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Avoiding a debacle on a greater scale than the SDU/Child Support Payment System Fiasco is as easy as A B C

- A** Don't Support the administration's proposals to change The Medicaid Mental Health Trust Fund and the Violent Crime Victim Assistance Fund and divert funds into GRF. These funds must not be changed.
- B** Support SB 2367h –Much needs to be done before safely increasing FFS as well as implementing the Children's Crisis Service RFP. DMH, DD and DASA consumers await details about the many planks needed in the platform from which agreement can be constructed including:
- Capacity grant amounts.
 - Safety net triggers.
 - Rates.
 - Payment methodologies: Grants? Advance and reconcile?
 - New FFP revenue distribution in FY '05 and beyond.
 - Responsibility for MISA and other special population needs.
 - Timing of and resources to be used for underserved communities.
 - Maintaining current access to care for the working poor, undocumented and severely disabled.
 - Medicaid Trust Fund for DD consumer services.
- C** Expanding Care and Pursuing Revenue safely. (**Stop and Go**)
- Stop** - the July 1st, 2004 untested conversion to FFS and the RFP implementation. To protect the very children and adults the systems are meant to care for field testing of both the proposed system changes, and assumptions; must be part of any safe conversion process. A July 1st conversion without field testing is unsafe and must be delayed.
- Go** - DHS should immediately pursue precursor activity and the revenue generated from these activities, prior to FFS conversion including:
- The assignment of the single client identifier.
 - Developing computer run retroactive claiming across divisions and Departments.
 - Defining billable services clearly and completely for applicable divisions within DHS and Medicaid.
 - Making DHS and DPA system changes needed to accept bills for all types of services and testing the system to ensure claims are properly accepted.

- **No changes to MH Medicaid Trust Fund**
- **No changes to Violent Crime Victims Assistance Fund**
- **SUPPORT SB 2367h**



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SUPPORT SB 2367h As Amended

SB 2367, House Amendment #2 codifies the Department of Human Services' MAX program (Maximizing Accountability and Excellence) related to fee-for-service contracting and competitive bidding for community services. This amendment codifies goals and objectives of the MAX program as articulated by the administration.

- I. The amendment sets out requirements for a 2-year competitive contracting program using request-for-proposals (RFP), which can be extended by a joint resolution adopted by the General Assembly. The period of the demonstration can also be extended by a joint resolution adopted by the General Assembly.
- II. The amendment sets out requirements for Fee-For-Service contracts beginning January 1, 2005, for which criteria, standards and procedures must be established by rule.
DHS:
 - May implement demonstrations for a fee-for-service payment system that will include providers willing to execute a contract prior to January 1, 2005 and must develop and issue a Memorandum of Understanding cooperatively for disabled individuals regarding the details of agreements on how the system will operate
 - Will establish rates after an evaluation and opinion by an independent certified public accountant comparing cost reports and proposed rates
 - Is required to conduct a comprehensive review of the rate methodology by November 1, 2004
 - Will not place reserves on moneys appropriated for services provided through divisions of Alcohol and Substance Abuse, Developmental Disabilities, and Mental Health.
- III. Changes to the State Prompt Payment Act: (1) Clarifies that the current law applies to grants-in-aid; and (2) adds the provision of House Bill 3512, which gives non-profit organizations providing services for the mentally ill or developmentally disabled who are reimbursed for those services by the Illinois Department of Human Services priority status in the state's processing and payment of bills, invoices or grant awards.
- IV. The amendment creates a Community Developmental Disabilities Services Medicaid Trust Fund to capture federal reimbursements.



Community Behavioral Healthcare Association

**Child Crisis Care: Personal Therapist Out, Operator Roulette In
For Child in Mental Health Crisis, New Proposal Forces Parents
to Call 800#, Not Crisis Therapist**

CRISIS CARE ISSUES	CURRENT	DPA/DCFS/DMH PROPOSED July 1, 2004
Immediate crisis screening	Yes	No Requires prior approval
Parent has direct contact with community crisis treatment team	Yes	No Manage Care operator will screen referrals for level of care need and forward to a provider via a conference call.
Immediate access to a face-to-face screening	Yes	No
Unlimited crisis care	Yes Child, family needs and clinical necessity drive care decisions	No Limitations arbitrarily imposed of 2.5 hours placed on the crisis assessment.
Parent, therapist and child decide on-going care	Yes Child, guardian, and therapist Decide need for more care.	No Extensions require prior approval by DHS and reported to the CARES manage care
Repeat crisis—same therapist provides care?	Yes Provided by current crisis provider	Maybe No. Each request for a crisis screening must have a prior approval determination before the crisis provider could service an active case.
Adequate funding to provide quality of care	Yes Quality ensured. Medicaid rate supported by state grant and local community money combine to ensure quality care.	No Substandard Medicaid rate without support of from state grant money will reduce funding by nearly 25% and, thus, quality.
Access to care for working poor, uninsured, and undocumented Illinois residents	Yes Community Crisis Teams serve Medicaid and Non-Medicaid	No Access to care for non-Medicaid children eliminated as FY'05 budget requires 50% hike in Medicaid money.