

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

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Administrator Andy Slavitt
Center for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Administrator Slavitt:

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. AFC 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, 22,598 people with HIV were on Medicaid in 2015.² 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 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.

Today, HIV is unique because while it can be treated as a chronic disease, AFC 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

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 Illinois Department of Healthcare and Family Services, special data request, received 11/14/2016

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.

AFC 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 significantly increase 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.

AFC supports establishing a supportive housing pre-tenancy and tenancy services benefit.

AFC supports the inclusion of individuals with a primary SUD diagnosis as an eligible diagnosis for these services and the clarification that an eligible individual's immediate family also be eligible for 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 comparison, the Department of Housing and Urban Development (HUD) has an extremely restrictive definition of homelessness. The definition from HHS AFC suggest using is as follows:

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

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)

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, which could serve as a supportive housing certification program. This would create standardization for the types and quality of services provided. AFC 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.

AFC recommend a per diem rate structure for tenancy support. To meet the state's goal of paying for value and outcomes, AFC 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 AFC 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, AFC 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.

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.

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 AFC 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.

To the extent that eligibility for these services is defined in the Special Terms and Conditions, AFC recommends a broad definition of homelessness and at-risk of homelessness beyond just the HUD chronically homeless definition. AFC also recommend that at-risk of institutional care include criminal facilities.

AFC supports establishing a supported employment IPS benefit.

AFC supports establishing a benefit to support returning citizens prior to their release from DOC/CCJ/DJJ facilities.

AFC supports the addition of individuals in DJJ facilities and the expansion of the MAT pilot to CCJ.

AFC recommends that pre-release services not be limited to only 30 days and only one visit with a community-based provider prior to release. AFC instead recommend that clinical needs and medical necessity dictate the number of days and visits prior to release.

AFC recommends that the MAT pilot not be limited to Naltrexone but rather to long-acting injectable MAT of all forms. This avoids concerns about diversion but gives the state flexibility to pilot other medications as needed and as they come to market.

AFC recommends including successful connection to a community provider as evaluation metrics for MCOs who are accountable to ensure the returning citizens are connected to needed supports.

AFC supports establishing new SUD benefits in the SUD service continuum, including removing the IMD exclusion for up to 30 days of inpatient SUD treatment.

AFC supports the removal of the certificate of need process for level III.5 facilities.

AFC supports establishing new MH benefits in the MH service continuum.

AFC recommends the waiver include strict guidelines regarding the medical necessity of IMD services and discharge policy to avoid unnecessarily long stays.

AFC supports establishing additional benefits for children and youth, as well as their caregivers.

AFC supports establishing intensive in-home services through pilots that include home-based clinical and support services. AFC also supports the state's approach that home-based support services are intended to support both the child and his/her family.

AFC supports extending the age range from 5-21 to 3-21.

AFC supports the establishment of Integrated Health Homes and expect the state to seek stakeholder input in their development and implementation.

AFC supports additional mental health initiatives for infants and young children, including Infant/Early Childhood Mental Health Consultation (I/ECMHC).

AFC supports the addition of home visiting for families of babies born with drug withdrawal syndrome.

AFC supports the range of workforce initiatives proposed by the state.

The state workforce needs assessment should be discussed in the implementation council and with a broad range of stakeholders.

The state's needs assessment should include assessing existing provider's ability to participate in Medicaid, including IT systems, billing systems, and electronic health records. The funds allocated to address workforce capacity issues should be used to address provider needs for administrative and IT systems if the needs assessment indicates that is the most pressing need. Telemedicine infrastructure should not be prioritized over other needs unless the needs assessment indicates it should.

Bonus pool payment should not be restricted only to safety net hospitals but also other safety net providers who establish tuition forgiveness programs, including FQHCs and community mental health centers.

AFC supports an expanded concept of "technical assistance" to include linking community service providers to managed care to linking them to Medicaid more broadly and recommend that the training and technical assistance resources provided by the state be developed in response to stakeholder input.

AFC supports the FEP initiative as a critical and evidence-based treatment to prevent early signs of serious mental illness early and prevent future disability.

AFC supports expanding eligibility beyond schizophrenia spectrum diagnoses to include any mental illness-induced psychosis or prepsychosis, as well as an expanded age range down to 12 from 14 years old.

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