TASC | Administrative Offices • 1500 North Halsted • Chicago, IL 60642
(312) 787-0208 • (312) 787-9663 fax • www.tasc.org

Comments on Illinois' 1115 Waiver Concept Paper
Submitted by Pamela F. Rodriguez, TASC President, November 22, 2013

Thank you for the opportunity to submit comments on Illinois' 1115 Waiver concept paper draft. We commend the State's leadership in its initiative to redesign the State's healthcare delivery systems to bring about a more integrated, rational, and efficient approach that will improve health outcomes and spend State and federal resources wisely.

Since 1976, TASC has engaged in care management, designing and administering numerous programs that connect courts, jails, and prisons with supervised community-based drug treatment and recovery support services. Across Illinois, TASC provides case management, monitoring, and referral to drug and mental health treatment services. We work with criminal courts and probation departments throughout Illinois to facilitate cost-effective treatment alternatives to prison for individuals with non-violent felony offenses. Similarly, we provide services to inmates and parolees leaving prison who are returning home to their communities, with a goal of reducing the costly cycle of re-offense, recidivism, and re-incarceration.

Because of our experience and expertise, we are particularly interested in ***the assurance of accessible community-based services for individuals with substance use disorders,*** with the understanding that they often also need mental and medical health services. We offer the following recommendations to inform the State's 1115 Medicaid Waiver concept paper:

1) **References in the concept paper related to "behavioral health" services should *explicitly* include substance use services.** *[Category: General Comments]*

The term "behavioral health" is not universally perceived. At times, it encompasses mental health *and* substance use problems, and at others mental health issues alone. This ambiguity muddles the fact that clinical differences between substance use and mental health conditions often require distinct clinical and supportive remedies and treatments, and the concept paper perpetuates such ambiguity. For example, on page 3, the section describing budget cuts includes general revenue funding (GRF) reductions to mental health services but excludes the parallel and significant reductions to addiction treatment services – GRF for addiction treatment services were cut by 41 percent ($45 million dollars) between FY09 and FY14.

Articulating explicitly the current need for substance use services is not merely an issue of semantics, but rather a foundational point driving behavioral health care delivery reform as part of a new integrated healthcare system in Illinois, one that aims to holistically approach individuals' health needs and bend the cost curve associated with providing care for the most expensive among them.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 14.2 percent of ACA adults – 71,000 individuals in Illinois – will have substance use disorders. Included in this group are people with *severe* substance use disorders, who will be among the highest-need and highest-cost members, which will be worsened if their substance use conditions are not treated appropriately. Appropriately treating the health conditions of this population brings not only the potential to improve health and related outcomes, but also to result in significant cost savings to State and county correctional systems, given that half of those in prison and two-thirds in jail have diagnosable substance use disorders (compared to less than 10 percent in the general population).

If the State expects to "produce the desired health outcomes – while bending the cost curve" for the most expensive clients, a goal we fully support, it is critical that the full spectrum of behavioral health needs of the population – including substance use disorders – be well understood.

2) The full spectrum of services clinically necessary and appropriate to treat and support individuals with substance use disorders – including substance use case management – should be included in the State's Medicaid program. *[Categories: General Comments AND Pathway #1]*

This recommendation is in alignment with recommendations we are offering to the Illinois Department of Healthcare and Family Services (HFS) in response to their invitation for comments on the State's Alternative Benefits Plan (ABP) for the newly eligible ACA adult population.

The July 2013 ruling from the federal Centers for Medicare and Medicaid Services (CMS) makes access to long-term supports and services (LTSS) for the "medically frail" ACA adult population an entitlement, at enhanced matching rates (100 percent, decreasing to 90 percent by 2020). Medical frailty has not yet been defined by HFS, but Director Hamos has indicated that, clinically speaking, it falls short of disability. We are providing recommendations to HFS about: 1) how to define this group with regard to substance use disorders using the latest diagnostic criteria from the behavioral health field (i.e., individuals whose clinical substance use disorder diagnosis meets "severe" criteria), and 2) which LTSS services are

clinically necessary and appropriate for this group. ***Please see the attached table, which includes more information about the definition of "medically frail" and diagnostic criteria relevant for individuals with substance use disorders, a definition and clinical justification for each recommended LTSS service for this population, and examples of such services.***

Among these services is case management. Because a significant portion of ACA adults have complex substance use and mental health disorders, case management – not only that which supports mental health treatment but also substance use disorder treatment – is a critical part of an integrated healthcare system. ***Within the array of behavioral health service benefits available, the State's current Medicaid plan provides reimbursement only for case management services that support mental health treatment, but not for those that support substance use disorder treatment.***

Besides violating principle and law related to parity – case management services related to behavioral health disorders must be available on par with those related to medical disorders – this policy will fall short of achieving desired outcomes and bending the cost curve. Substance use case management is instrumental in increasing the likelihood of success in completing treatment through assessment, planning, coordination, and advocacy for each individual, and in engaging other medical and social services available to them to realize their engagement in addiction recovery in the community. Case management's effectiveness and value is well-recognized, as evidenced by inclusion in SAMHSA's National Registry of Evidence-based Programs and Practices, and SAMHSA has issued a Treatment Improvement Protocol (TIP #27) recognizing case management as a best practice guideline.

To meet the State's goals, the full spectrum of services clinically necessary and appropriate to treat and support individuals with substance use disorders, including case management, should be available to those for whom they are clinically indicated, through whatever mechanism best achieves it – within the ABP for ACA adults as LTSS services, or as costs not otherwise matchable (CNOMs) in the 1115 waiver application.

Thank you again for the opportunity to submit comments. Please feel free to contact me.

Pamela F. Rodriguez
President | TASC, Inc.
1500 N. Halsted | Chicago, IL 60642
(312) 573-8372 | prodriguez@tasc-il.org