

February 11, 2019

Christopher Gange
Acting General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield, IL 62763-0002

Dear Mr. Gange:

On behalf of the Illinois Health and Hospital Association's (IHA's) more than 200 member hospitals and nearly 50 health systems, I am writing to provide comments on the [notice of proposed amendments](#) to Specialized Health Care Delivery Systems published on December 28 in the Illinois Register (89 Ill. Adm. Code 146, pp. 24603-24628). Overall, 112 IHA members provide inpatient and outpatient mental health treatment; 85 provide inpatient and/or residential services and 10 are dedicated, freestanding psychiatric hospitals. Approximately 80 hospitals already provide outpatient mental health treatment, including flexible partial hospitalization services.

The amendment presents the demonstration pilot services contained in the 1115 Demonstration Waiver [approved by](#) the federal Centers for Medicare & Medicaid Services (CMS) on May 7, 2018 to initiate a comprehensive strategy to combat substance use disorder. These services have great potential to improve access to and coordination between healthcare providers along the care continuum, if implemented appropriately. Investment in mental health must be prioritized to overcome provider shortages, inadequate payment and the insufficient number of acute inpatient beds and outpatient services.

The following comments on the proposed rules center on the crisis intervention services, due to the opportunity for service access to prevent or ameliorate a crisis and reduce acute symptoms of mental illness by providing continuous observation and supervision for patients who do not require inpatient services. Furthermore, mental health-related emergency department (ED) visits can cost up to 50 percent more than other ED visits. Enhancing hospital eligibility for services like mobile crisis units and crisis intervention services will reduce boarding in the ED, while improving clinical transitions and health outcomes.

However, the existing service was designed without discussion with hospital providers and does not reflect how hospitals would deliver crisis stabilization unit services based on acuity and medical necessity. The proposal also does not reflect discussions held with stakeholders in past 1115 Waiver Advisory Council meetings. In order to maximize the federal 1115 Waiver funding,

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we recommend relaxing some of the crisis requirements that may not result in a financially sustainable model for providers and could result in delayed, substandard care for patients. We also recommend delaying these rules in order to incorporate formal discussion with experts that work in hospitals and acute care settings to better understand how crisis intervention services based in an acute care setting should be designed and reimbursed.

There are several components important to the hospital and health system community. In particular, IHA supports:

- 1) Safeguarding a maximum threshold of utilization controls that could be specified for crisis intervention services, while reducing the proposed controls to ensure services intended to begin treatment as soon as possible.
 - If a threshold is not set for maximum utilization control on this higher acuity service, managed care organizations will have flexibility to create unnecessary prior approval steps, resulting in delayed care for a service intended for delivery in the first 24 hours a patient enters a hospital. This will likely result in denied services that have already been provided in alignment with medical necessity criteria.
 - Similarly, the existing proposed requirements include referral to the Crisis and Referral Entry Service (CARES) hotline, screening by a Mobile Crisis Response (MCR) provider and completion of a Crisis Safety Plan. These service approval requirements are more lengthy and stringent than those required for higher acuity inpatient services. This could delay needed services unnecessarily, especially as MCR services can sometimes take 90 minutes or more. One of the core principles of a crisis intervention service is to avoid the ED (if possible) and start treatment as soon as possible.
- 2) The service model proposed is a community outpatient model similar to a living room, including services delivered only by mental health professionals. There is significant benefit to integrating medical and behavioral health in this acute service, and delivery should incorporate nursing and psychiatry to include that medical perspective. Based on an analysis by an existing hospital-based crisis stabilization unit in Illinois, the existing array of services proposed for the intervention does not reflect the services that may be delivered in that setting. For these reasons, we recommend a delay in implementation to accommodate discussion with experts in these acute care settings that have experience with acute crisis stabilization.
- 3) Maximizing federal funding by negotiating with federal CMS to delay the first annual programmatic period to follow the finalization of rules and actual implementation. The first annual period is currently stated as beginning January 1, 2019, which has already passed and would result in less time for providers to prepare for program implementation and less time for access to this service for patients.

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Again, thank you for your interest in increasing access to Medicaid-covered services, reducing administrative barriers to enhance service delivery, and advancing the integration of medical and behavioral healthcare. If you have any questions or comments, please contact me at pgallagher@team-iha.org or 630-276-5496, or Lia Daniels at ldaniels@team-iha.org or 630-276-5461.

Sincerely,

Patrick Gallagher
Senior Vice President, Health Policy and Finance

cc: Theresa Eagleson, HFS
Lia Daniels, IHA