

Community Behavioral Healthcare Association of Illinois
Comments and Recommendations

TITLE 59: MENTAL HEALTH
CHAPTER I: DEPARTMENT OF HUMAN SERVICES
PART: 140
COMMUNITY-BASED RESIDENTIAL LEVELS OF CARE
FOR PERSONS WITH MENTAL ILLNESSES

Proposed Draft

August 29, 2013 - PDF Version

Pages 1-41

Comments on Specific Sections of the Proposed Revised Rule

Section/ Page Number	Comments	Recommendations or Questions	DMH RESPONSE
<i>Purpose</i> 140.10 <i>Page 2</i>			
c)	This section states that an institute for the mentally diseased will not be funded by DMH as Supervised Transitional Level of Care.	Will SMHRFs be certified to provide Supervised Transitional Residential services? If yes will they be certified prior to approval from CMS for the establishment of SMHRFS's?	SMHRFs can provide Recovery and Rehabilitation units and Transitional Living units as under their proposed Rule and NOT be able to apply for Supervised Transitional LOC through DMH

<p><i>Definitions</i></p> <p>140.25</p> <p><i>Pages 3- 6</i></p>			
<p>Site</p>	<p>The language specifying a “site” under “one continuous roof “ requirement raises concerns on section 140.75 Rates for staff configurations and efficiencies needed to maintain quality services.</p> <p>The states histories of its difficulties in financially supporting state requirements as well as rates that are frozen since the turn of the century are well known.</p> <ul style="list-style-type: none"> • Has this requirement been considered against the current housing stock that houses individuals who could qualify as program recipients under the proposed staffing models? • If staffing patterns can be established for the proposed requirements for which consumers receiving a residential level of care reside would a program not be certified due to the continuous roof requirement? A dry topic 	<p>We recommend deleting the reference to one continuous roof and therefore changing the definition to: Any building, under one continuous roof, but not limited to houses. Apartment buildings and duplexes in which a consumer receiving a residential level of care lives.</p>	<p>The definition of ‘site’ does need to be modified.</p> <p>DMH wishes to be clear that it expects, that because of acuity of consumer need for entry into Supervised Residential, that the “site” should reflect characteristics to adequately respond to the needs of the consumer.</p> <p>The site should afford all participating consumers individual living quarters as defined in Rule with communal facilities for food, recreation and care all within the same distinct section or unit in which all admitted consumers at the same time can receive supervision through the physical presence of, at the minimum, one staff member.</p>

	that may put otherwise certifiable programs and the consumers needing these services underwater.		
Staff	The definition does not include other staff who are employed by an agency, such as, non-clinical staff, physicians; an advanced practice nurse with psychiatric specialty licensed under the Nurse Practice Act [225 ILCS 65]; a clinical psychologist licensed under the Clinical Psychologist Licensing	We recommend changing the definition to: <i>Persons who meet the requirements for Qualified Mental Health Professional, Mental Health Professional or Rehabilitative Services Associate</i> <u>employed by the agency and clinical professionals listed under 59 Ill. Adm. Code 132 under 59 Ill. Adm. Code 132 and who are paid by the provider to provide services in a residential level of care.</u>	The staff positions mentioned all qualify more broadly as a Q, M or R under the current 132 definitions.
Supports		We recommend changing the definition to: <i>Activities including but not limited to behavioral interventions and assistance with activities of daily living, for which the consumer needs reminding, prompting, or coaching, that cannot be claimed as Rule 132 services and are included as part of the per diem rate for each residential level of care. <u>Examples include, transportation or waiting with a consumer for an appointment.</u></i>	The deletion section is meant to only suggest some -more obvious ‘activities’. There is no provision for transportation to be a covered portion of the supervised transitional residential level of care rate.
Survey		Is this definition referring to the BALC audits or something else?	Survey means the review done to determine provider compliance with this rule. Who will do that has yet to be determined.

<i>Provider Qualifying Conditions</i> 140.30 <i>Pages 6-7</i>			
c) 5)	Address Change	CARF International 6951 East Southpoint Road, Tucson, AZ 85756 Phone: (888) 281-6531 Fax: (520) 495-7188 http://www.carf.org/events	ACCEPT
c) 6)	Address Change	CARF International 6951 East Southpoint Road, Tucson, AZ 85756 Phone: (888) 281-6531 Fax: (520) 495-7188 http://www.carf.org/events	ACCEPT

<p><i>Application and Initial Certification</i></p> <p>140.35</p> <p><i>Pages 7- 10</i></p>			
<p>a)</p>	<p>In this version of Rule 140, there is no section 140.215 or 140.220.</p>	<p>Will Rule 140 include additional levels of care which this subsection references?</p>	<p>ACCEPT to delete reference to 140.220. Rule 140 applies only to Supervised Transitional Residential Level of Care.</p>
<p><i>Post Payment Review</i></p> <p>140.55</p> <p><i>Pages 14- 16</i></p>		<p>Based on PA 97 – 0558 it may be prudent for DMH in support of the work groups convened by the Secretary under the MIIC initiative that:</p> <ul style="list-style-type: none"> • Post payment reviews shall be conducted for Rule 132 and 140 simultaneously. 	<p>Not for Rule inclusion but DMH would continue to work toward compliance to MIIC</p>
		<p>When providers contract for services with Managed Care Organizations who will be responsible for Rule 140 post payment review when a provider is under contract with a MCO?</p>	<p>DMH will do post payments reviews only for those persons paid for by DMH.</p>
<p>c)</p>		<p>We recommend that a Notice of Suspension be given if less than 80% of billings reviewed are substantiated.</p>	<p>Billing reflects only a single data feature of ‘occupied beds’, a statistic that should be easily identified and routinely correct such that errors would be significantly infrequent.</p>
<p>d)</p>		<p>We recommend the removal of the “extrapolation” and that a process be established to review the past months billings</p>	<p>DMH wishes to maintain this option which is consistent with Rule 132 and HFS standards. DMH’s action to</p>

		in question for any potential additional recovery.	initiate this option would be published well in advance of implementation.

<p><i>Utilization Management</i></p> <p>140.70</p> <p><i>Page 18- 19</i></p>			
a) – j)		<p>If DMH continues to conduct Utilization Management of DMH funded residential sites when the provider is under contract with a MCO, providers will be subject to multiple and most likely redundant processes that rates will not support.</p>	<p>Providers are bound by the contract provisions for each separate payer</p>
c)		<p>We recommend that this UM process shall also involve consultation with the provider, along with the consumer, before a decision is made on whether the level of care is appropriate.</p>	<p>Utilization Management Review is a well-established administrative function. Providers /consumers have appeal rights should they wish to challenge the review decision.</p>

<p><i>Rate Setting</i></p> <p>140.75</p> <p><i>Page 19-20</i></p>	<p>Please see above comments under Definitions “site” . This section Rate Setting 140.75 would benefit from language that ensures a fair per diem rate setting method based on standards will be used so that in their totality the Purposes defined under Section 140.10 can be achieved.</p>		
<p>b)</p>	<p>There is no mention of how frequently rates will be set and this section also suggests that only the factors listed can be considered.</p>	<p>Address these concerns so that it will read: <u>Every two years</u> DMH shall calculate rates on a per diem basis considering the following factors <u>including</u>:</p>	<p>DMH cannot assert to a recalculation of or modifying rates which incur a financial obligation without having appropriations authority to support an adjustment.</p>
<p>b) 1)</p>	<p>This subsection references section 140. 215 and 140.22 which this Draft rule does not include.</p>	<p>Will Rule 140 include additional levels of care which this subsection references? If yes than information is needed on section 140. 215 and 140.22</p>	<p>The proposed rule only pertains to Supervised Transitional LOC. ACCEPT to delete reference to 140.220</p>
<p>b) 2)</p>		<p>We recommend this section be changed by deleting the word “site” So it would read: The number of beds certified for each residential level of care. site.</p>	<p>The definition of ‘site’ does need to be modified. Sites are certified for this LOC not the beds. It should read: “The number of beds at the certified site for this level of care.”</p>
<p>b) 3)</p>	<p>We believe this language may be a drafting error. We suggest a language change that reflects providers receive the certification.</p>	<p>Change this section to read: The residential level of care for which the site <u>provider</u> is certified.</p>	<p>This statement is not needed at this time, because all certified sites will be for the Supervised Transitional LOC as the rule has no other levels of care.</p>
<p>b) 4)</p>	<p>Substitute the word Fair Market for reasonable</p>	<p>Change this section to read: Reasonable <u>Fair Market</u> costs for room and</p>	<p>“Reasonable” costs is a term widely and routinely used in all other</p>

		board including.	financial sections or audit rules
b) add 6)	The region or local economy of where an agency is located should be taken into consideration.	We recommend adding: <u>6) Local economy shall be considered.</u>	Factoring multiple regional or local adjustments into rates would present significant obstacles and be contra-indicated towards uniformity
c)	<p>How have the listed deductions been</p> <ol style="list-style-type: none"> 1. proofed i.e. tested against per diem models? 2. aligned with section d) and e) of 140.105 Fiscal Requirements. <p>We have not been able to answer these provider questions especially with the DMH decision to submit a proposed rule prior to establishing the residential levels of care rate(s).</p>	The states histories of its difficulties in financially supporting state requirements, performing calculations by “backing” into calculations based on budgets the state predetermines it can afford, as well as rates that are frozen since the turn of the century are well known	<p>The SSI deduction is well established in HFS and DDD rates structures. DMH is allowing the consumer to keep 70% of their SSI – a far higher number to allow them to save money for moving into housing from this transitional residential level of care.</p> <p>DMH rates are expected to support payment in full for the residential services as defined. Other subsidies would assume the provider is getting reimbursement from two governmental entities for the same or similar service</p>

<p><i>Fiscal Requirements</i></p> <p>140.105</p> <p><i>Pages 27--28</i></p>	<p>Section 140.105 Rate Setting and this Fiscal Requirements section are linked. As mentioned above we have not been able to ascertain how the listed deductions in Section 140.105 Rate Setting are</p> <ul style="list-style-type: none"> 3. proofed i.e. tested against per diem models? 4. aligned with section d) and e) of 140.105 Fiscal Requirements. <p>We have not been able to answer these provider questions especially with the DMH decision to submit a proposed rule prior to establishing the residential levels of care rate(s).</p>	<p>We believe the consumers who rely on these proposed Rule 140 services as well as the providers who could become certified deserve a process that does not leave these questions unanswered.</p>	<p>The SSI deduction is well established in HFS and DDD rates structures. DMH is allowing the consumer to keep 70% of their SSI – a far higher number to allow them to save money for moving into housing from this transitional residential level of care.</p> <p>DMH rates are expected to support payment in full for the residential services as defined. Other subsidies would assume the provider is getting reimbursement from two governmental entities for the same or similar service</p>
<p><i>Clinical Records</i></p> <p>140.110</p> <p><i>Pages 28- 29</i></p>			
<p>a)6)</p>		<p>What is the “assessment criteria developed by DMH”?</p> <p>We recommend that the assessment criteria be part of this Rule.</p>	<p>Criteria and interpretative guideline-s would be independently published as is the case with the DMH program book and Rule 132 interpretive guidelines so that industry changes to the criteria can be made without proceeding through an elongated Rule making process</p>

<p><i>Sites</i></p> <p>140.115</p> <p><i>Pages 29- 34</i></p>			
<p>e)5)A)</p>		<p>We recommend that evacuation drills shall be held annually.</p> <p><i>Evacuation drills are conducted at a frequency determined by the provider to be appropriate based on the needs and abilities of the consumers living at the site but no less than three times per year in Transitional Level of Care and Crisis Level of Care sites and no less annually.</i></p>	<p>We would accept drills to be completed consistent with accreditation standards or this section added onto deemed status requirements.</p> <p><u>We would? Isn't fire safety in residential programs critical?</u></p>
<p><i>Consumer Rights and Choices</i></p> <p>140.200</p> <p><i>Pages 37- 38</i></p>			

<p><i>General Provisions</i></p> <p>140.205</p> <p><i>Pages 38- 39</i></p>			
<p>b) 1) and 2)</p>	<p>Occasionally, there is an unplanned discharge when a consumer leaves prior to a formal discharge or against staff advice.</p>	<p>We recommend adding: c) which states: <u>When a consumer leaves the residential level of care prior to a formal discharge or against staff advice, the provider shall:</u> <u>1) Document in the consumer’s record that the consumer refused referrals or transfers to another program and left against staff advice.</u></p>	<p>ACCEPT with the addition of “2) Document attempts at re-engaging the consumer and or provide referrals to follow-up care to the consumer.”</p>
<p><i>Supervised Transitional Residential Level of Care</i></p> <p>140.215</p> <p><i>Pages 39- 41</i></p>			
<p>b) 1-5)</p>	<p>This sub-section list five criteria that must be met to be reimbursed for a consumer’s Supervised Transitional Residential level of Care but does not state how many of the five must be met.</p>	<p>How many of the five criteria must be met? 1? 3? or All?</p>	<p>ALL</p> <p>Rule writing language says that in a series of statements, like this, if before the final one there is an “and”, it means all must be met.</p>
<p>c) 3)</p>	<p>In some agencies, staff with</p>	<p>We recommend that “<i>clinical</i></p>	<p>We would accept this and change if</p>

	credentials higher than a QMHP provides supervision.	<i>supervision shall be provided by a <u>minimum</u> of a QMHP.</i>	submitted during the Public hearing phase
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