MCDERMOTT CENTER dba HAYMARKET CENTER

COMPREHENSIVE ALCOHOL & DRUG TREATMENT PROGRAMS

FOUNDED IN 1975 BY MSGR. IGNATIUS MCDERMOTT AND DR. JAMES WEST

November 14, 2016

Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Illinois Behavioral Health Transformation Section 1115 Demonstration Waiver

Greetings:

McDermott Center, dba Haymarket Center, appreciates the opportunity to comment on the Illinois Behavioral Health Transformation Section 1115 Demonstration Waiver application (the Waiver).

Haymarket Center is Chicago's largest provider of substance use disorder and mental health services, serving nearly 16,000 clients each year from every area of Illinois, at every level of care according to American Society of Addictions Medicine (ASAM) currently in operation in Illinois. Haymarket is very pleased that Illinois has chosen to devise a Waiver focused on transforming Behavioral Health in Illinois.

The overall vision of the health and human services transformation in Illinois, the Waiver goals, and the identified Waiver services are very well thought out and are in line with national trends (where Illinois hasn't always done so).

Haymarket Center gladly supports all six of the Waiver's goals. Highlighting the need to integrate behavioral health with physical health, the clients Haymarket serves who are enrolled in Medicaid are low income and medically fragile populations with substance use disorders (SUD), many of whom (75%) are living with a co-occurring mental illness. Typically, 78% of our clients have never received routine healthcare, and most have multiple untreated chronic health conditions in addition to their substance use, including 88% with hypertension, 70% asthma, and 68% diabetes. Responding to these needs, Haymarket Center opened a health care clinic within our main facility in 1994; for the past three years it has been operated by Heartland Health Outreach, a federally qualified health center (FQHC). The State's plan to address this need for integration is a welcome step toward bringing Illinois' behavioral health system into the 21st century.

In the spirit of supporting the Waiver, Haymarket wishes to offer the following comments which we hope will be useful in refining the Waiver application and helping to provide an even better set of outcomes for our most vulnerable client populations.

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General

While the Waiver does include separate sections discussing mental health (MH) and substance use disorder (SUD) services, often enough the Waiver language blurs the distinctions between MH and SUD in a way that causes us some concern. In Illinois, mental health and substance use disorder services operate under separate rules and have separate funding budget lines, so the distinctions are important here. Most notably, there is a repeated desire to reduce inpatient/residential services. There may well be a need to reduce inpatient psychiatric stays. A Chicago Tribune article on September 9, "DCFS Wards Languish in Psych Hospitals," provides an excellent example of what Director Sheldon is working to address and some of the Waiver language is also designed to address.

However, Haymarket cautions that SUD residential treatment should not be swept into the same bin as psychiatric inpatient services. Psychiatric stabilization is dramatically different from moving someone with an SUD into recovery. In fact, if an individual with a long-term addiction to heroin is discharged from residential treatment in too short a period, our own experience shows that **relapse is highly likely**. His level of tolerance for the drug will have dropped, and if he uses heroin at the level he used prior to admission, he is likely to overdose. An argument could be made that providing a shorter period of residential treatment may thus do more harm than good.

We will address length of stay issues later in our comments, but as a summary to this general comment, we urge CMS to work with the State to make clearer distinctions between MH inpatient and SUD residential treatment throughout the Waiver.

Comments on Specific Provisions

Supportive Housing

The range of supportive housing services proposed in the Waiver is truly impressive and shows a deep understanding of key—essential—supports needed to help move many individuals into recovery.

During the draft comment phase, Haymarket urged that the State expand the eligible population for this service to homeless individuals with an addiction serious enough to require an episode of residential treatment. The stresses associated with homelessness, the likelihood of individuals staying temporarily with friends or family who also abuse substances, all serve as triggers to relapse for homeless individuals with a substance use disorder. No less than SMI populations, these populations need the exact supportive housing services identified in the Waiver for SMI populations. We were extremely pleased to see that Illinois made this revision and now includes SUD populations in this component of the Waiver, and we urge CMS to work with the State to keep this provision.

Supported Employment Services

We strongly support this component of the Waiver. Haymarket Center does provide some workforce development services to our clients, but not nearly enough. We find that in applying for available workforce development dollars, we compete against agencies that both specialize in these services and who turn away clients with substance use disorders. The individual with SUD faces many more barriers to employment and, in the case of a large percentage of Haymarket clients, may have little to no work history. We could provide more details if requested, but essentially the structures of available workforce development funding are a very poor fit for the individual with SUD. We hoped that the Waiver services will allow for services more tailored to what the individual with SUD actually needs to become employed.

However, we were disappointed to see that the State dropped the SUD population from participation in this component of the Waiver in its final application. We urge CMS to work with Illinois to reinstate the SUD population into this component.

Pre-Release Services for IDOC- and CCJ-Involved Populations

While some of the services proposed in this section overlap with services fundable through Second Chance Act grants from the US Bureau of Justice Assistance, we support the need for all of the services identified. We echo the comment made by Doug Elwell of the Cook County Health and Hospital Systems at the Chicago Public Hearing on September 9, requesting the State expand the eligibility of pre-release injectable naltrexone to Cook County Jail. We were pleased to see that the State made this revision in the application.

Redesign of Substance Use Disorder Continuum

The opening passages of this section of the Waiver suggest that the proposed Integrated Health Homes (IHHs) will assist with assuring individuals with SUD have access to a full continuum of necessary services. However, sections of the Waiver addressing the IHHs, later in Section 4.1, merely state that individuals will be assessed for SUD and referred. Discussion of behavioral and physical health integration appear otherwise to leave SUD services completely out. So while we support the principle of IHHs, the lack of detail on how SUD will be treated by IHHs causes concern.

As we stated earlier, Haymarket has had a primary health clinic integrated into our system for 22 years. We would like to see the Waiver help us improve our integration further still, but don't currently see how the Waiver will do that.

Outcome Based Payment

The National Outcome Measures DASA has implemented over the past few years have been an important way to help providers track and measure their outcomes and provide much-needed guidelines for us to improve our services. We support these fully. Haymarket also understands the need to move to outcome-based payments. There is extremely little detail as to what this

means exactly, and how it will implemented. We strongly urge the State to recognize what the SUD provider field has suffered: 1) overall reduction of funding by over 45% over the past ten years and 2) reimbursement rates that the Illinois Association for Behavioral Health (IABH, formerly IADDA) reported are 118% below where they should be—and do not cover our costs. This one-two punch to our field has left SUD providers weakened, reduced, and with little ability to invest in transitioning to a different system of payments.

CMS should work with the State to ensure service agencies will have the needed supports in making the transition to a new payment system.

Recommendation: We recommend a phased approach, in which the first phase could include a bonus payment for achieving certain outcomes. For example, a bonus payment for achieving greater than 85% of the engagement and 85% of retention goals already tracked by the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse. As so many of the changes to the system in recent years—as necessary as they have been—have had the effect of feeling punitive and have in fact reduced revenues even further, we recommend this bonus payment as a positive incentive to help providers see value in improving our outcomes.

IMD

For individuals in Illinois with serious SUD, the IMD provision may be the single most important provision of the Waiver. Not only has the IMD exclusion severely limited access to treatment for populations newly Medicaid eligible through the Affordable Care Act, it has been costly in that a 16-bed residential program cannot achieve economies of scale.

State officials, state legislators, and Illinois US representatives and senators all know that Haymarket Center has been at the forefront of trying to get IMD addressed at the federal level. We cannot commend the State enough for including this provision in the Waiver.

Still, some details of the Waiver language cause us some concern, which Haymarket mentioned in comments during the draft phase and appear not to have been addressed in the submitted application. For example, the Waiver proposes "Treatment within licensed ASAM level III.5 residential treatment services with more than 16 beds for 15 to 30 days for members enrolled in managed care." We aren't sure what the reference to 15 to 30 comes from, but suspect it is related to the CMS final rule for Medicaid managed care, which allows for up to 15 days in a given month in an IMD in certain limited cases for which CMS has promised further guidance. In Haymarket's own conversations with CMS, officials of CMS stated that they do not intend their guidance to pertain to SUD and that States should address SUD IMDs through 1115 waivers.

Most research on residential lengths of stay for SUD show that better outcomes are associated with longer stays.[1] In fact, much of this research demonstrates that clients who spend three months or more in an alcohol or drug program experience more long-term positive outcomes,

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[1] Bruni, Jacob & Robb, The Effectiveness of Substance Abuse Treatment in Illinois: Results of the Illinois Statewide Treatment Outcomes Project (2001).

including continued abstinence from drugs and/or alcohol.[2] Other studies have similarly demonstrated that the more time spent in treatment yields higher rates of sobriety than shorter time periods spent in treatment.[3]

After extensive review of experiments, meta-analyses, and expert consensus efforts on effectiveness and cost effectiveness of adult[4] substance use treatment, the National Institute on Drug Abuse found that research has consistently demonstrated that longer lengths of stay are more effective and cost effective than shorter lengths of stay. NIDA explicitly recommends at least 90 days and then step down/continuing care after that for residential treatment. As these data establish, a short-term stay in a sub-acute residential SUD treatment facility is typically equal to or greater than 30 days in duration and SUD treatment is most effective when an individual remains in treatment for at least this amount of time. This research amply supports an extension in the time allowed for treatment of an enrollee within an IMD to a minimum of 30 days, and would justify longer residential stays of up to 90 days for SUD treatment.

Further, in reviewing lengths of stay in residential substance use treatment in the US overall and by age, SAMHSA found5 that only 30% of the clients in residential treatment have lengths of stay as short as 15 days. If the length of stay cut point was increased to 90 days, it would cover 80% of the patients; if it was increased to 160 days would cover 94%. Thus, to be consistent with practice, a higher standard of no less than 90 days for residential is more appropriate.

It is important to note that placement into a residential level of care for SUD, and determining the length of stay, in Illinois and 30 other states, is based on comprehensive assessment and review of six domains as established by the American Society on Addictions Medicine (ASAM). If ASAM criteria determine that a longer stay is needed, the State should not contravene ASAM for an arbitrary cap of 30 days.

While the State may be concerned about the costs of allowing a longer stay, research has shown that adequate residential stays in SUD treatment are highly cost effective. Under a NIDA grant,[6] a cohort of 436 adults admitted to Haymarket Center in Chicago were interviewed at intake between February to March, 2004 and quarterly for 4 years (with over 95% completion). In 2009 dollars the clients accessing residential SUD treatment averaged $4,749 in costs to society in the 90 days before accessing treatment. Some of these costs were to other systems, but many were emergency room, hospital, and other healthcare costs that would be covered by Medicaid. It only

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[2] DeLeon, (1986); Goldapple and Montgomery, (1993); Hubbard et al., (1997); Simpson, Joe and Brown, (1997).

[3] Burgess, John, Efficacy of Long-Term and Short-Term Residential Substance Abuse Treatment Modalities (2005).

[4] National Institute on Drug Abuse. (2000). *Principles of drug addiction treatment: A research-based guide.* National Institute on Drug Abuse, National Institutes of Health. Retrieved from http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment

[5] United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. Treatment Episode Data Set -- Discharges (TEDS-D), 2011. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2014-05-12. doi:10.3886/ICPSR35074.v1

[6] Christy K Scott, Ph.D., Michael Dennis, Ph.D., Mark D.Godley, Ph.D., and Susan H.Godley, Rh.D., National Institute on Drug Abuse (NIDA) grant no R37 DA011323.

took an average of 18 months before the cost of treating these people at Haymarket was offset by reductions in other costs, and at the end of four years there was an average net **savings of $14,589 per client.**

For these reasons, we strongly urge CMS and the State to revise its proposed limited exception related to the IMD Exclusion and permit MCOs and PIHPs to receive capitation payments from the State for patients with severe SUD in an IMD, provided the stay is for 30 days or less.

SUD Case Management

We commend the State for including SUD case management in the Waiver. Limitation to circumstances where SUD clients "are not receiving case management services through any other provider" makes sense on paper, but not in practice. Clients at Haymarket may have another case manager, such as a TASC case manager if they are court-referred or a managed care case manager if they are enrolled. But Haymarket clients have so many immediate needs that cannot be attended to by TASC or MCOs. For just one example, an increasing percentage of Haymarket clients have medications for physical or mental health conditions. Logging and monitoring the medications themselves and monitoring administration of the medications takes an increasing amount of time and staff effort that is considered a case management activity. An alternative would be for the State to reform reimbursement rates to include these costs, but otherwise SUD case management should not be limited in the way proposed.

Withdrawal Management – Level III.2

Due to the budget crisis, Haymarket Center was forced to close a 16-bed Level III.2 program in February of this year. The program served 1,049 individuals in the year prior to its closure. We are very pleased that the State has recognized how crucial this level of care is and has included it in the Waiver.

SUD Recovery Coaching

Haymarket Center has invested a tremendous amount of energy and resources into implementing recovery coaching in as many of our programs as possible. We have found no other SUD approach that achieves such outstanding outcomes. Next to the IMD provision, this may be the single most important provision of the Waiver for the individual with SUD. Haymarket Center advocates the highly structured and evidence-based *Manual for Recovery Coaching and Personal Recovery Plan Development,* by Loveland and Boyle, which was developed through DASA funding. Having implemented this model in multiple federally-funded grant projects, Haymarket has a wealth of independent evaluation data confirming positive outcomes in reducing substance use, reducing crime, and increasing overall health. The model is cost effective, providing a year of recovery support for approximately $2,500 per client (depending on scale of the program). We support this provision of the Waiver 100%.

Support for Workforce Initiatives

The Waiver's excellent proposals for workforce support, such as loan repayment/forgiveness, must include certified alcohol and drug counselors (CADCs). Certification standards for CADCs were carefully designed by the Illinois Certification Board to incorporate international standards established by the International Certification and Reciprocity Consortium, which are also used by all but two states in the US. Illinois' comprehensive approach to transforming the behavioral healthcare system must not leave behind CADCs, which are the backbone to SUD services. Following the draft comment period, the State did revise the Waiver specifically to include psychiatrists, but otherwise mentions only "a wide range of professionals including….," so we would like to ensure CADCs are included.

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Haymarket Center's overall support for the Waiver is based on our belief that this package of improvements to the behavioral healthcare system in Illinois will help individuals with mental illness and substance use disorders find and maintain recovery. Haymarket always seeks to improve our own services, and in so many ways this Waiver will provide much-needed assistance to achieve this goal. If there are any questions about our comments, or desire for additional detail or clarification, please feel free to contact me at dlustig@hcenter.org or 312-226-7984, ext. 488.

Sincerely,

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Haymarket Center
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