Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CENTERS FOR MEDICARE & MEDICAID SERVICES

September 25, 2012

Julie Hamos, Director
Illinois Department of Healthcare & Family Services
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, IL 62763-0001

Dear Ms. Hamos:

This letter is being sent as a companion to our approval of State plan amendment (SPA) 12-013 submitted June 29, 2012 by the Illinois Department of Healthcare and Family Services. This SPA proposes to update the criteria required to be classified as a mental health professional and is effective May 1, 2012. We are recommending a SPA submission to resolve our corresponding reimbursement page issues related to mental health services found on Attachment 4.19-B and identified in this letter.

Attachment 4.19-B

For our review we identified reimbursement for mental health rehabilitative services on pages 35, 36, 40 and 41. If these are not the appropriate pages, please identify the reimbursement pages for our review.

Item 21. Mental Health Services

Section 1902(a)(30)(A) of the Act requires that states have methods and procedures in place to assure that payments to providers are consistent with efficiency, economy and quality of care. To be comprehensive, payment methodologies should be understandable, clear and unambiguous. Since the plan is the basis for Federal Financial Participation (FFP), it is important that the plan language provide an auditable basis for determining whether payment is appropriate. The language identified for mental health services reimbursement is problematic. Items 21.a. and b. language that was approved with TN 98-014 lacks comprehensive descriptions. Some of the concerns with the language is it lacks the name of the CMS approved cost report from which costs are identified, lacks that costs are allocated according to OMB circulars and allows the State to establish new rates every year based on a formal cost methodology.

We propose a simple way to eliminate these concerns by suggesting the State submit a SPA to amend the language which identifies that the State pays for mental health services at the lesser of charge or the Medicaid maximum fee schedule. As with any SPA that changes the methodology in the State plan, this SPA submission would require appropriate public notice. Based on our review of the Illinois mental health manual, we believe you are currently using a fee schedule rate to reimburse for mental health services that are the subject of this SPA. We think the State and providers would be open to our suggested resolution of the payment issues by implementing a fee schedule consistent with rates identified in the Illinois Mental Health Billing Manual (7/11/11).

Based on the review of the manual pages, we have several additional recommendations for State plan changes that incorporate assurances associated with the service settings.

Services provided by Community Mental Health Agencies

1. Please provide an assurance in the State plan that services provided by community mental health agencies are not providing residential care. Our recommended language for assurance that community mental health agencies is as follows:

   "the State shall not claim FFP for any non-institutional service provided to individuals who are residents of facilities that meet the Federal definition of an institution for mental diseases or a psychiatric residential treatment facility as described in Federal regulations at 42 CFR 440.140 and 440.160 and 42 CFR 441 Subparts C and D.

   The State shall not claim FFP for any services rendered by providers who do not meet the applicable Federal and/or State definition of a qualified Medicaid provider.

Services provided in a Residential Facility

2. Please provide an assurance in the appropriate item of the State plan that services provided in a residential or State facility are not IMDs. We think this assurance would pertain to Community Support (residential) and Crisis Intervention State Ops and Psychosocial Rehabilitation (Facility Based). Our recommend language for this assurance is as follows:

   With respect to individuals who are receiving rehabilitation services as residents of facilities the State shall not claim FFP for room and board and for non Medicaid services as a component of the rate for services authorized by this section of the State plan.

   The rates in the department's service fee schedule as authorized by this plan amendment shall be set using methods that ensure the rates do not include costs not directly related to the provision of Medicaid services such as costs associated with the cafeteria. Only those facility (direct or indirect) costs that can be identified as directly support the provision of the non-institutional services will be included in the rates.

Psychotropic Medicaid Administration

3. Please clarify if there is a billing limit for the unit of service, e.g., event. If there is a billing limit, please identify this on the State plan page or your fee schedule.

The State has 90 days from the date of this letter, to address the issues described above. Within that period the State may submit SPAs to address the inconsistencies or submit a corrective action plan describing in detail how the State will resolve the issues identified above in a timely manner. Failure to respond may result in the initiation of a formal compliance process. During the 90 days, CMS will provide any required technical assistance.

If you have any questions concerning this SPA, please contact Cathy Song, of my staff, at (312) 353-5184 for more information.

Sincerely,

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Mark McCurdy, HFS
Greg Wilson, HFS
Mary Doran, HFS