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Centers for Medicare & Medicaid Services

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Baltimore, MD 21244

The following are the comments of the Illinois Association for Behavioral Health (IABH) on the Section 1115 Demonstration Waiver submitted to the Centers for Medicare & Medicaid Services (CMS) by the State of Illinois, Department of Healthcare and Family Services (ILHFS). Established in 1967, IABH (formerly known as the Illinois Alcoholism and Drug Dependence Association) is a statewide organization representing 65 community-based substance abuse and mental health prevention, treatment, and recovery agencies and affiliated organizations and more than 200 individual members across the State of Illinois. IABH's mission is to advocate for sound public policies in the behavioral health field, on behalf of the clinicians, consumers, family members, individuals in recovery and youth who are in need of services. IABH educates the general public about addiction and mental health; sharing the message that addiction can be prevented, mental health wellness opportunities exist, there are effective treatment strategies for those struggling with addiction and mental illness, and recovery is possible for everyone. IABH staff works with and educates legislators, policy makers and key stakeholders to develop and implement sound public policy that creates and supports healthier families and safer communities.

IABH commends ILHFS for its forward-thinking approach of utilizing the Section 1115 Waiver process to further transform the delivery of behavioral healthcare services in the State of Illinois. IABH is proud to work alongside ILHFS as it seeks to improve population health, improve experience of care, and reduce unnecessary costs. IABH members are committed to serving clients and patients in need of behavioral healthcare services with the highest quality care as well as that which is most attentive to the needs of the State. IABH members desire to assist ILHFS to address coordination of care; identifying those in need of treatment; increasing community-based service capacity; providing support services; addressing gaps in agency oversight; and improving data analytics and transparency within the limits of applicable law.

On behalf of the behavioral health providers and consumers IABH represents, we support the State of Illinois and the 1115 Demonstration Waiver (Waiver) submitted by ILHFS. We reserve our comments below only to those areas that are in need of clarification. IABH believes that the remainder of the Waiver is a forward-thinking approach that attempts to address the needs of the residents of Illinois while balancing fiscal concerns. As such, IABH offers only the following points of clarification while supporting the remainder of the Waiver.

Institutions for Mental Diseases (IMD) – SUD Residential Services

The Waiver describes a comprehensive evidence-based process to redesign substance use disorder (SUD) treatment. The Waiver proposes to allow for those facilities with more than 16 beds, referred to under the Medicaid program as Institutions for Mental Diseases (IMDs), to provide residential treatment services. An IMD is defined as a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment, or care of persons with mental illness, including medical attention, nursing care, and related services (42 U.S.C. §1396d(i)). CMS has determined that SUD treatment facilities fall under the IMD exclusion, which prohibits federal financial participation in Medicaid reimbursement for services provided within an IMD.

It is important to note that the discussion regarding the re-design of the SUD treatment service continuum should not start from the erroneous assumption that residential treatment is high-cost or in some way inefficient. Studies have confirmed the benefit and long-term value of residential treatment. A more intense, longer stay of treatment has consistently been found to achieve better outcomes for SUD clients.¹

The Waiver would allow for American Society of Addiction Medicine (ASAM) level 3.5 residential treatment to be provided under Medicaid fee-for-service in an IMD for a period up to 30 days and under Medicaid managed care for 15-30 days. While a step in the right direction, we do not believe the proposal goes far enough to address the lack of level 3.5 treatment services available in the State. According to a 2015 report, Illinois ranked first in the US for the percent decline in treatment capacity from 2007-2012, a loss of more than half of its treatment episodes— a 52% decrease.² The addition of residential treatment by way of expanded utilization of IMDs will increase access and reduce the cost to the State for those individuals who are unable to obtain treatment and return to work and more productive lives. Other states, including New York and California, have extended Medicaid reimbursement to IMDs providing residential treatment for longer lengths of stay. In California, residential treatment for adults is available for up to 90 days in one 365 day period, with an extension up to another 30 days.³ CMS guidance “New Service Delivery Opportunities for Individuals with a Substance Use Disorder”⁴ recognizes the need to expand residential treatment to ensure that a continuum of care is available to individuals with SUD. That guidance did not distinguish between Medicaid fee-for-service and managed care in describing average lengths of stay. We understand that ILHFS has crafted the 15-30 day extension for managed care SUD treatment in an IMD based upon the Final Medicaid Managed Care Rule issued on May 6, 2016.⁵ ILHFS apparently has interpreted the Final Medicaid Managed Care Rule to allow for up to 15 days of level 3.5 or level 4.0 SUD treatment per month to be provided in an IMD. IABH is unaware of CMS guidance on the application of the Final Medicaid Managed Care Rule exception for IMD and would ask for clarification from CMS on whether

¹ See, [Hser YI, Evans E, Huang D, Anglin DM](#). Relationship between drug treatment services, retention, and outcomes. *Psychiatr Serv.* 2004 Jul;55(7):767-74; [D. Dwayne Simpson, PhD; George W. Joe, EdD; Bennett W. Fletcher, PhD; Robert L. Hubbard, PhD; M. Douglas Anglin, PhD](#). A National Evaluation of Treatment Outcomes for Cocaine Dependence. *Arch Gen Psychiatry.* 1999;56:507-514; Greenfield L, Burgdorf K, Chen X, Porowski A, Roberts T, Herrell J. Effectiveness of long-term residential substance abuse treatment for women: findings from three national studies. *Am J Drug Alcohol Abuse.* 2004 Aug; 30(3):537-50; [Zhang Z, Friedmann PD, Gerstein DR](#). Does retention matter? Treatment duration and improvement in drug use. *Addiction.* 2003 May; 98(5):673-84.

² <https://www.roosevelt.edu/~media/Files/pdfs/CAS/IMA/ICDP/DiminishingCapacity.ashx?la=en>.

³ http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_FINAL_STC_12-30-15.pdf.

⁴ <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>.

⁵ 81 Fed. Reg. 27497 (May 6, 2016).

the exception includes level 3.5 services. We believe that all Medicaid beneficiaries receive longer, more clinically-appropriate lengths of stay not tied to an artificial limitation that is not grounded in scientific research, ASAM criteria, or best practices.

Level 3.5 residential treatment is a critical component of SUD treatment and the Waiver must provide sufficient opportunities for the length of treatment necessary to address the burgeoning SUD/opioid crisis in Illinois. As a result, IABH recommends that the Waiver be modified to closely follow that which was granted to California.

Financing the Cost of the System Re-Design

The transition to integrated health homes (IHHs) will require training and systems modification for behavioral healthcare providers. While IABH supports the IHH model, it must be accompanied by sufficient financial and other support for providers to transition to this new integrated care model. In addition, there needs to be adequate training and guidance for Managed Care Organizations (MCOs) to comprehend the changes and ensure a seamless transition. Without guidance and supervision, MCOs may not be as invested in the transformation and IABH wants to avoid the negative impacts falling upon the behavioral healthcare providers who must carry out the process alone. Further, ongoing technical assistance and resources will be necessary throughout the life of the Waiver beyond training curriculum and education to ensure proper implementation and integration by a competent workforce.

There is a national trend towards reimbursement based upon outcomes and quality. IABH supports such efforts. Paying for performance is an admirable goal. However, ILHFS needs to recall that behavioral health has only recently begun the transition to managed care. Behavioral health providers, and MCOs, have not yet fully implemented the managed care model. Transforming yet again will be a burden without sufficient education, training, and financial support. Behavioral healthcare providers are not currently adequately reimbursed for their services. The MCOs utilized the Medicaid reimbursement rate which has not historically met costs and expenses. With the advent of managed care these providers must now implement billing, coding and accounts receivable staff and accompanying overhead. How will behavioral healthcare providers begin to track outcomes and measure quality without the infrastructure in place to do so or the financial assistance to reach that level of sophistication? The transition to IHHs will also be a financial and staffing burden for providers and leveraging the power of teams will not necessarily result in reimbursement that meets expenses.

The Waiver proposes enhanced licensing and credentialing requirements under the Division of Alcoholism and Substance Abuse (DASA). This enhancement will include reference to ASAM criteria and providers' ability to follow evidence-based protocol. Further, DASA will impose annual training requirements and other additional trainings for providers wishing to perform new services. IABH has concerns with these enhancements and new training obligations. Licensing and credentialing are important for ensuring providers meet standards. Training requirements are also important to ensuring a competent workforce. However, the time and expense necessary to undergo the trainings and meet enhanced criteria do not appear to be offset by any State or federal support. IABH is concerned that these new requirements will fall on the shoulders of the behavioral health provider community, which has just experienced a State budget impasse. The new requirements should be reduced or eliminated until resources and funding are available. The State must provide the training and the financial support necessary for providers to meet these new and more stringent obligations.

Including All County Jails in Waiver

The Waiver recognizes the need for additional services to ensure successful transitions for individuals involved in the justice system. These services include behavioral health screenings and assessments administered prior to release, linkage with behavioral healthcare providers prior to release allowing those providers to bill upon release for one outpatient behavioral health visit, enrollment in a managed care plan, and coverage for medication-assisted treatment. These additional services apply to individuals in the Illinois Department of Corrections, the Cook County Jail, and the Illinois Department of Juvenile Justice. While IABH enthusiastically supports this expansion, we request that the Waiver be expanded to cover all county jails and not just Cook County. This would provide the full array of these services to those individuals in all county jails in a variety of locations and settings.

IABH thanks CMS for its consideration of these comments and looks forward to partnering with the State, ILHFS and CMS on this exciting transformation.

Sincerely,

A handwritten signature in black ink, appearing to read "Sara Moscato Howe". The signature is fluid and cursive, with a long horizontal stroke at the end.

Sara Moscato Howe
CEO
Illinois Association for Behavioral Health