illinoisans will continue to be uninsured or underinsured and resources need to be retained for such populations.

More specificity is needed to understand the proposed transformation. The proposal provides insufficient detail on how eligibility will be determined for new benefits, how pilot programs will be targeted, the size and scope of pilot programs, the amount of funding allocated for provider and workforce capacity initiatives, and many other integral definitional and policy provisions. These questions should be addressed in the waiver proposal and the public should be allowed to comment prior to the state making such important implementation decisions.

AFC suggests that HFS convene an Advisory Implementation Committee. The state should solicit public comments and establish an ongoing partnership with stakeholders (MCOs, providers, advocates, etc..) and implement the programs included in the waiver, SPAs and administrative rules changes. This will allow for full input of all stakeholders as we move this Demonstration Waiver forward. Full participation is key to successful partnerships. This committee should work in cooperation with the Medicaid

Advisory Committee, the formally established working groups on the state design to help design and implement Medicaid policies and programs.

AFC supports the inclusion of First Episode Psychosis programs in the waiver proposal. The 1115 Waiver proposes that the state’s First Episode Psychosis program be targeted to 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. Limiting to schizophrenia is too restrictive.

Payment for the FEP program should be modeled as a bundled payment, allowing for flexibility in the level of care needed in each aspect of the intervention (i.e. case management vs. supported education). Bundled payments are also easier to translate to commercial insurance and this is an opportunity to set up the intervention in a way that can be used in the commercial market.

Include justice-involved individuals with substance use disorders in the pilot population that receives access to substance use case management through the 1115 Waiver. We understand that the state is opting to cover a number of substance use services, including substance use case management, through the 1115 Waiver in lieu of adding them to the state’s Medicaid Plan because of budgetary constraints. Due to this design, they will not become blanket services available for all individuals enrolled in Medicaid, but instead will be “piloted with targeted populations” (see chart on p. 45). Given the high prevalence of substance use disorders among justice-involved individuals, we urge the State to include this population as one of those that is able to access substance use case management via the waiver. In the pilot, we also urge the state to cover substance use case management in the same manner that mental health case management is covered, with equivalent rates and scope. For example, providers should be able to provide substance use case management for up to 30 days before needing a substance use diagnosis, as is stipulated in the requirements for mental health case management.⁷

Concerning the role of MCOs in ensuring continuity of care following release from jail and prison:

a. Build on current interventions by mandating that MCOs partner with providers who have a history and experience working with and inside justice systems and coordinating care for individuals who go through them.

The state is requesting to waive the “inmate exclusion” clause in federal Medicaid policy that prohibits reimbursement for services rendered to individuals inside of correctional institutions. This reflects an enormous advancement towards continuity of care during the period of transition following release from jail or prison for individuals with substance use and mental health conditions.

Beyond waiving the inmate exclusion, the draft waiver application also requests that Medicaid cover the activity of “identifying providers in the community” who will be responsible for caring for such individuals once they are released. However, it only requests coverage of this service for fee-for-service providers (see pp. 39 and 41), and indicates that MCOs will be responsible for identifying providers in the community who will be responsible for an individual’s care upon release into the community. The state’s intentions are unclear with respect to who it expects to perform the activity of “identifying providers in the

⁷ State of Illinois. (2014). *Community mental health services: Service definition and reimbursement guide*. Retrieved from <https://www.illinois.gov/hfs/SiteCollectionDocuments/cmhs.pdf>.

community.” If the state expects MCOs to perform this function, AFC urges the State to re-think this provision, given the complexity of the criminal justice system.

In jails and prisons, there are arrangements in place to link individuals who receive treatment while incarcerated to care in the community post-release. This work is often done in partnership with county and state correctional agencies, local health departments, and various social service providers. A lack of funding for this work has limited the availability of this service to only a portion of those with the highest needs. Such processes not only consider an individual’s treatment needs, but also criminogenic risk factors, which are used together to create a discharge plan for the individual prior to release. For those on probation or parole, medically-necessary treatment coupled with case management is often a component of an individual’s criminal justice mandate, which includes reporting back to the criminal justice system on the individual’s progress and compliance. Those who work to connect individuals to care upon release must be competent in both criminal justice and behavioral health treatment systems and processes in order to satisfy the requirements of both systems.

The waiver states its intention to expand on the work already underway, yet the proposed provision for MCOs to identify providers in the community post-release runs counter to how that work occurs today. It is reasonable to require that individuals enrolled in an MCO are linked to in-network providers, however is it problematic to require that the MCOs themselves perform this function from within correctional facilities given the criminal justice related functions that go along with performing that role. In alignment with the concept of health homes, MCOs should be required to partner with community-based agencies that have a history and experience in working with this population.

b. Treat the transitions experienced by the justice-involved population in the same manner as those of other members transitioning from an institution to the community, which prompts a higher care coordination rate. This rate would better allow MCOs to partner with community-based organizations to provide services at a level sufficient to facilitate successful transitions to the community.

The waiver application only requests waiver funds to cover this activity for enrollees in fee-for-service Medicaid but not for those in Medicaid managed care, thus implying that MCOs will be expected to use existing care coordination payments from the state for this new function. If the state expects the MCOs’ care coordination responsibilities to intersect with the justice system, it will need the on-the-ground expertise of organizations already serving this population. In order to make such partnerships a reality, the state should consider individuals leaving correctional care in the same group as other members who leave institutional care, thus granting MCOs access to higher care coordination rates which would then better allow for innovative partnerships and value-based payment models.

Allow public safety agencies to participate in Medicaid Administrative Claiming. By not enabling justice agencies to engage in Medicaid Administrative Claiming (MAC), Illinois is leaving federal funding on the table—funding that does not require the state to provide any match. Instead the state must only demonstrate it is already spending money on activities reimbursed in part for activities that are considered “necessary for the proper and efficient administration of the state Medicaid plan.” Similar to schools and local hospitals who already participate in MAC, a number of city, county, and state public safety agencies in Illinois spend money on activities that qualify for a minimum of 50% reimbursement from federal Medicaid. Some of these activities include: Medicaid outreach, Facilitating Medicaid applications, Case management, Referral, coordination, and monitoring of Medicaid services, Arranging transportation, Provider relations, and Program planning, policy development, and interagency coordination of medical services.

These services are not tied to a diagnosis and are offered outside of the traditional fee-for-service reimbursement structure. State's Attorneys, public defenders, probation officers, parole officers, and IDOC, IDJJ, or county-contracted community-based providers often provide such services to individuals involved in the justice system using either general revenue fund (GRF) dollars or county expenditures. Reimbursements are made on a quarterly basis and amounts calculated using "random moment time studies." County Sheriff's Offices in California and a juvenile probation department in King County (Seattle), Washington⁸, have taken advantage of this federal funding.

While this is not something that needs to be achieved through an 1115 waiver, it directly supports the goals of the State's Health and Human Services Transformation. Further, it does not require federal approval, only State HFS approval. Therefore, we urge the State to consider allowing justice agencies and their contracted community-based providers to participate in MAC.

Waive the parental income requirement for at-risk youth on Medicaid applications. Jurisdictions seeking ways to connect detained youth to care are likely to face a common barrier—the requirement for parental income information to be included on a youth's Medicaid application. This information can be very difficult to come by at all, and even more difficult to obtain in a timely manner. Often, by the time social workers are able to contact a parent and obtain the information, a youth already has been discharged, and the opportunity for enrollment in time to facilitate care during the transitional period has passed. Many youth are discharged without being enrolled in Medicaid. Enrollment prior to release increases the likelihood of engagement in services upon return to the community. Increased continuity of care supports efforts to reduce recidivism and health care costs among this population.

By including a request to waive this requirement which exists under Section 1902(a)(17) of the Social Security Act, justice personnel could satisfactorily complete Medicaid applications for minors without having to include parental income information.

The AIDS Foundation of Chicago appreciates the opportunity to present its thoughts on this document. We are very encouraged by the direction of the waiver, and hopeful of its approval from the federal government. We remain committed to working with the state in order to create a behavioral health system that is first in the nation.

Sincerely,



Daniel M.O. Frey
Director of Government Relations

⁸ Washington State Health Care Authority. (2013). *Medicaid administrative claiming cost allocation plan for King County Superior Court Juvenile Probation Services (KCSCJPS)*. Retrieved from http://www.hca.wa.gov/sites/default/files/billers-and-providers/KCSCJPS_CAP.pdf