



101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB2486

by Rep. Deb Conroy

SYNOPSIS AS INTRODUCED:

New Act

Creates the Mental Health Modernization and Access Improvement Act. Requires the Department of Healthcare and Family Services to apply for a Medicaid waiver or State Plan amendment, or both, within 6 months after the effective date of the Act to develop and implement a regulatory framework that allows, incentivizes, and fosters payment reform models for all Medicaid community mental health services provided by community mental health centers or behavioral health clinics. Requires the regulatory framework to: (i) allow for and incentivize service innovation that is aimed at producing the best health outcomes for Medicaid enrollees with mental health conditions; (ii) reward high-quality care through annual incentive payments to community mental health centers and behavioral health clinics; (iii) require community mental health centers and behavioral health clinics to report on specified quality and outcomes metrics; and other matters. Provides that all documentation and reporting requirements under the regulatory framework must comply with the federal Mental Health Parity and Addiction Equity Act of 2008 and the State mental health parity requirements under the Illinois Insurance Code. Contains provisions concerning quality and outcomes metrics reporting; data sharing; the establishment of a Stakeholder Quality and Outcomes Metrics Development Working Group; statewide in-person trainings to ensure provider readiness for the regulatory framework; quality and patient safety protections; implementation timeline; certification of community mental health centers that opt into the regulatory framework; and other matters. Provides that the Act shall be implemented upon federal approval and only to the extent that federal financial participation is available. Effective immediately.

LRB101 04928 KTG 53067 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning mental health.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 1. Short title. This Act may be cited as the Mental
5 Health Modernization and Access Improvement Act.

6 Section 5. Findings. The General Assembly finds as follows:

7 (1) Insufficient access to mental health care in
8 Illinois has led to numerous consent decrees, children
9 remaining in psychiatric hospitals beyond medical
10 necessity, custody relinquishment to get treatment, and
11 growing suicide rates. These major problems are direct
12 consequences of: (i) a State regulatory structure for
13 mental health services that does not allow for or align
14 with payment for outcomes, integration, or care delivery
15 innovation; and (ii) limited State investment in Medicaid
16 reimbursement rates for community mental health services.

17 (2) Illinois must align its regulatory framework for
18 community mental health services with the modern era of
19 health care delivery to enable and reward high-quality
20 health outcomes and to reduce costs, and must also reform
21 payment rates to allow for service growth and increased
22 participation of psychiatrists and other mental health
23 professionals in the State's Medicaid program.

1 (3) The existing regulatory framework for Medicaid
2 mental health services is fee-for-service, even under
3 managed care. Nearly all Medicaid managed care contracts
4 with mental health providers are fee-for-service
5 contracts, rather than value-based contracts. This is due
6 largely to the fee-for-service regulatory framework for
7 mental health and an encounter-based Medicaid system that
8 stymies payment reform.

9 (4) The existing mental health fee-for-service
10 framework: (i) impedes delivery of care that produces the
11 best health outcomes and reduces unnecessary costs; (ii)
12 allows for no innovation; (iii) disincentivizes care
13 coordination and integration; and (iv) prevents the growth
14 of psychiatry and team-based treatment models that could
15 improve access to care.

16 (5) Pay-for-performance and value-based payment models
17 that provide financial incentives to providers for
18 achieving defined quality and outcomes metrics have shown
19 early evidence of producing better health outcomes and
20 reduced Medicaid costs.

21 (6) A value-based payment model for community mental
22 health care delivery will dovetail and further the
23 value-based payment model for care coordination and
24 integration being implemented through integrated health
25 homes.

26 (7) To modernize mental health service delivery,

1 Illinois must develop a regulatory framework for mental
2 health services that allows for and encourages payment
3 reform consistent with the framework established by the
4 U.S. Department of Health and Human Services' Health Care
5 Payment Learning and Action Network (LAN) Alternative
6 Payment Model (such as incentive payments linked to quality
7 and outcomes metrics, shared savings, and bundled payment
8 models) combined with reimbursement rates that enable
9 service growth to meet Illinois' mental health treatment
10 needs. The payment reform models developed shall work with
11 both managed and unmanaged Medicaid.

12 Section 10. Community mental health payment reform model.

13 (a) Regulatory framework for community mental health
14 providers. To move away from the antiquated fee-for-service
15 payment model for community mental health services and to
16 foster increased access to high-quality care, particularly for
17 services for individuals with serious mental health
18 conditions, the Department of Healthcare and Family Services,
19 as the sole Medicaid State agency, in partnership with the
20 Department of Human Services' Division of Mental Health, and
21 with meaningful stakeholder involvement, shall apply for a
22 Medicaid waiver or State Plan amendment, or both, within 6
23 months after the effective date of this Act to develop and
24 implement a regulatory framework that allows, incentivizes,
25 and fosters payment reform models for all community mental

1 health services provided by community mental health centers
2 licensed or certified by the Division of Mental Health and for
3 behavioral health clinics established under 89 Ill. Adm. Code
4 140. Such payment reform models shall be consistent with the
5 Health Care Payment Learning and Action Network Alternative
6 Payment Model framework developed by the U.S. Department of
7 Health and Human Services. Upon federal approval, and the
8 adoption of rules to implement this Act, all community mental
9 health services provided by community mental health centers or
10 behavioral health clinics shall be subject to the regulatory
11 framework for providers that opt in. Providers that do not opt
12 in shall be governed by the existing administrative rules for
13 community mental health services. Community mental health
14 centers and behavioral health clinics that opt into the
15 regulatory framework shall be given the opportunity to opt out
16 every 2 years. Community mental health centers and behavioral
17 health clinics that do not opt in shall be given the
18 opportunity to opt in annually. This Act shall be implemented
19 only to the extent that federal approval is granted and federal
20 financial participation is available.

21 (b) Incentivizing service innovation. The regulatory
22 framework established under this Act shall allow for and
23 incentivize service innovation, enabled through service and
24 workforce flexibility, consistent with all scope of practice
25 laws for all mental health professionals, that is aimed at
26 producing the best health outcomes for Medicaid enrollees with

1 mental health conditions and combined with reporting quality
2 and outcomes metrics. The regulatory framework shall reward
3 high-quality care through annual incentive payments to
4 community mental health centers and behavioral health clinics
5 participating in the regulatory framework.

6 (c) Mental health professionals; practice. To address
7 Illinois' mental health workforce challenges, the regulatory
8 framework shall allow mental health professionals to practice
9 at the top of their qualifications and the regulatory framework
10 shall not restrict this ability (such as maximum use of advance
11 practice nurses with a psychiatric specialty, maximum use of
12 mental health professionals with a bachelor's degree, maximum
13 use of licensed clinicians, and maximum use of persons with
14 lived experience) enabling staffing flexibility that reflects
15 the local workforce, particularly for team-based treatment
16 models. All workforce requirements established pursuant to
17 this regulatory framework shall comply with and be consistent
18 with all scope of practice laws for all mental health
19 professionals. In developing minimum staffing requirements
20 within the regulatory framework, the Department of Healthcare
21 and Family Services shall take into account the inability of
22 community mental health centers and behavioral health clinics
23 to hire and retain certain mental health professionals in
24 workforce shortage areas across the State and the effect this
25 has on restricting access to care, while recognizing the full
26 value of mental health professionals not currently relied upon

1 or permitted in certain roles or to fulfill certain functions
2 (such as mental health professionals with a bachelor's degree,
3 advanced practice registered nurses with a psychiatric
4 specialty, licensed clinicians, and persons with lived
5 experience who are not certified recovery support specialists)
6 and shall maximize the use of telehealth and telepsychiatry.

7 (d) Provider outreach and engagement. To address the need
8 to encourage Medicaid enrollees with the most serious mental
9 illnesses to participate in treatment, the regulatory
10 framework shall allow for and incentivize significant provider
11 outreach and engagement for individuals with serious mental
12 illnesses who are often homeless, difficult to reach, and the
13 hardest to connect to treatment. The regulatory framework shall
14 also take into account the significant distances providers
15 employing team-based treatment models must travel to
16 effectively engage and treat such individuals.

17 (e) Quality and outcomes metrics. To ensure high-quality
18 care, patient satisfaction, and patient safety, the regulatory
19 framework shall require community mental health centers and
20 behavioral health clinics opting into the regulatory framework
21 to report on specified quality and outcomes metrics that shall
22 be used to determine eligibility for an annual incentive
23 payment. The quality and outcomes metrics established by the
24 Department of Healthcare and Family Services shall be done in
25 accordance with Section 15. Eligibility for an incentive
26 payment is addressed in Section 25. Section 30 sets out the

1 consequences for community mental health centers and
2 behavioral health clinics participating in the framework that
3 do not meet a minimum level of quality and outcomes metrics.

4 (f) Mental health parity compliance. Provider utilization
5 management processes, prior authorizations, assessment and
6 treatment plan reviews and updates, and all related
7 documentation and reporting required through the regulatory
8 framework shall be in compliance with the federal Mental Health
9 Parity and Addiction Equity Act of 2008 and the State mental
10 health parity requirements set forth in Section 370c of the
11 Illinois Insurance Code. The Department of Healthcare and
12 Family Services shall not require more onerous processes for
13 mental health treatment, treatment plans, assessments, or the
14 frequency of provider reviews or updates of assessments and
15 treatment plans, and related reporting or documentation than
16 the processes the State imposes on treatment providers of other
17 similar chronic medical conditions (such as providers treating
18 diabetes or heart disease). More onerous requirements for
19 access to treatment, treatment plan reviews and updates,
20 utilization management processes, prior authorization
21 requirements or documentation, and reporting requirements for
22 mental health conditions compared to those requirements for
23 other similar chronic medical conditions can be construed as
24 non-quantitative treatment limitations, which would be a
25 violation of the federal Mental Health Parity and Addiction
26 Equity Act of 2008 and Section 370c of the Illinois Insurance

1 Code. To ensure and demonstrate to the General Assembly that
2 the regulatory framework complies with the federal Mental
3 Health Parity and Addiction Equity Act of 2008 and Section 370c
4 of the Illinois Insurance Code, upon the date the Department of
5 Healthcare and Family Services submits to the Joint Committee
6 on Administrative Rules its proposed rule to implement this
7 Act, as provided in Section 40, the Department shall also
8 submit to the Joint Committee on Administrative Rules a
9 detailed analysis demonstrating that the provider utilization
10 management requirements, assessment or treatment planning
11 frequency, and related documentation and reporting
12 requirements imposed under the regulatory framework are no more
13 onerous for mental health treatment than the requirements the
14 State imposes on treatment providers of other comparable
15 chronic medical conditions.

16 (g) Managed care contracts. The regulatory framework shall
17 align with the ability of community mental health centers and
18 behavioral health clinics to provide services through managed
19 care contracts linked to (i) quality and performance metrics
20 (LAN Category 2) or (ii) a shared savings or shared risk model
21 or bundled or episode-based payments with managed care
22 organizations (LAN Category 3), all of which require service
23 and workforce flexibility to achieve quality and outcomes
24 metrics. The documentation required by the State from community
25 mental health centers and behavioral health clinics for
26 services provided through these payment reform models through

1 managed care organization contracts shall not be duplicative or
2 inconsistent with these payment reform models, meaning that
3 State reporting and documentation requirements must align with
4 what is required through managed care so duplicative processes
5 or reporting are not required to the State and to managed care
6 organizations. The Department of Healthcare and Family
7 Services shall pay an annual incentive payment to community
8 mental health centers and behavioral health clinics that
9 achieve the State specified quality and mental health or health
10 outcomes metrics for enrollees in Medicaid managed care. The
11 incentive payment shall be in addition to the base Medicaid
12 reimbursement rate and any Medicaid rate add-on payments for
13 the specific service.

14 (h) Non-managed Medicaid services; community mental health
15 centers and behavioral health clinics. Because a large
16 percentage of Medicaid enrollees with serious mental health
17 conditions are dually eligible for Medicare and Medicaid and
18 therefore cannot be required to be in managed Medicaid under
19 federal law, the regulatory framework shall also apply to
20 non-managed Medicaid services delivered by community mental
21 health centers and behavioral health clinics. For the
22 non-managed Medicaid population, the payment model shall
23 reward services with an annual incentive payment paid by the
24 Department of Healthcare and Family Services to community
25 mental health centers and behavioral health clinics that
26 achieve specified quality and outcomes metrics. The incentive

1 payment shall be in addition to the base Medicaid reimbursement
2 rate and any Medicaid add-on payments for the specific service.
3 Shared risk or penalties shall not be a part of the regulatory
4 framework for non-managed Medicaid services.

5 Section 15. Quality and outcomes metrics reporting.

6 (a) Quality and outcomes metrics. The Department of
7 Healthcare and Family Services, in partnership with the
8 Department of Human Services' Division of Mental Health and
9 with meaningful stakeholder participation through the
10 establishment of a Stakeholder Quality and Outcomes Metrics
11 Development Working Group, shall establish or select (i)
12 metrics that community mental health centers and behavioral
13 health clinics opting into the regulatory framework must report
14 on annually to the Department of Healthcare and Family Services
15 upon implementation of this Act and (ii) metrics that determine
16 eligibility for an annual incentive payment.

17 (1) For guidance in adoption of the most appropriate
18 and feasible quality and outcomes metrics, the Department
19 of Healthcare and Family Services shall use the relevant
20 metrics it uses for Illinois Medicaid managed care
21 organizations and integrated health homes, as well as those
22 established or used by the National Committee for Quality
23 Assurance or the federal Certified Community Behavioral
24 Health Clinic pilot program. The Department of Healthcare
25 and Family Services shall establish 4 categories of

1 metrics:

2 (A) Quality metrics. Quality metrics are
3 claims-based and intended to be used to measure
4 business processes that lead to and support
5 high-quality care. The Department of Healthcare and
6 Family Services shall establish quality metrics, which
7 must include some of the relevant quality metrics the
8 Department of Healthcare and Family Services uses to
9 measure the performance of Medicaid managed care
10 organizations, by which to measure the quality of care
11 delivered by community mental health centers and
12 behavioral health clinics participating in the
13 regulatory framework. Annual reporting on quality
14 metrics shall begin in the first year after
15 implementation of this Act.

16 (B) Health outcomes metrics. Health outcomes
17 metrics are intended to measure improvement in health
18 outcomes across populations. These metrics must be
19 clinically relevant, feasible, and reliable. Any
20 health outcomes metrics established or used for
21 measuring mental and behavioral health outcomes for
22 community mental health centers and behavioral health
23 clinics participating in the regulatory framework
24 shall be claims-based, standard health outcome
25 measures. Annual reporting on claims-based standard
26 health outcomes metrics shall begin in the second full

1 calendar year after the implementation of this Act.

2 (C) Patient experience and patient satisfaction
3 metrics. The Department of Healthcare and Family
4 Services shall develop quality of life and patient
5 experience measures. Reporting on these metrics shall
6 begin in the second full calendar year after
7 implementation of this Act.

8 (D) Social determinants of health metrics. Social
9 determinants of health metrics take into account a
10 person's social factors and the physical condition of
11 the environment in which the person lives, works,
12 learns, plays, and ages. Measuring the social
13 determinants of health may include evaluating improved
14 housing status, reduced justice involvement, and
15 school, work, civic, or volunteer participation that
16 are a result of mental health treatment. The Department
17 of Healthcare and Family Services shall include at
18 least 2 social determinants of health metrics that are
19 reported to the State for purposes of this Act.
20 Reporting on these metrics shall begin in the third
21 full calendar year after implementation of this Act.

22 (E) Payment-for-performance metrics. The
23 Department of Healthcare and Family Services, with
24 meaningful stakeholder input through the Stakeholder
25 Quality and Outcomes Metrics Development Working
26 Group, shall select clinically relevant, feasible, and

1 reliable metrics that are claims-based metrics for
2 purposes of the payment-for-performance metrics. The
3 payment-for-performance metrics shall be used in
4 determining eligibility for an annual incentive
5 payment in year 3 of implementation of the regulatory
6 framework and every year thereafter. The Department of
7 Healthcare and Family Services shall use no more than 6
8 payment-for-performance metrics, including
9 sub-measures. To ensure provider certainty and
10 provider readiness to meet the payment-for-performance
11 metrics, payment-for-performance metrics shall be
12 established and shared with providers at least 6 months
13 prior to such metrics becoming operative and they shall
14 remain in effect for at least 2 years. Because the
15 payment-for-performance metrics will be a main driver
16 of provider behavior, the Department of Healthcare and
17 Family Services shall take into consideration what
18 metrics drive high-performing care that leads to
19 improved mental health symptom management over the
20 long term, as well as maintenance of recovery and
21 wellness for the individual. The Department of
22 Healthcare and Family Services shall ensure that the
23 payment-for-performance metrics it selects do not
24 result in providers serving those with the least severe
25 mental illnesses. The Department of Healthcare and
26 Family Services shall ensure that there are

1 payment-for-performance metrics that encourage and
2 reward providers that serve those with the most serious
3 mental illnesses. The metrics developed must be aimed
4 at measuring care delivery that leads to positive
5 mental health and health outcomes for the individual
6 but must also reflect that mental health recovery can
7 be a life-long process with periods of stabilization
8 and wellness, but also may include periods of illness
9 exacerbation (i.e., serious mental health conditions
10 are chronic medical conditions and recovery is not
11 linear or static).

12 (2) To ensure that providers and the State are not
13 overburdened by data tracking and reporting, no more than
14 20 metrics in total, including sub-metrics, shall be
15 established.

16 (3) The Department of Healthcare and Family Services,
17 in partnership with the Department of Human Services'
18 Division of Mental Health, shall develop a formula for how
19 the payment-for-performance metrics are weighted for
20 purposes of determining a community mental health clinic's
21 or a behavioral health clinic's eligibility for an annual
22 incentive payment.

23 (4) Solely for purposes of evaluating provider credit
24 for achieving the metrics outlined in this Section, the
25 Department of Healthcare and Family Services, with
26 meaningful input from the Stakeholder Quality and Outcomes

1 Metrics Development Working Group, shall determine a
2 minimum threshold of service provision any individual must
3 have received from a community mental health clinic or
4 behavioral health clinic participating in the regulatory
5 framework to include that individual's outcomes metrics in
6 that provider's total outcomes measurement.

7 (5) Given that the federal government and many states
8 are updating quality metrics for behavioral health as the
9 field modernizes, the Department of Healthcare and Family
10 Services may periodically update the metrics reported to
11 the State and the payment-for-performance metrics, but
12 only following meaningful input from stakeholders through
13 the Stakeholder Quality and Outcomes Metrics Development
14 Working Group on the value and feasibility of the new
15 metrics.

16 (6) Mental health parity compliance. The Department of
17 Healthcare and Family Services shall ensure that the
18 metrics established in accordance with this Act: (i) are in
19 compliance with the federal Mental Health Parity and
20 Addiction Equity Act and Section 370c of the Illinois
21 Insurance Code and (ii) do not result in a non-quantitative
22 treatment limitation.

23 (b) Data sharing. The State and Medicaid managed care
24 organizations shall be required to timely share claims and
25 encounter data with community mental health providers
26 participating in the regulatory framework for the individuals

1 for which the provider is serving to enable the provider to
2 evaluate and improve its own performance and to be able to
3 deliver care that results in the best mental health and overall
4 health outcomes. Data, including claims information,
5 utilization management data, and health outcomes measures,
6 shall be shared between the State and the community mental
7 health clinic or behavioral health clinic assigned to the
8 individual for purposes of metrics evaluation, and between the
9 managed care organization and the community mental health
10 clinic or behavioral health clinic assigned to the individual
11 for purposes of metrics evaluation in compliance with all
12 health information privacy laws. Standardized data elements,
13 reporting methods, and data systems shall be established across
14 managed care organizations and community mental health clinics
15 or behavioral health clinics to prevent unnecessary
16 development of different reporting systems for each managed
17 care organization.

18 (c) Stakeholder Quality and Outcomes Metrics Development
19 Working Group. The Department of Healthcare and Family
20 Services, in partnership with the Department of Human Services'
21 Division of Mental Health, shall establish and convene a
22 Stakeholder Quality and Outcomes Metrics Development Working
23 Group that includes mental health providers, advocates,
24 including persons with lived experience of a mental health
25 condition, and representatives from Medicaid managed care
26 organizations to (i) assist in the development of the metrics

1 that will be reported to the State in accordance with this
2 Section and (ii) assist with selecting the
3 payment-for-performance metrics. The Stakeholder Quality and
4 Outcomes Metrics Development Working Group shall be
5 established and convened at least once prior to the date upon
6 which the Department of Healthcare and Family Services applies
7 for a Medicaid waiver or State Plan amendment as provided in
8 subsection (a) of Section 10. The Stakeholder Quality and
9 Outcomes Metrics Development Working Group shall meet at least
10 monthly for no less than 8 months to assist in the development
11 of the metrics that will be reported to the State and used to
12 determine eligibility for incentive payments.

13 Section 20. Provider readiness.

14 (a) To ensure provider readiness for the implementation of
15 the payment reform models developed in accordance with this
16 Act, the Department of Healthcare and Family Services shall
17 require community mental health centers and behavioral health
18 clinics choosing to opt into the regulatory framework to submit
19 an initial self-assessment of readiness, including
20 demonstrating the delivery of person-centered care or
21 family-centered care, the ability to track quality and outcomes
22 data for Medicaid enrollees, and a data-driven quality
23 improvement process. The Department of Healthcare and Family
24 Services shall engage in statewide provider education for
25 implementation of the regulatory framework and process through

1 statewide in-person trainings, train-the-trainer models, and
2 webinars at least 6 months prior to implementation to enable
3 provider readiness. Such education shall continue throughout
4 the first year of implementation. The Department of Healthcare
5 and Family Services shall establish an ongoing statewide
6 learning collaborative for providers opting into the
7 regulatory framework to share successes, challenges, lessons
8 learned, and provider and systemic issues that need to be
9 addressed to foster these payment reform models. The learning
10 collaborative shall be convened by the Department of Healthcare
11 and Family Services, in partnership with the Department of
12 Human Services' Division of Mental Health, on a quarterly basis
13 after the initial date of implementation of the regulatory
14 framework.

15 (b) Provider infrastructure development for
16 implementation. A total not to exceed \$5,000,000 a year for
17 each of 3 years shall be available for provider infrastructure
18 development for implementation of this Act, including, but not
19 limited to, systems for data tracking of the metrics outlined
20 in Section 15, or other start-up or infrastructure costs, for
21 providers opting into the regulatory framework. The Department
22 of Healthcare and Family Services shall have the authority to
23 determine the process for application and eligibility for
24 provider infrastructure development dollars under this
25 subsection.

1 Section 25. Annual incentive payments for community mental
2 health centers and behavioral health clinics.

3 (a) Annual incentive payment.

4 (1) Year one of implementation and the first 2 full
5 calendar years of implementation. For the first partial
6 calendar year of implementation (if implementation begins
7 mid-year) and for the first 2 full calendar years after
8 implementation of this Act, community mental health
9 centers and behavioral health clinics participating in the
10 regulatory framework that score above the median score of
11 the relevant quality metrics the Department of Healthcare
12 and Family Services uses for Medicaid managed care
13 organizations that the Department has selected to measure
14 the quality of care provided by community mental health
15 centers and behavioral health clinics as provided under
16 subparagraph (A) of paragraph (1) of subsection (a) of
17 Section 15 for at least 80% of such quality metrics for
18 that calendar year shall receive an incentive payment
19 related to that calendar year. If implementation begins in
20 the middle of a calendar year, a provider's incentive
21 payment for that year shall be prorated based on the date
22 the regulatory framework went into effect.

23 (2) Year 3 and every calendar year thereafter. For the
24 third full calendar year after implementation of this Act,
25 and every year thereafter, community mental health centers
26 and behavioral health clinics participating in the

1 regulatory framework shall receive an annual incentive
2 payment related to that year if:

3 (A) the provider scores above the median score of
4 the quality metrics the Department of Healthcare and
5 Family Services uses for Medicaid managed care
6 organizations that the Department has selected to
7 measure the quality of care provided by community
8 mental health centers and behavioral health clinics as
9 provided under subparagraph (A) of paragraph (1) of
10 subsection (a) of Section 15, for at least 80% of such
11 quality metrics related to that calendar year; and

12 (B) the provider meets at least 75% of the
13 payment-for-performance metrics established in
14 accordance with this Act for that calendar year.

15 (3) For any calendar year following the first 2 full
16 calendar years after implementation, the Department of
17 Healthcare and Family Services shall have the ability to
18 adjust the benchmark for measuring minimum eligibility for
19 an incentive payment (the median score of the relevant
20 quality metrics used to measure Medicaid managed care
21 organizations that the Department of Healthcare and Family
22 Services applies to the regulatory framework) by 10% upward
23 or downward to ensure an appropriate benchmark for
24 eligibility for an annual incentive payment. The
25 Department of Healthcare and Family Services shall give
26 providers participating in the regulatory framework at

1 least 6 months notice prior to the benchmark going into
2 effect for a calendar year.

3 (4) Number of metrics used to determine annual
4 incentive payments. No more than 10 metrics (including
5 sub-metrics), including the payment-for-performance
6 metrics, shall be used in any given year to determine
7 eligibility for an annual incentive payment to ensure that
8 neither the State nor providers are overwhelmed by data
9 tracking.

10 (5) Provider preparedness. The Department of
11 Healthcare and Family Services shall give all community
12 mental health centers and behavioral health clinics notice
13 of the metrics that will be used to determine eligibility
14 for an annual incentive payment at least 6 months prior to
15 those metrics taking effect for that calendar year.

16 (6) Amount of annual incentive payment. For community
17 mental health centers or behavioral health clinics that
18 meet the requirements set forth in this Act for an
19 incentive payment for any calendar year, the incentive
20 payment shall be equal to a 6 percentage point increase in
21 the base Medicaid reimbursement rates plus any rate add-on
22 payment, for all Medicaid community mental health services
23 that the provider delivered during that calendar year. The
24 incentive payment shall be paid to the community mental
25 health center or behavioral health clinic within 8 months
26 following the end of the calendar year.

1 Section 30. Eligibility for participation. Community
2 mental health centers and behavioral health clinics subject to
3 the regulatory framework that do not meet the median score of
4 the quality metrics the Department of Healthcare and Family
5 Services uses for Medicaid managed care organizations and for
6 which the Department has selected as provided under
7 subparagraph (A) of paragraph (1) of subsection (a) of Section
8 15 for at least 50% of such quality metrics for that calendar
9 year for 3 consecutive calendar years shall be ineligible for
10 further participation under the regulatory framework for the
11 following 3 calendar years. A community mental health center or
12 behavioral health clinic that does not meet the median score of
13 the quality metrics the Department of Healthcare and Family
14 Services uses for Medicaid managed care organizations for which
15 the Department has selected as provided under subparagraph (A)
16 of paragraph (1) of subsection (a) of Section 15 for at least
17 30% of such quality metrics for that calendar year shall no
18 longer be eligible for participation under the regulatory
19 framework until they are able to demonstrate to the Department,
20 through a formal plan, that they can achieve at least 75% of
21 these quality metrics.

22 Section 35. Community mental health services; rates.

23 (a) Beginning on July 1, 2019, Medicaid reimbursement rates
24 for all community-based mental health services provided in

1 accordance with 59 Ill. Adm. Code 132 or 89 Ill. Adm. Code
2 140.452 through 140.455 for which there was an enhanced payment
3 rate or rate add-on in effect on November 1, 2017 for community
4 mental health centers, or for behavioral health clinics that
5 were formerly community mental health centers, shall be
6 increased by the amount equal to the enhanced payment rate or
7 rate add-on. The enhanced payment rate or rate add-on shall be
8 simultaneously reduced by an equal amount. The Department of
9 Healthcare and Family Services shall hold harmless community
10 mental health centers, and any relevant behavioral health
11 clinic that was formerly a community mental health center,
12 receiving such mental or behavioral health enhanced payment
13 rates or rate add-on payments. This subsection is intended to
14 convert the enhanced rate and rate add-on payments into the
15 Medicaid reimbursement rate for community-based mental health
16 services.

17 (b) For State Fiscal Year 2020, Medicaid reimbursement
18 rates for all community mental and behavioral health services
19 that can be delivered by a community mental health center or
20 behavioral health clinic in accordance with 89 Ill. Adm. Code
21 140.452 through 140.455, for which there is no enhanced payment
22 rate or rate add-on payment, and for all Medicaid psychiatry
23 services provided by an advance practice nurse with a
24 psychiatric specialty delivered through or on behalf of a
25 community mental health center or a behavioral health clinic,
26 shall be increased by 7% annually for each state fiscal year

1 for 3 years. Beginning in State Fiscal Year 2023, and every
2 state fiscal year thereafter, Medicaid reimbursement rates for
3 those community mental and behavioral health services and those
4 services covered in subsection (a) provided by community mental
5 health centers and behavioral health clinics shall be adjusted
6 upward by an amount equal to the Consumer Price Index from the
7 previous year, not to exceed 2% in any state fiscal year. If
8 there is a decrease in the Consumer Price Index, rates shall
9 remain unchanged for that state fiscal year.

10 (c) To increase the number of psychiatrists practicing in
11 Illinois' Medicaid Program that serve individuals with the most
12 serious mental health conditions, the Department of Healthcare
13 and Family Services shall develop an encounter-based rate and a
14 billing and payment mechanism for all Medicaid psychiatry
15 services delivered by a psychiatrist to be paid at a rate equal
16 to the average Medicaid reimbursement rate paid to
17 Illinois-based federally qualified health clinics over the 3
18 most recent years for such psychiatry services or for the same
19 or comparable services. This encounter-based Medicaid rate,
20 and billing and payment mechanism, may be a Medicaid
21 reimbursement rate adjustment or an enhanced Medicaid payment.
22 This rate adjustment shall be phased in equally over 4 calendar
23 years beginning on January 1, 2020. The provisions of this
24 subsection on psychiatry reimbursement shall not impact other
25 provider reimbursement rates that may be tied to psychiatry
26 rates.

1 (d) To reduce the rate of children with serious mental
2 health conditions remaining in psychiatric hospitals beyond
3 medical necessity because there is a lack of residential
4 treatment placements available for the child, reimbursement
5 rates paid to providers for services provided under the Family
6 Support Program, formerly known as the Individual Care Grant
7 program, shall be adjusted upward by 7% a year for 3 years
8 beginning July 1, 2019. Beginning in State Fiscal Year 2023,
9 and each state fiscal year thereafter, such reimbursement rates
10 shall be adjusted upward by an amount equal to the Consumer
11 Price Index from the previous year, not to exceed 2% in any
12 state fiscal year. If there is a decrease in the Consumer Price
13 Index, such rates shall remain unchanged for that state fiscal
14 year.

15 Section 40. Implementation timeline; rulemaking authority.

16 (a) The Department of Healthcare and Family Services shall
17 file a proposed rule implementing this Act no later than 9
18 months after the date of federal approval of its waiver or
19 State Plan amendment filed pursuant to this Act.

20 (b) Stakeholder working group. The Department of
21 Healthcare and Family Services, in partnership with the
22 Department of Human Services' Division of Mental Health, shall
23 establish and convene a stakeholder working group that includes
24 community mental health providers across the State, advocates,
25 persons with lived experience, and representatives from

1 Medicaid managed care organizations to help guide and assist
2 the Department of Healthcare and Family Services in the
3 development of the rule that implements this Act. This
4 stakeholder working group shall meet at least monthly beginning
5 immediately after federal approval of the State Plan amendment
6 or waiver filed pursuant to this Act and shall continue until
7 the filing of a proposed rule implementing this Act.

8 Section 45. Rule revision. 59 Ill Adm. Code 132 shall be
9 revised to align with and match the regulatory framework
10 developed pursuant to this Act for community mental health
11 centers participating in the regulatory framework established
12 by this Act and shall not impose service, staffing,
13 certification, documentation, or reporting requirements that
14 are inconsistent with this Act for those community mental
15 health centers to enable the modernization of the community
16 mental health regulatory framework. The Department of Human
17 Services' Division of Mental Health shall file its proposed
18 amendments to 59 Ill Adm. Code 132 with the Joint Commission on
19 Administrative Rules simultaneously with the Department of
20 Healthcare and Family Services' filing of the rule implementing
21 this Act.

22 Section 99. Effective date. This Act takes effect upon
23 becoming law.