As a non-profit organization experienced in Illinois’ maternal and child health program and advocacy efforts for over 27 years, EverThrive Illinois works to improve the health of Illinois women, children, adolescents and families over the lifespan through community engagement, partnerships, policy analysis, education, and advocacy. Through the work of our five initiative areas - Maternal and Infant Mortality, Child and Adolescent Health, Health Reform, Healthy Lifestyles, and Immunization - as well as the organization’s policy advocacy work, we have developed expertise in Medicaid policy, policies implementing the Affordable Care Act Marketplace, policies aimed at reducing maternal and infant mortality, and policies impacting the health and well being of children and adolescents. With our health advocacy partners, we work to strengthen policies that assist populations who are living with mental illness and/or substance use disorder and need access to appropriate treatment options. These populations may be individuals involved in the justice system, at-risk youth, children experiencing trauma, and/or people experiencing homelessness, mental illness or other chronic conditions.

We have thoroughly reviewed Illinois’ 1115 Waiver application and participated in the September 9, 2016 public hearing held in Chicago. We will continue to participate in other public involvement opportunities provided by the state related to the 1115 Waiver and the broader Illinois Health and Human Services Transformation (HHS) (e.g. HHS Consumer Advocates Working Group). EverThrive IL respectfully submits the following comments and recommendations related to Illinois’ 1115 Waiver application and welcomes the opportunity to provide further information or clarification if needed.

Global Comments and Recommendations:

- EverThrive IL commends the state and the Illinois Department of Healthcare and Family Services (HFS) for its leadership in applying for this 1115 Waiver with the goals of transforming the behavioral health system, integrating behavioral health and physical health, and optimizing outcomes for Illinoisans. We wholeheartedly support these goals of the Waiver. At the same time, we urge the Administration to provide more specificity so stakeholders can better 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.

- 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 before they are finalized. These changes are integral to how the waiver will be implemented.

- The state should solicit public comment and establish an ongoing partnership with stakeholders to design and implement the programs included in the waiver, SPAs, and administrative rule changes. Regular and frequent reports on waiver implementation should occur at the Medicaid Advisory Committee, the formally established working groups and other venues. The state should report on the evaluation metrics on a regular basis and make these reports available to the public.
State grants must be continued and any transition from grant-based reimbursement to Medicaid financing should be gradual and done in a publically transparent, data-driven process. Many Illinoisans will continue to be uninsured or underinsured and resources need to be retained for such populations.

We want to emphasize the importance of looking at each area of the Waiver, some that are heavily focused on services for adults, such as supportive housing, and creating language that will encompass the needs of children and families. There is an urgency and necessity to respond to the mental health needs of Illinois’ children in ways that challenge the status quo and maximize Illinois’ very limited resources, all while ensuring services are culturally and linguistically appropriate, family-driven, and youth-led, as appropriate.

Beneficiary eligibility for services should be determined by level of functioning, existing needs, and available supports rather than specific diagnostic or definitional requirements. The uniform assessment to be established through a SPA may be a good start, but it is unclear how this tool will be used to authorize services. The assessment scores necessary to authorize services must allow early interventions for those who may need services and prevent further deterioration of their level of functioning.

The myriad of new benefits and initiatives will only be successful if a straightforward and easily accessible assessment and authorization process is put in place. Managed care and state authorization practices should be standardized and consistent to facilitate timely needed care.

Rates must be increased. 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. Illinois Partners for Human Service research clearly shows the need for increased rates simply to sustain current levels of services. Targeted rate increases for the services proposed in the waiver alone will not adequately address the capacity issues we currently face.

Specific Comments:
Program Description and Eligibility:
Section 1 – Program Description
- We support 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.

1.3.5 – Designated State Health Programs (DSHPs)
- We recognize the importance of drawing down additional federal resources to enable new state investments through the waiver proposal. It is our understanding that DSHPs that receive Federal Financial Participation will not require all grantees to become Medicaid certified providers, nor all program participants to be enrolled in Medicaid. The state must ensure that this is the case to prevent significant service disruption.

1.4 – Demonstration hypothesis and evaluation
- For the evaluation component of the waiver, we recommend that the Administration include soliciting feedback from the provider and consumer advocate community regarding the implementation of the
waiver and including this feedback in its analysis. We also recommend seeking more in-depth and qualitative responses from impacted Medicaid beneficiaries beyond the CAHPS survey.

Section 2 – Demonstration eligibility

- We strongly support the inclusion of all Medicaid beneficiaries in the waiver demonstration and are appreciative the proposal does not include any limitation of Medicaid eligibility.

Demonstration Benefits:

3.1.1 – Supportive housing services

- We strongly support the implementation of a Medicaid benefit for supportive housing tenancy and pre-tenancy supports. While this coverage is an important step forward in improving stability and lowering overall costs for the most complex and vulnerable members of our community, we recommend expanded eligibility for this benefit to include those who:
  - Are currently eligible for rule 132 services or have a substance use disorder.
  - Meet a broadly defined level of serious mental illness based not only on specific diagnostic criteria but also on level of functioning and need. Acceptable diagnoses should not be limited to psychotic disorders but should also include mood and anxiety disorders.
  - Meet a broad definition of homelessness or risk of homelessness.
  - Are defined by the state as very high cost users of Medicaid services.
  - Have an intellectual and developmental disability and might otherwise select an intermediate care facility under the state plan or are homeless or have experienced long-term or repeated housing instability.
  - Are currently in an institutional setting or at-risk of entering an institutional setting without supportive housing services. Institutional settings include but are not limited to nursing homes, intermediate care facilities, institutes of mental disease, state psychiatric hospitals, and correctional facilities.
  - Are current supportive housing tenants in programs that receive state funding for populations described above.

- In order 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.

- 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.

- 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
rental subsidy pool must be created with enough flexibility to be accessible to managed care
organizations, hospital systems, and local regions or counties. PA has done this with MCO savings in
their behavioral health system and the model should be replicated.

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

• Increased rate differentials for difficult to serve populations should be developed for supportive housing
waiver services. For example, persons experiencing chronic homelessness or leaving long term
incarceration may need specialized support services that need to be considered in rate development.

3.1.5 – Optimization of the mental health service continuum

• The state should consider a range of models for crisis stabilization, both for the crisis bed waiver benefit
and crisis stabilization and mobile response planned SPA. One promising approach is the “Living Room”
model. This community based model is currently in use through the Welcoming Center at Swedish
Covenant. It includes crisis intervention and peer support services. Research shows promising cost

3.1.6 – Additional benefits for children and youth with behavioral health conditions and/or serious emotional
disturbance

• We support the inclusion of these benefits within the waiver proposal and urge the Administration to
continue to work with stakeholders to ensure proper implementation.

3.2 – Cost sharing requirements

• We strongly support the Administration’s decision to include no cost sharing requirements for waiver
services.

Other Waiver Initiatives:

4.1 – Behavioral and physical health integration activities

• We strongly support including behavioral health and physical health integration activities as an initiative
within the waiver proposal, and urge the state to seek to improve integration more broadly. These
supports in the Waiver appear to be focused just on those entities who will be involved in Integrated
Health Homes (IHH) but the state must improve the integration of services beyond just that program.

• We urge the state to use this opportunity to expand school-based approaches to prevention, early
intervention, and access to care, including expansion of school-based health centers (SBHCs).
Furthermore, in order to increase access to behavioral health services for children and adolescents, we
ask that HFS update its practitioner fee schedule for behavioral health services provided in Type 56
SBHCs. The goal of this practitioner fee schedule update would be to ensure proper payment structures
are established in the practitioner fee schedule for a comprehensive set of behavioral health services
provided within Type 56 SBHCs, ultimately increasing access to behavioral health services for the tens of
thousands of children and adolescents served by SBHCs annually (NOTE: Type 56 SBHCs are SBHCs who
are sponsored by an organization other than an FQHC. Type 56 SBHCs’ sponsoring organizations can include but are not limited to hospitals, school districts, local public health departments, and community based organizations).

4.2 – Infant/early childhood mental health consultation

- We would like to commend the Administration for including infant and early childhood mental health consultation (I/ECMHC) as one of four initiatives to be pursued through the 1115 Waiver. The recognition of the importance of early childhood mental health by Administration leaders will continue to allow children to begin life with the best start possible. Indeed, Illinois has been a national leader when it comes to emphasizing early childhood mental health. Illinois has a relatively long history of investing in I/ECMHC in various systems, though we have yet to take I/ECMHC to scale, as indicated in the Waiver application. Due to Illinois’ pioneering work in this field, a foundation for I/ECMHC has been firmly established in some systems, creating a prime opportunity within this demonstration to create an infrastructure that will continue to support this effective intervention. The Waiver application highlighted the use of I/ECMHC within evidenced-based home visiting (EBHV) programs as a successful intervention; however, it should be noted that I/ECMHC has had strong utilization in other early care and education environments throughout the State for many years. While I/ECMHC is a component within EBHV, the two should not be mistaken as the same intervention. We appreciate that Medicaid funding will not supplant existing funding streams (state, federal, and private), but will be an enhancement to these investments, allowing for greater depth and reach, particularly in underserved communities. For this approach to be successful, it is essential that cross-agency collaboration continues, including detailed discussions on plans for the sustainability of this initiative. Additionally, we encourage the Administration to use this opportunity to systemically address the need for a qualified workforce to provide I/ECMHC services.

- To further the positive impact of infant/early childhood mental health consultation (and treatment), we encourage and recommend the state consider the mother’s mental health, specifically when it comes to maternal depression, and how that impacts the healthy development of the child. To this end, we recommend the incorporation of Maternal Depression Screening and Treatment for mothers who are not or are no longer Medicaid eligible post-partum in the 1115 Waiver application. CMS encourages states to provide Maternal Depression Screening and Treatment for the care of both mother and child despite the mother’s Medicaid eligibility. Maternal depression has a negative impact on a child’s health and development. Currently, The Illinois Department of Healthcare and Family Services (HFS) covers perinatal depression screening when an approved screening instrument is used. If the postpartum depression screening (for the woman) occurs during a well-child visit or episodic visit for an infant (under age one) covered by HFS’ Medical Programs, the screening may be billed as a "risk assessment" under the infant’s Medicaid identification number. Alternatively, if the woman is postpartum and covered by HFS’ Medical Programs, the postpartum depression screening may be billed under the woman's identification number. Diagnostic and treatment services directed solely at the mother would be coverable under the Medicaid program only if the mother is Medicaid eligible.
The 1115 waiver process presents an opportunity to expand treatment services for both mother and child. Mothers who are not Medicaid eligible should receive benefits from diagnostic and treatment services directed at treating the health and well-being of the child (such as family therapy services) to reduce or treat the effects of the mother’s condition on the child. Consistent with current policy regarding services provided for the “direct benefit of the child,” such diagnostic and treatment services would actively involve the child, be directly related to the needs of the child and such treatment would be delivered to the child and mother together, but can be claimed as a direct service for the child. Such services would be coverable under one or more section 1905(a) benefit categories such as rehabilitative services or other licensed practitioner services.

4.3 – Workforce initiatives

Training and learning collaboratives to support community providers in working with MCOs is insufficient. Financial resources to assist organizations in acquiring and installing needed IT and billing systems is needed.

- Telemedicine infrastructure should consider ways to leverage the technology to help individuals who are hard to serve due to their behavioral health conditions and not just focus on health professional shortage information.
- Allow APNs to practice at the top of their license and consider reforms to increase their scope of practice.
- We recommend the Administration include stronger language around the plans to develop a workforce capable of addressing the specific needs of children and youth. We often hear that access to services appropriate for children and youth is lacking due to gaps in the workforce. We ask the Administration to clearly highlight the need for more mental health professionals able to address the unique needs of children and youth in the Waiver, and include strategies for investment for these disciplines.

Stakeholder engagement and public notice

Section 7 – The stakeholder community and the public appreciates the opportunities the state has provided to provide comment and input on the waiver process. We urge the state to continue and expand upon these opportunities after the waiver is submitted and implementation begins.

We again appreciate the opportunity to comment on this potentially system-changing endeavor. EverThrive IL staff is available to discuss these comments and recommendations further and we look forward to continued conversations as the 1115 Waiver application process unfolds.

Sincerely,

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