March 10, 2014

Theresa Eagleson, Administrator
Division of Medical Programs
Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62794
Via email: hfs.bpra@illinois.gov

Re: 1115 Waiver Final Application for Illinois Medicaid

Dear Ms. Eagleson:

We write today to submit comments regarding the 1115 Waiver Final Application for Illinois Medicaid. These comments follow-up and elaborate on the first two sets of comments we submitted on the 1115 Waiver Concept Paper in November, 2013 and the 1115 Waiver Draft Application in January, 2014.

Heartland Alliance for Human Needs & Human Rights is a service-based human rights organization focused on investments in and solutions for the most vulnerable men, women and children in our society. Through a network of dozens of direct service programs located throughout the Chicago-area, Heartland Alliance provides housing, health care, jobs, and justice services and supports to hundreds of thousands of people each year. We are a health care provider to vulnerable populations, operating federally qualified health centers (FQHCs), a healthcare for the homeless program, and several health clinics and school-based health centers in Chicago as well as community-based treatment and prevention programs. We provide primary health care, oral health care, and a full range of mental health and addictions treatment services and prevention programs to people who are homeless, as well as to refugees and immigrants and other vulnerable populations. Based on this work, our organizational experience is that of a health care provider that bills public as well as private insurance, a housing and human service provider, and as an advocate for the vulnerable populations we serve.

As a multi-faceted health, housing, and human service provider, we see first-hand the needless hospitalizations, emergency room visits, or repeated tests that result from the existing patchwork of health, housing, and human services available to vulnerable populations. We commend the team developing the 1115 Waiver for working to craft a plan that recognizes the variety of health care needs of people who benefit from

Medicaid coverage in Illinois, including the social determinants of health, and for also recognizing that a robust network of community services, often outside those traditionally associated with health care, are vital to creating a healthier state.

As negotiations begin between the State and the Centers for Medicare and Medicaid Services (CMS) regarding the 1115 Waiver application, we ask that the following be considered:

Pathway 1: Delivery System Transformation

The supportive housing, human service, and behavioral health sectors will be key components of successfully transforming the health care delivery system. Community-based providers in these sectors are already connected with the most vulnerable people in Illinois and have developed the skills, outreach, and tools that allow them to work with people who may not otherwise connect with health care or the government. Providers in these sectors know how to engage those who are the hardest to serve.

As the health care delivery system transforms and the state works to accomplish its goal of addressing the social determinants of health and the impact of poverty on individual and population health, it is crucial that community-based providers and networks of care, including supportive housing, human service, and behavioral health providers, be given the tools and the federal and state financial investments they need to adapt and grow.

Similar to the financial investments and flexibility being proposed in the 1115 Waiver Application for large public health and hospital systems and traditional Managed Care Organizations, community-based providers and provider-led networks of care, including supportive housing, human service, and behavioral health providers, as well as Care Coordination Entities (CCEs) and Accountable Care Entities (ACEs), need strategic financial investments from the state and federal government and flexibility to experiment and propose pilot projects in order to fully participate and support the transformation of the Illinois Medicaid program and achieve the triple aim of better health, improved care, and reduced costs. For example, allowing, encouraging and financially supporting CCEs to propose pilot projects that take advantage of medical respite for certain, vulnerable populations (e.g. homeless, justice-involved) (pg. 19), address food insecurity for the populations

within their networks (pg. 19), and be eligible for payments from incentive pools to invest in stable housing (pg. 45) are three examples of expanding financial and technical support as well as flexibility from the state and federal government to more than just our large public health and hospital systems and traditional Managed Care Organizations.

In addition, we ask the state of Illinois and CMS to consider the creation of an incentive pool to help fund Medicaid co-pays (for primary and behavioral health visits as well as for medications) for those Medicaid recipients struggling with the dire negative impact of living in or near poverty as well as the impact of social determinants of health. A CCE's ability to access such a "Medicaid Copays Incentive Pool" can very positively impact the level and consistency of engagement in care of its members.

Pathway 3: Workforce

We commend the state on including increased resources, including loan repayment, training and Graduate Medical Education, to build the healthcare workforce necessary to meet the needs of the growing Medicaid population. We also commend the state on its explicit focus to ensure that all health care workers are paid at a living wage. We urge the state to continue to consider the existing network of safety net and community based providers already serving this population and make sure that they are included in any coordinated care, managed care, or integrated delivery systems in order to ensure continued access to this experienced workforce. We encourage the state to look at other types of incentives that could be used to build and retain a workforce of paraprofessionals that provide the types of wraparound services which support health outcomes. We also encourage the state to be as open as allowed by federal and state law and appropriately take into account patient safety to allowing persons with conviction records to join the health care work force and take advantage of assistance or incentives available to those without conviction records.

We also support and commend the state on its focus on the development and investment in Community-Health Workers (CHWs). This workforce is critical to the success of the outreach and engagement part of care and therefore to the overall health and well-being of the Medicaid recipient. Training, support and a clear path to reimbursement, both within a Fee-For-Service system and Medicaid

managed/coordinated/integrated care will be critical to the success of utilizing Community Health Workers in Illinois' Medicaid program. However, it will also be critical that the certification process for CHWs (e.g. classes, prerequisites) should not be the only means of "showing competence" for current and future CHWs, as this may inadvertently end up acting as a barrier for the successful use and expansion of the CHW program in Illinois.

Lastly, the draft 1115 Waiver application seems to indicate that the state's loan repayment program, currently unfunded but which will be funded through the 1115 Waiver, may be broadened to include other professions such as social workers and other professionals. We hope the state will consider including behavioral health professionals in this group as it is very difficult to train and retain staff in the community behavioral health arena. A state loan repayment program would make it more attractive for these professionals to stay with non-profit community providers.

Pathway 4: Home and Community Based Infrastructure, Coordination and Choice

Since the process of development of the Universal Assessment Tool (UAT) has been ongoing throughout the Balancing Incentive Program (BIP), we urge the state to continue to include additional measures and assessments designed to understand an individual's needs specifically for behavioral health, housing, and human services in the UAT. We also encourage the Illinois Department of Healthcare and Family Services (HFS) to open up the UAT draft creation process and work group to additional stakeholders including behavioral health, human service, and housing providers, advocates, and consumers. The current HCBS waivers in Illinois have not traditionally provided an expansive and flexible array of services to address the social determinants of health – which is one of the stated reasons to create an 1115 waiver and to use a uniform method for determining the needs of the population and the flexibility to use Medicaid funding to provide the targeted services that can improve health outcomes. Given that the state has not traditionally provided extensive and flexible behavioral health, supportive housing, case management, and employment supports as a part of the Medicaid program, care will be needed to ensure that these supportive services are included in the design and implementation of the 1115 waiver in an appropriate manner.

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As related to coordinated care, we commend the State on the multi-year effort to move Medicaid recipients into coordinated care programs, including health homes, in order to improve health outcomes and reduce unnecessary emergency care and cost. To that end, we recommend that incentivizes be provided for the entire system to provide flexible services, not only for managed care plans (e.g. MCOs and MCCNs). We recommend that the state support, incentivize, and encourage all providers and networks of care, including CCEs and ACEs, to provide flexible support services that improve health outcomes and reduce costs, even if these services are provided outside of traditional, capitated managed care (e.g. MCOs and MCCNs).

We also believe that there is a continuing role for case management, behavioral health, permanent supportive housing and other support services which will continue to have a need to be paid through state-only line items within the state budget, state grants, and/or fee-for-service funds, at least during the transition to managed, coordinated, and integrated care. In the transition, we recommend that the state proceed carefully so as not to disrupt current access, care patterns, provider-patient relationships, or vital community and safety net supports. In particular, permanent supportive housing, supports provided through numerous human services, and care coordination are vital to this population and to ensure stable health.

As related to Costs Not Otherwise Matchable (CNOM), we continue to encourage the state to ensure the inclusion of a broad variety of services in the 1115 Waiver application, including housing/tenancy supports, wellness and prevention services, food and nutrition services, all levels of case management, violence recovery services, supportive services and supported employment, outreach and engagement services, transportation, and medical respite.

In addition, while interpretive services and adult dental services are matched by Federal Medicaid dollars, Illinois has chosen not to take advantage of these Federal Medicaid match dollars and provide these two services currently. In order to provide holistic, comprehensive healthcare services and reduce costs, especially within a managed/coordinated/integrated care environment, access to adult dental services is critical. While the state legislature debates the restoration of the adult dental program in Illinois Medicaid, we encourage the Governor's office to factor-in the restoration of adult dental services to Illinois Medicaid in the 1115 Waiver

application. Factoring in access to vital dental services for all adults on Medicaid may provide the state legislature a clearer sense of the lost federal dollars and impact on total cost of other services within Illinois Medicaid when adult dental services are not covered.

As related to ACT and CST teams, we commend the state for the focus within the 1115 Waiver Draft Application on increased investment in ACT and CST services across the state. These evidence-based practices are proven to help individuals recover and manage other chronic medical conditions as well as stay out of hospitals and institutional settings. This investment, combined with an investment in affordable, supportive housing, is necessary to reverse the expensive and inappropriate trend to institutionalize people with SMI in Illinois.

Lastly, we urge the State to reconsider the request to waive the IMD exclusion for SMHRFs. The IMD exclusion was put in place because the federal government does not want to support a public policy of institutionalizing individuals living with a mental illness in nursing homes. SMHRFs remain institutional settings and the state does not need nearly as many SMHRF beds as we have in existence today. The passage of the SMHRF Act has not changed this. Becoming recovery-oriented facilities and encouraging individuals to move back to community-based living will be an enormous philosophical, cultural and treatment shift for the SMHRFs and will take time for the ones who are committed to the change in mission. Moreover, some SMHRFs may not reform. If Illinois policymakers are truly committed to rebalancing the state's mental health safety-net in favor of increased access to community-based treatment services and housing in the community, as the 1115 Waiver application states, the state must close many SMHRF and nursing home beds for people with SMI as the state invests in ACT, CST and affordable housing. Waiving the IMD exclusion to get federal match for SMHRFs will make it next to impossible for the state to close the facilities that do not reform and take beds off-line.

Cost Sharing

In Section V Cost Sharing Aggregate Limits, the State proposes to waive consumer protections for the imposition of cost sharing on Medicaid recipients until such time as the State can improve its computer system to track these costs. (pp. 46-47) We object to any waiver of these provisions. The federal law is designed to

inform consumers when they have reached their cost-sharing maximums and to protect consumers from providers who charge co-payments beyond maximum limits allowed. If the State does not have the capacity to track and inform consumers when they have reached these limits, then the state should not impose co-payments until that capacity is acquired. Beneficiaries do not have the means to track these costs on their own and federal law puts the burden on the State for that reason. To expect Medicaid recipients to be aware of their own out of pocket maximums which must be individually calculated based on a percentage of their family income; to track their co-payments until they reach that limit; and then to affirmatively inform their medical providers that they can no longer be charged is unrealistic and burdensome. Cost sharing has a chilling effect on consumers causing delays in necessary care because of fear and embarrassment over failure to be able to pay co-pays. See generally Families USA Fact Sheet citing the Rand Health Study, http://familiesusa.org/sites/default/files/product_documents/Cost-Sharing-in-Medicaid.pdf and http://www.cbpp.org/cms/index.cfm?fa=view&id=1938. The State should meet its burden to ensure that recipients know when their share is paid and they are no longer responsible to pay more.

In addition, in Section V Cost Sharing Non-Emergency Services Furnished in an Emergency Department, the State proposes to waive the requirement that it can only impose cost sharing on the use of an emergency department for non-emergency services if the hospital informs the patient of alternative care opportunities and refers the patient to a non-emergency setting where they would not have to pay a co-payment. This federal provision is intended to transition Medicaid patients who use the emergency room to receive non-emergency care to a community-based provider who could provide the same care in a non-emergency setting. Without these notice and referral procedures, Medicaid recipients who use the emergency room because they do not have access to or do not know of a non-emergency provider who they can go to are instead punished by being charged a co-payment without any assistance to find appropriate care. This is completely in opposition to Illinois' stated goals in this waiver proposal to improve health outcomes and reduce unnecessary costs by transitioning Medicaid populations into more appropriate coordinated primary care.

Lastly, CMS has denied other states' waiver requests which included increased cost-sharing under an 1115 Waiver Proposal. Illinois already imposes cost sharing and should not be allowed to further burden Medicaid recipients under an 1115 Waiver by eliminating consumer notice, referral and tracking provisions. See http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf.

General Comments

As in our 1115 Waiver Concept Paper as well as our 1115 Waiver Draft Application comments, we would like to remind the State that not all low-income individuals in the state will participate in the Medicaid program, and that there will be unmet needs throughout the state even after the transformation of our health care system. While Heartland Alliance urges that the broadest number of services be included as CNOM in the 1115 waiver application, we also ask that the state remain mindful that the 1115 waiver be constructed in such a way that recognizes that not all CNOM service dollars should be rolled over into the Medicaid program. For the foreseeable future, a portion of funds for all CNOM services must remain available for people not eligible or enrolled in Medicaid in order to ensure that vulnerable Illinoisans do not fall through the cracks.

Finally, we strongly encourage the state to include all interested stakeholders in the waiver application process once the 1115 Waiver application is submitted to CMS and the state begins the negotiation process with CMS on the 1115 Waiver details. The state's proposed 1115 waiver is an enormous undertaking, and providers, advocates and consumers should be very involved in something as big and transformational to the Medicaid program as this. Thank you again for the opportunity to comment on the final 1115 Waiver application.

Sincerely,

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