SB1673

LRB101 04927 KTG 53068 b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

SB1673

Introduced 2/15/2019, by Sen. Heather A. Steans

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.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning mental health.

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

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

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

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

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

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

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

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

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

(7) To modernize mental health service delivery,

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

Section 10. Community mental health payment reform model.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 15. Quality and outcomes metrics reporting.

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

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

metrics:

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

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

calendar year after the implementation of this Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 20. Provider readiness.

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

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

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

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

(a) Annual incentive payment.

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

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

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

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

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

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

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

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

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

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

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

Section 35. Community mental health services; rates.

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

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

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

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

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

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

Section 40. Implementation timeline; rulemaking authority.

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

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

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

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

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