Clarifications to the Illinois CCBHC Letter of Intent Process
February 19, 2016

On Monday February 15, 2016, representatives of the Illinois trades (specifically IARF and IADDA) sent an email to the state of Illinois seeking clarification and/or deletion of the April 1, 2014, CCBHC lifespan requirement (which required both DASA and DMH licensure of potential applicants as of April 1, 2014) in the Letter of Intent released by the State on February 10, 2016. On Tuesday February 16th multiple representatives of the State of Illinois met via conference call with the trade representatives to discuss the request. That call was immediately followed with a conference call by the State with representatives of SAMHSA to clarify what precisely is required of CCBHC applicants as of April 1, 2014, and how may a state verify those requirements.

From a legal perspective, licensure/certification are not required by SAMHSA, because those are State specific. However, Illinois will stand by the previous Letter of Intent request with the below explanations. If a Letter of Intent applicant can show that it can provide all lifespan services (specifically by adding services that were not licensed as of April 1, 2014) at locations which existed as of April 1, 2014, DASA, DMH and HFS urge that the applicant explain this scenario. In addition, nothing in this memo affects a provider's ability to become a DCO (designated collaborating agency). If a provider is not going to submit a Letter of Intent, but does want to consider becoming a DCO, please send an email to DHS.DMHCCBHC@illinois.gov know so that we can include you on a potential DCO list.

First, it is important to recognize that virtually every level of stakeholder (federal, state, trade or provider) has frequently used the terms "entity", "location" and "services" as synonyms. The reality is that each word conveys very different meanings, as will be explained further.

Additionally, many within the healthcare world view as equivalents "services" and "facility", largely because in the modern healthcare world "services" are very site specific. For example dental work might be handled in one building, diabetes care another building, depression counseling a third building and opiate work a fourth entirely different building. So while services and facilities might be practically equivalent in the real world, they can often represent entirely different ideas from a legal perspective.

Second, while the CCBHC enabling statute and the Federal RFP do not literally require the "lifespan" (mental health, substance abuse, adult, and children) requirements as of April 1, 2014, they do require that states "verify" the existence of "facilities" as of April 1, 2014. While it is possible to verify the existence of the legal *entities* (i.e. non-profit incorporation) as of April 1, "entity" verification is very different than verifying a "facility" - i.e. an address or a building, which is what is required by federal CCBHC guidance.

After discussing these concepts with our federal partners, who admit that a number of states are having these very same conversations with them as well, (indeed the federal partners themselves are struggling to provide specific answers, as ultimately the underlying legislation is very limiting) Illinois is providing the following questions, answers and explanations to further explain and inform potential Letter of Intent applicants.

> *Question*: May a provider at a single specific location expand a pre-existing mental health licensed location to provide substance abuse services under the CCBHC framework? *Answer*: Yes, so long as the mental health provider was in existence as of April 1, 2014.
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> *Question*: May a substance abuse non-profit at 51 Main Street legally merge with a mental health non-profit at 22 Broadway and provide services under the CCBHC framework? *Answer*: Yes, so

long as both the mental health and the substance abuse facilities existed as of April 1, 2014. The merger between the two pre-existing non-profits into one big non-profit is totally irrelevant. The required facility analysis is based on the status of the facilities, both of which existed before April 1, 2014.

Question: May a mental health provider at 4001 Main Street add new substance abuse services at 4005 Main Street and qualify as a CCBHC? *Answer*: No. These are two different locations and the new location at 4005 Main Street fails the April 1, 2014 test.

Question: May a substance abuse provider located at 4002 Main Street buy or rent a building at 4004 Main Street, knock down the shared wall between the two buildings at the two addresses, and claim that this is a single location? *Answer*: Unclear. Two addresses are in play, which implies two different locations. Creating one unified work space may overwhelm that.

Question: May a mental health provider on the 2nd floor of 4001 Main Street rent out the 6th floor of 4001 Main Street, and add new substance abuse services on the 6th floor? *Answer*: Again unclear - federal authorities may decide that these remain two different locations even though they share the same street address.

Question: A substance abuse provider at 5002 Main Street owns an immense building with lots of unused space. They add mental health services in the unused space. Does this qualify as a CCBHC? *Answer*: Yes. This already was a single space at a single address and using additional capacity does not affect the facility analysis.

Question: Provider X, established in 2010, owns or rents a building at 6001 Main Street. Provider X needs more space and moves to a new building at 7002 Main Street in 2015. Can Provider X be a CCBHC? *Answer*: Yes, although Provider X is moving to a new location, for CCBHC purposes the move is ignored. *Unknown answer to subsequent question*: Whether Provider X can both move and add new services.

Question: Provider Z, established in 2010, starts offering services outside "the 4-walls" in 2015. Are those services omitted from CCBHC cost calculations? *Answer*: Those services and costs are eligible for CCBHC activities, as non-4 wall services (including in schools, prisons, in-home and telemedicine) do not enter into a CCBHC facility analysis.

Overall, it is possible to add brand new services to a location which existed before April 1, 2014. However this hinges on the ability of a provider applicant to show how without adding new locations. The existence of a pre-existing legal entity (i.e. the original non-profit) does not matter at all when conducting facility-based analysis, which ignores legal entity status and focuses on mundane concepts like addresses, buildings and work-spaces.

Illinois still believes that it is likely that the only realistic way to satisfy the statutory requirements of both April 1, 2014, and Illinois' responsibility to verify that facility's existence, will be through requiring that an applicant already be DASA and DMH licensed/certified as of April 1, 2014. The CCBHC statutory authority (see https://www.congress.gov/bill/113th-congress/house-bill/4302/text/pl) sets a problematic and very high bar - all physical locations must exist as of April 1, 2014. Given that a successful CCBHC applicant must provide both substance abuse and mental health services in four to nine key areas to both adults and children, it will be challenging to add services without breaking the April 1, 2014, facility requirement; hence the DMH/DASA licensure/certification requirements in the CCBHC Core Service Matrix attachment to the LOI. Again, if an applicant believes that it can provide all lifespan services (specifically by adding services that were not licensed as of April 1, 2014) at locations which existed as of

April 1, 2014, then the applicant is encouraged to submit an LOI, the matrix, and an explanation as to how this can be demonstrated.