Health and Human Services Transformation

HHS Transformation Update: 1115 Waiver Public Hearing

September, 2016

Agenda

Context for focus on behavioral health

Stakeholder engagement to date

1115 review

Next steps

Behavioral health is a pressing issue that transcends agencies and populations across Illinois

Governor's Office and 12 Illinois agencies with shared sense of mission

Disproportionate level of spend on members with behavioral health needs

Rapid increase in opioid-related deaths

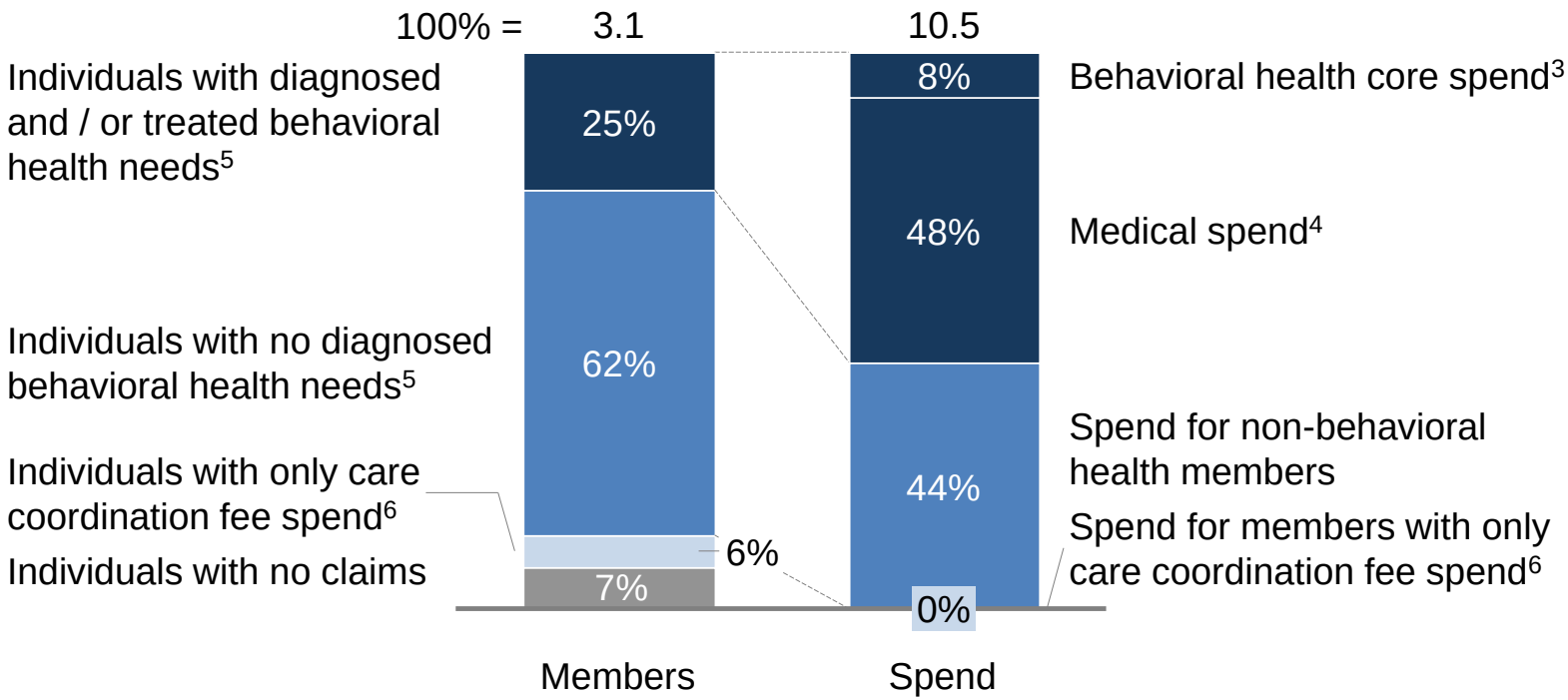
Large undiagnosed or untreated subpopulations

Underutilization of community services and overreliance on intensive institutional care

Medicaid individuals with diagnosed and / or treated behavioral health needs make up ~25% of the population, but ~56% of the total spend

FY2015 members and spend[1,2]

Annualized members (millions), dollars (billions)



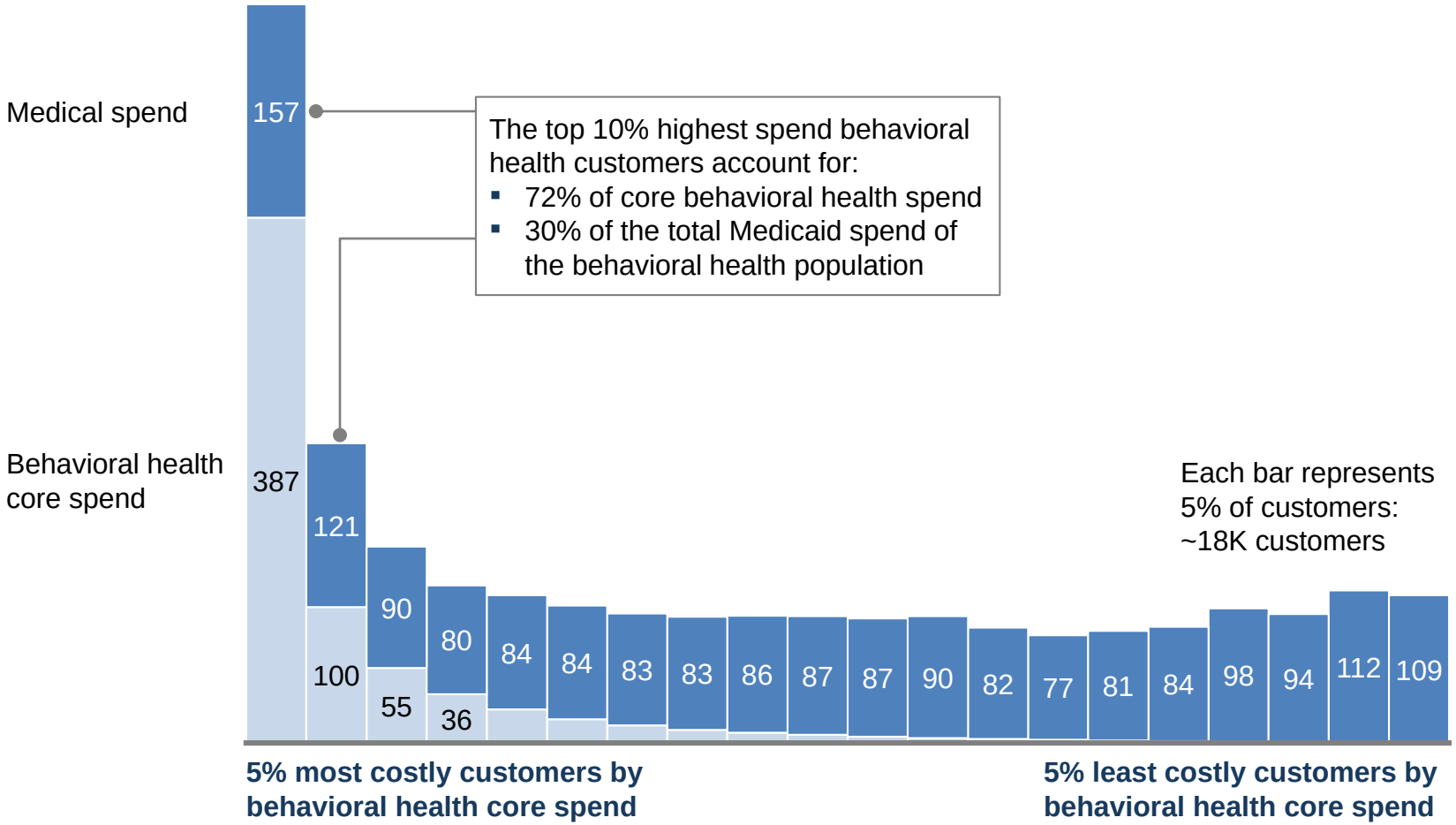
1 Annualized members (not unique members) shown here with no exclusions made on population or spend. Annualized member count = Sum of member months/12
2 Most inclusive definition of behavioral health population used here of members who are diagnosed and treated, diagnosed but not treated, and treated but no diagnosis present. Behavioral health core spend defined as all spend with a behavioral health primary diagnosis or behavioral health-specific procedure, revenue, or HIC3 pharmacy code.
3 Behavioral health core spend is defined as spend on behavioral health care for individuals with behavioral health needs
4 Medical spend is defined as all other spend for individuals with behavioral health needs. See appendix for additional methodology notes
5 Behavioral health diagnosis is defined as a behavioral health diagnosis in any of the first 18 diagnosis fields of any claim during the year. Behavioral health treatment is identified on the basis of a claim with a behavioral health primary diagnosis or a behavioral health-specific procedure, revenue, of HIC3 drug code during the year
6 Annualized members with only spend for care coordination fees. Care coordination fee is identified by HCPCS codes - G9002, G9008

SOURCE: FY15 State of Illinois DHFS claims data

The costliest 10% of Medicaid members account for 72% of behavioral health spend

Distribution of Medicaid behavioral health primary population[1] by behavioral health core spend rank

Total spend = $2.55 Billion

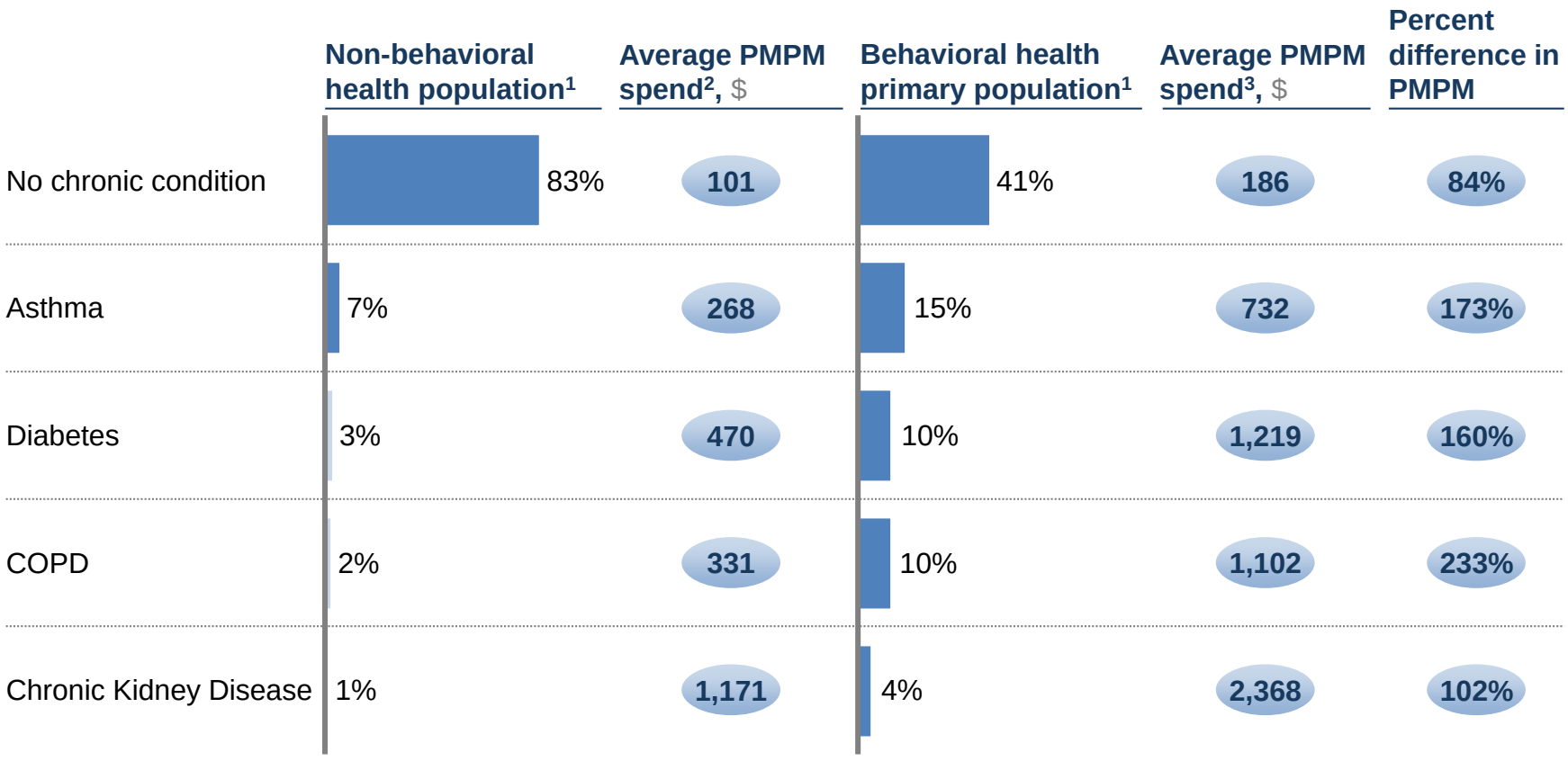


1 Distribution of unique members shown here
2 Primary population defined as Medicaid members with behavioral health needs minus those who have been treated but not diagnosed and those who have been diagnosed but not treated. It also excludes those with dual eligibility or non-continuous eligibility or third-party liability, It also excludes those who died during their inpatient stays

SOURCE: FY15 State of Illinois DHFS claims data

Behavioral health Medicaid members 3.5x as likely to have a chronic condition, ~2x the spend of the non-behavioral health population

Chronic medical condition prevalence and cost in non-behavioral health population vs. behavioral health primary population

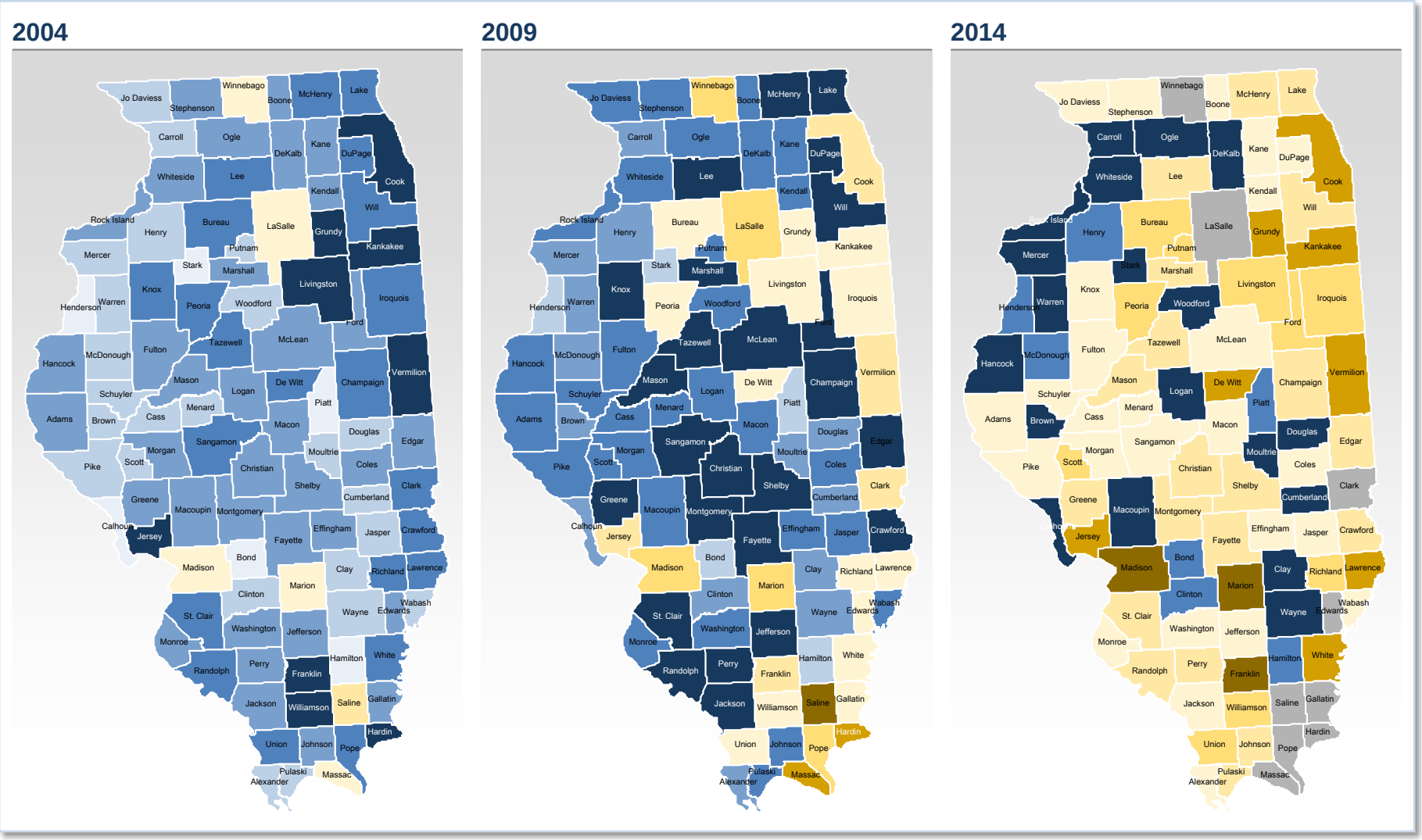


1 Valid population after non-Medicaid and business exclusions; excludes any members without claims or with only coordination fee claims
2 Represents total spend incurred by members of the non-behavioral health population
3 Represents cost of medical treatments for members of the behavioral health primary population

Illinois has experienced a significant rise in drug-related deaths

Estimated Age-adjusted Death Rate[1]

0-2.0 | 2.1-4.0 | 4.1-6.0 | 6.1-8.0 | 8.1-10.0 | 10.1-12.0 | 12.1-14.0 | 14.1-16.0 | 16.1-18.0 | 18.1-20.0 | >20.0



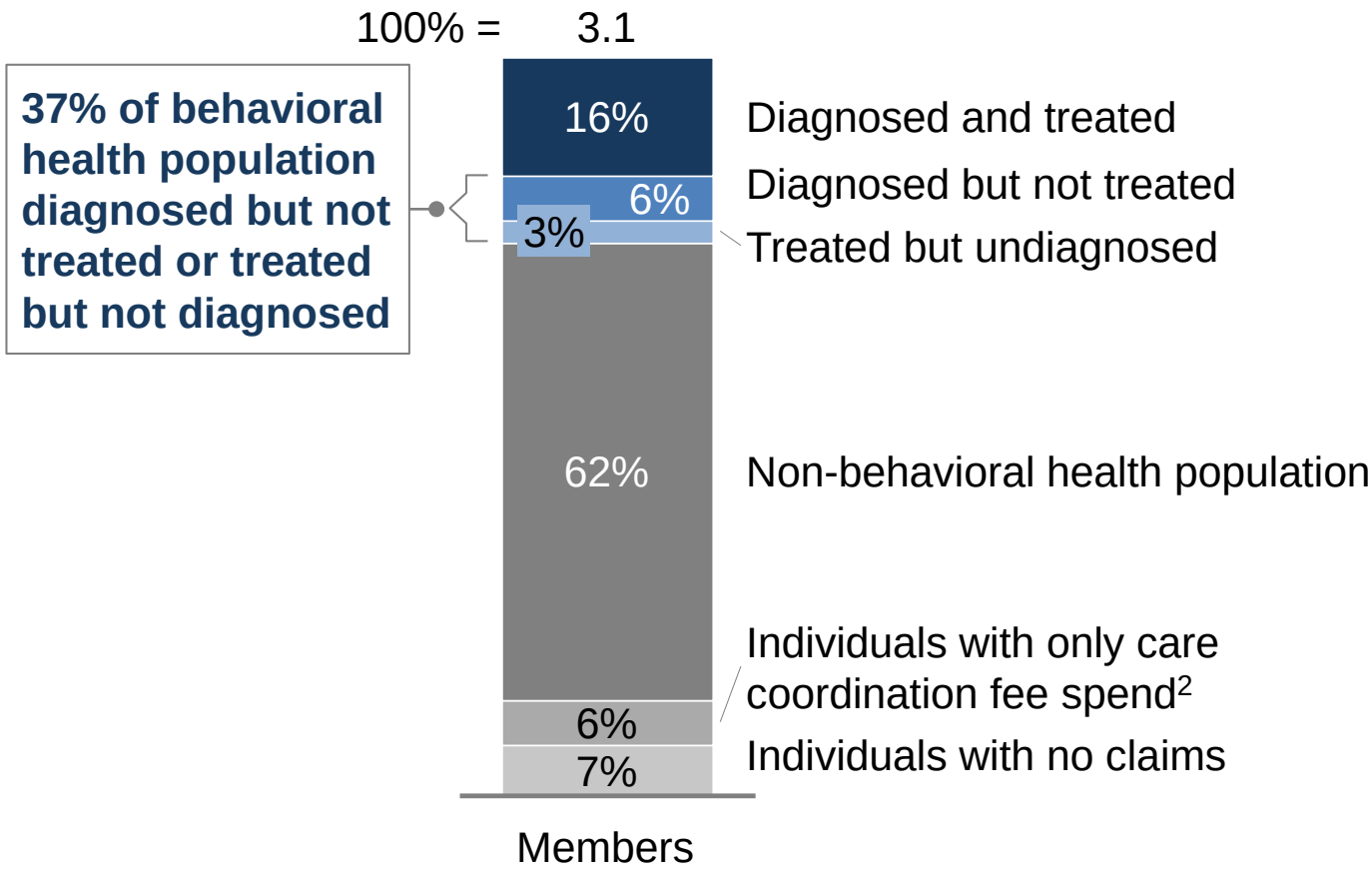
1 Drug-poisoning deaths defined as ICD–10 underlying cause-of-death codes unintentional, suicide, homicide, or undetermined intent

SOURCE: CDC: Drug Poisoning Mortality County Trends

37% of the Medicaid behavioral health population are either treated but undiagnosed or diagnosed but not treated

Overall members by population, FY2015[1]

Annualized members (millions)



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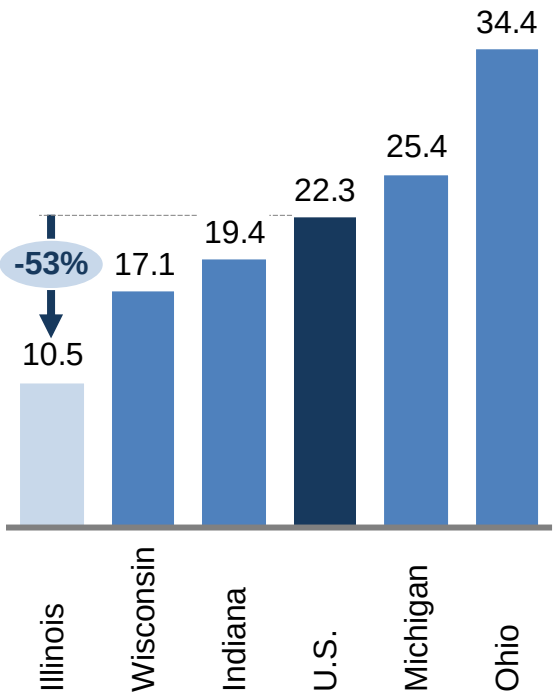
2 Annualized members with only spend for care coordination fees. Care coordination fee is identified by HCPCS codes – G9002, G9008

SOURCE: FY15 State of Illinois DHFS claims data

Illinois' behavioral health system utilizes substantially less community care and significantly more inpatient care than peers with varied outcomes

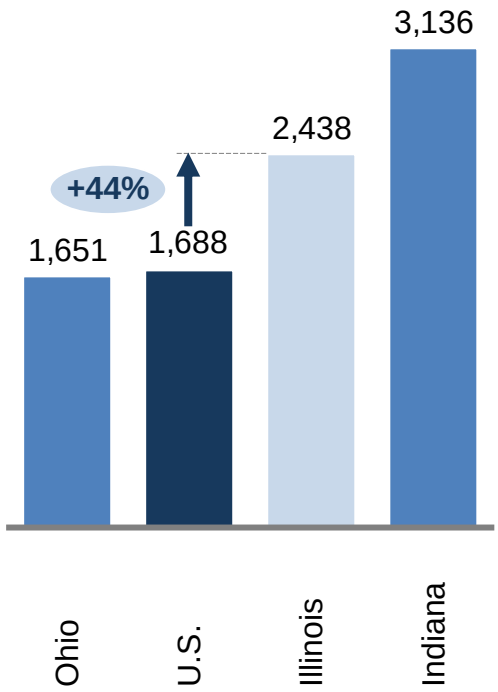
Illinois consumers access community services 50% less than the national average

Community Utilization
Utilization per 1,000 population, 2014



Customers stay in state operated psychiatric hospitals (SOPHs) more than 40% longer than national average

Length of Stay of customers in SOPHs (Days), 2014



Illinois outcomes vary across behavioral health indicators

- Performing above national average
- Performing at national average
- Performing below national average

	Value	State rank
Youth with dependence or abuse problems	5.8%	11
Adult with dependence or abuse problems	8.8%	26
Mental health workforce availability[1]	1: 844	30
Decline in treatment capacity for heroin[2]	53%	50
Preterm birth[3] (*can be driven by substance use)*	11.75	32
Violent crime[4] (*often linked to substance use)*	380.2	31

1 Ratio of the state population to the number of mental health providers including psychiatrists, psychologists, licensed clinical social workers, counselors, and advanced practice nurses specializing in mental health care; 2 Over the years 2007-2012; 3 Percentage of babies born before 37 weeks gestation; 4 Per 100,000 population

SOURCE: SAMHSA Uniform Reporting System- 2014 State Mental Health Measures; HFS claims analysis SFY 2015; Parity or Disparity: The State of Mental health in America, 2015; America's Health Rankings, United Health Foundation 2015; Diminishing Capacity: Heroin Crisis 2015

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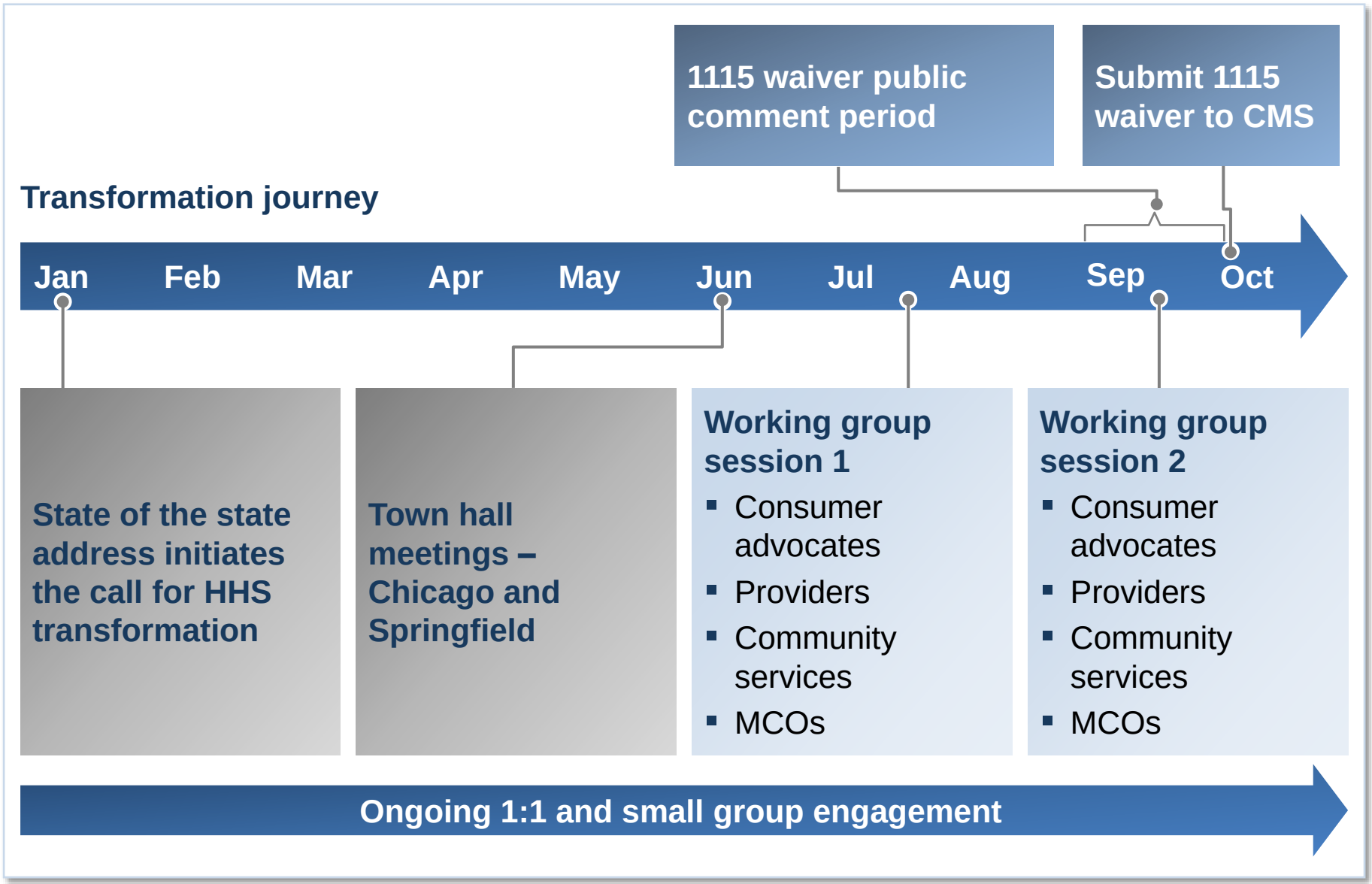
Stakeholders have been engaged throughout the behavioral health strategy and 1115 development process



The State has received input from a variety of stakeholders across multiple fora

2,000	Stakeholders involved in SHA (State Health Assessment), SHIP (State Health Improvement Plan), and SIM (State Innovation Models), encouraging Illinois' focus on behavioral health and the broader HHS Transformation
4	Working groups representing consumer advocates, community services providers, behavioral health providers, and managed-care organizations that have contributed to the behavioral health strategy and this waiver
2	HHS Transformation town halls accompanied by an additional 5 held by DCFS to collect input from hundreds of stakeholders
4	SIM workgroups including consumer needs, data and technology, quality measure alignment, and, most closely related, physical and behavioral health integration
11	Focus groups and organizational presentations held as part of the State Health Assessment in Champaign, Cook, Lee, St. Clair, and Sangamon Counties
>200	Written recommendations from stakeholders to be considered in development of the behavioral health strategy

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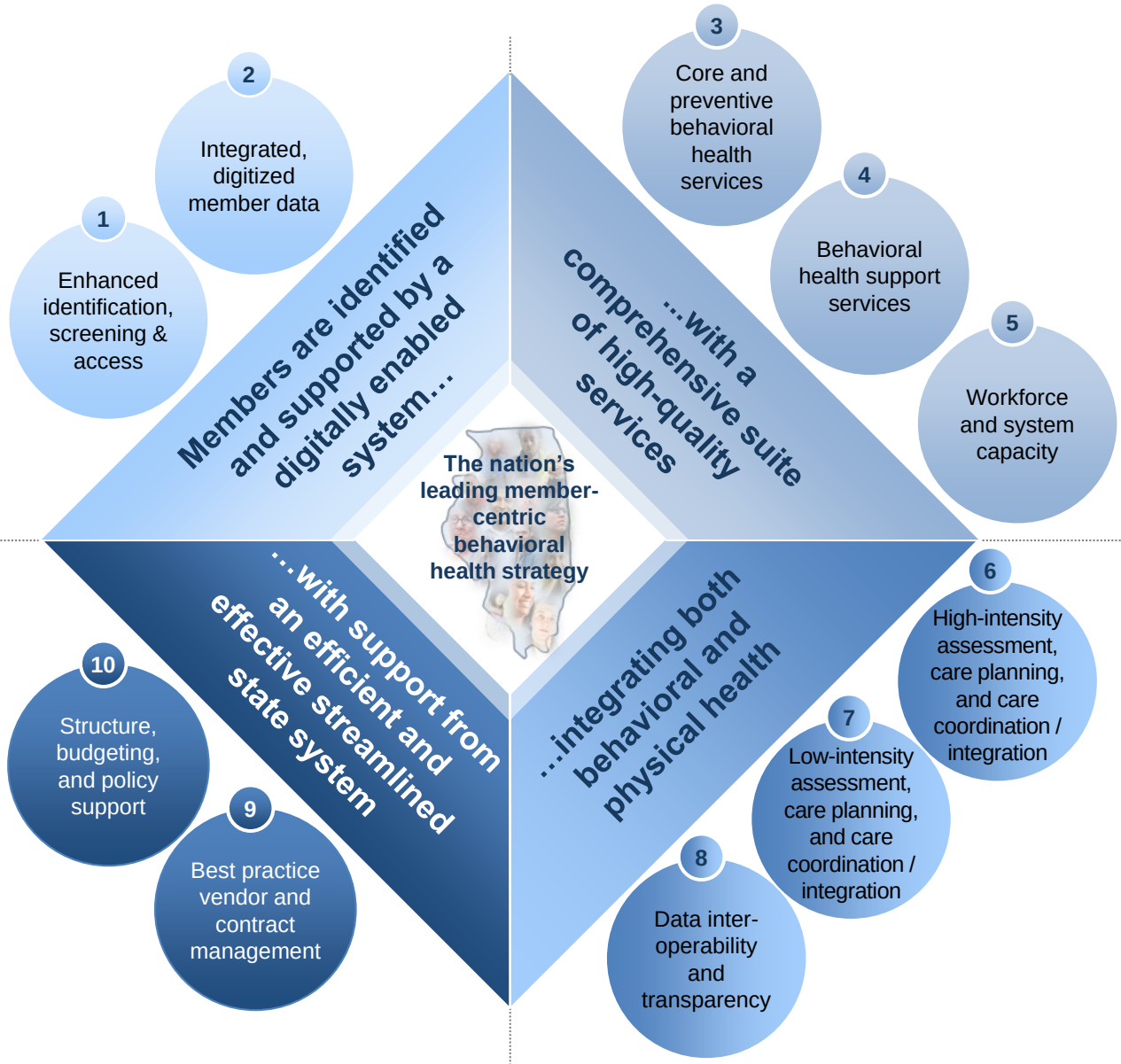
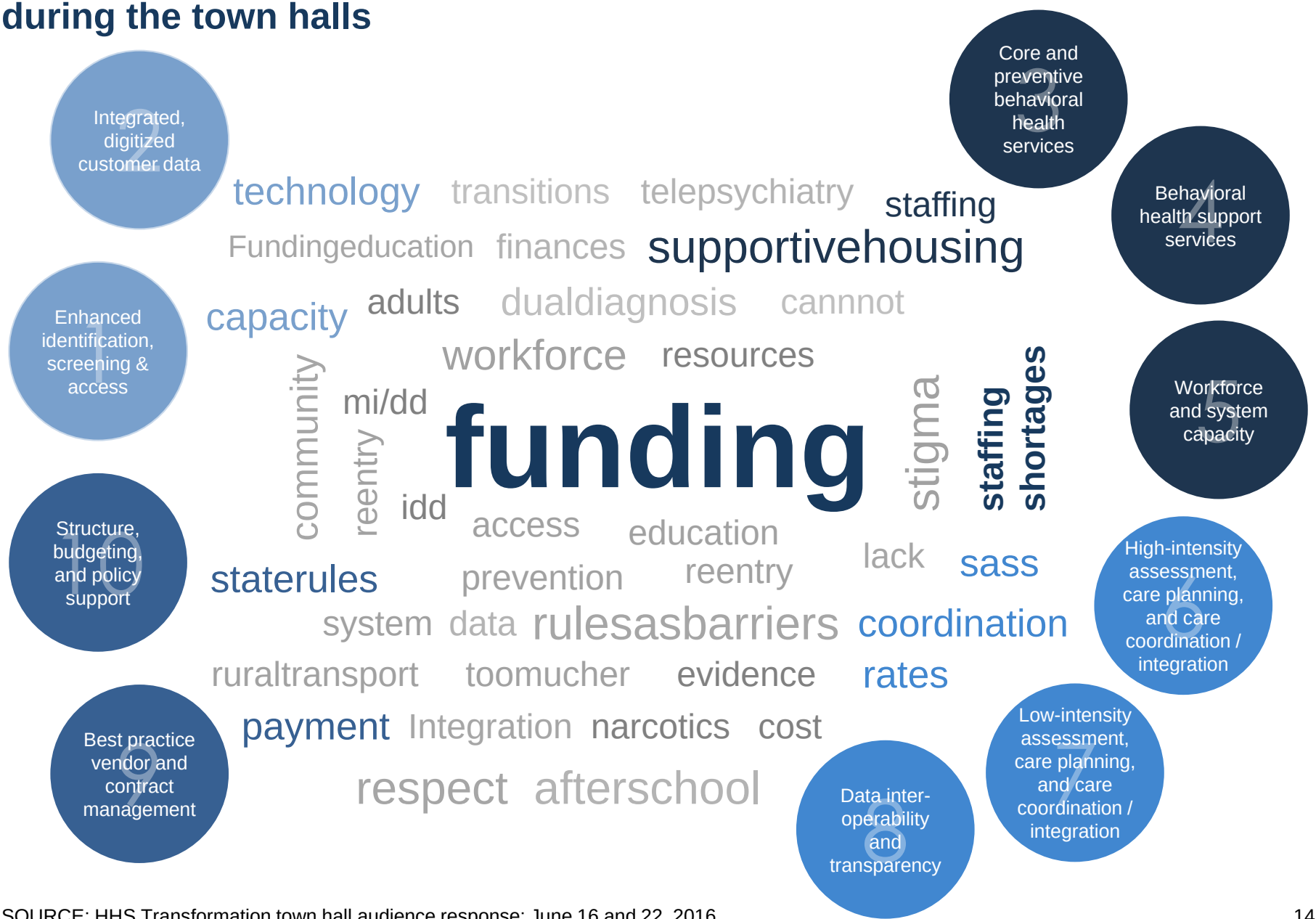
Informed by stakeholders, Illinois envisions a member-centric behavioral health system enabled by ten key elements



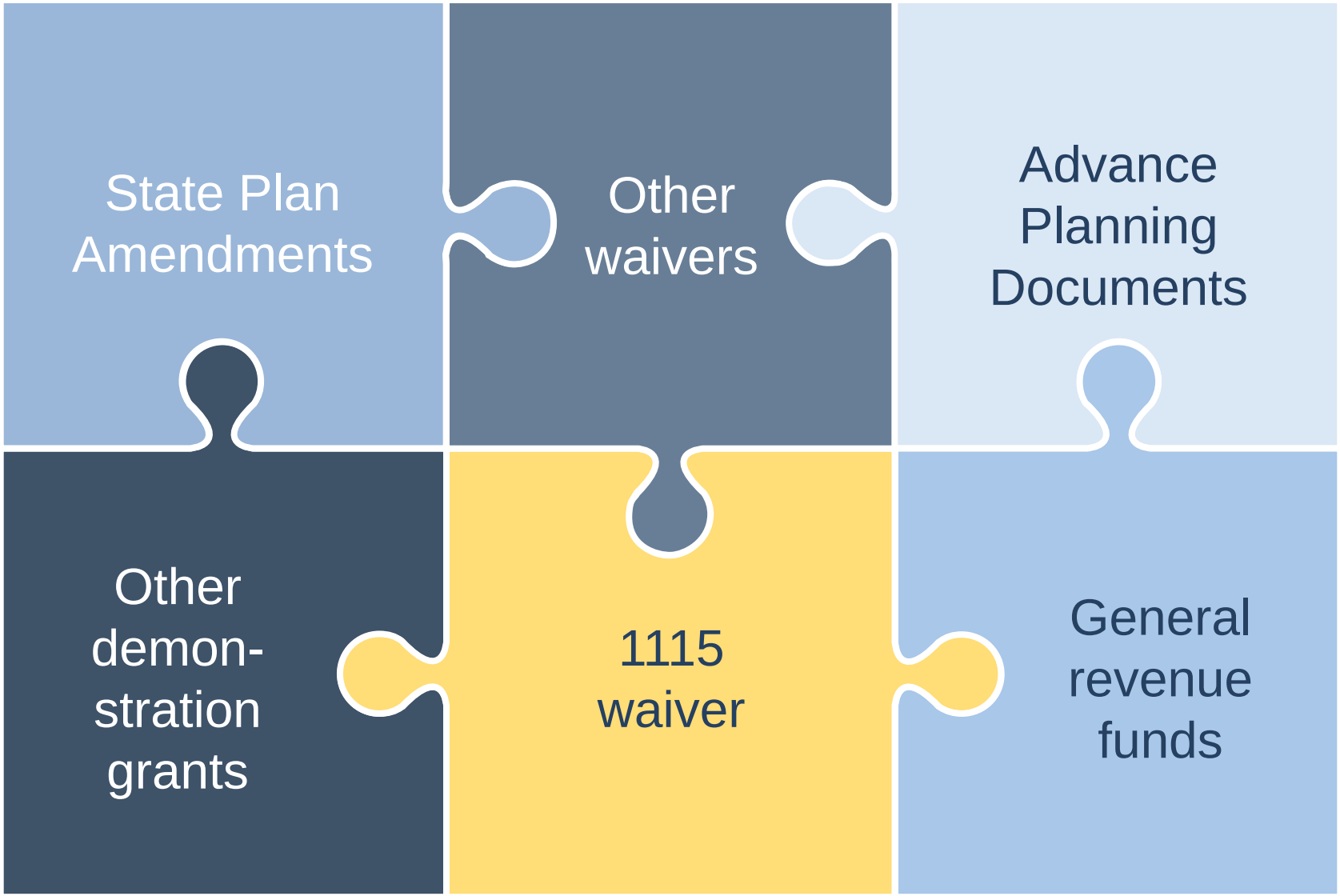
The strategy addresses many of the additional pain points that were cited during the town halls



SOURCE: HHS Transformation town hall audience response; June 16 and 22, 2016

The 1115 waiver is one component of a diverse range of initiatives to be employed by the HHS Transformation

Focus of today's public hearing



Illinois intends to use an 1115 waiver to help achieve the behavioral health strategy and reinvest federal dollars back into the system

What 1115 waivers are

- Opportunities to test and implement innovative approaches to Medicaid coverage that do not fall within current federal rules
- States commonly enact waivers to:
  - Incorporate additional services not coverable under Medicaid state plan
  - Test and evaluate innovative initiatives to improve care, increase efficiency, and/or reduce costs
  - Integrate care or streamline service delivery across populations, services, or providers
- 1115 waivers must be budget neutral to CMS but allow IL the opportunity and flexibility to reinvest identified federal dollars back into the system

Why Illinois needs an 1115 waiver

- Desire not to let federal dollars Illinois finds "go to waste," ensuring reinvestment of federal and non-federal shares in the behavioral health transformation (though IL must stick to its commitments)
  - Note that if Illinois receives the waiver, CMS expects a commitment to reinvest trend-adjusted savings
- Need for catalytic investments to create a nation's leading behavioral health system
- Desire to make payment and delivery system reforms

Today's public hearing offers a comprehensive overview of the current draft of the 1115 waiver

Waiver components	Description
A Waiver goals	▪ **Goals** to transform Illinois' behavioral health system
B Waiver benefits	▪ **Services provided** to a targeted population by a set of eligible providers *(may be limited)*
C Waiver initiatives	▪ **Investments** in key infrastructure, processes, trainings, and incentive structures to enhance impact of waiver benefits and overall behavioral health transformation

A Illinois has identified 6 goals it hopes to achieve through this waiver

1. Rebalance the behavioral health ecosystem, reducing overreliance on institutional care and shifting to community-based care
2. Promote integrated delivery of behavioral and physical health care for behavioral health members with high needs
3. Promote integration of behavioral health and primary care for behavioral health members with low needs
4. Support the development of robust and sustainable behavioral health services that provide both core and preventative care to ensure that members receive the full complement of high-quality treatment they need
5. Invest in support services to address the larger needs of behavioral health patients, such as housing and employment services
6. Create an enabling environment to move behavioral health providers toward outcomes- and value-based payments

B This waiver will allow Illinois to realize a set of high-priority benefits (1/3)

Demonstration waiver benefits

#	Benefit	Description
1	Supportive housing services	▪ Services to address behavioral health through a "whole-person" approach and support an individual's ability to prepare for and transition to housing and maintain tenancy once housing is secured
2	Supported employment services	▪ Services to address behavioral health through a "whole-person" approach and support behavioral health members who, because of their illnesses, need intensive ongoing support to obtain and maintain employment
3	Services to ensure successful transitions for justice-involved individuals at IDOC- and Cook County Jail (CCJ)	▪ Screening, assessment, treatment, and coordination-focused services for IDOC- and CCJ-incarcerated individuals 30 days prior to release to improve linkages with community behavioral health treatment, ensure appropriate utilization of high-end services, and reduce recidivism ▪ Immediate enrollment in managed care upon discharge for eligible individuals. For those released from CCJ after more than 60 days detainment and without previous attribution to an MCO (or opt for another), auto-enrollment in CountyCare ▪ Deferral of redetermination to ensure continuity of care upon release ▪ Pilot for vivitrol pre-release for subset of those discharged with clinical indications

B This waiver will allow Illinois to realize a set of high-priority benefits (2/3)

Demonstration waiver benefits

#	Benefit	Description
4	Services for individuals with substance use disorder in short-term stays in IMDs	▪ Services provided to individuals with substance use disorder during critical, stabilizing, and recovery-oriented short-term stays in IMDs to ensure individuals have access to the right type of care at the right time in the right setting
	SUD case management	▪ Provision, coordination, and arrangement of ancillary services designed to support a specific individual's treatment with the goal of improving clinical outcomes
	Withdrawal management	▪ Services that provide 24-hour support for individuals with varying intensities of withdrawal to increase likelihood of continuing recovery
	Recovery coaching for SUD	▪ Strengths-based support for individuals with SUD and those actively recovering from SUD

B This waiver will allow Illinois to realize a set of high-priority benefits (3/3)

Demonstration waiver benefits

#	Benefit	Description
5	Services for individuals with mental health issues in short-term stays in IMDs	▪ Services provided to individuals with mental illness during critical, stabilizing, and recovery-oriented short-term stays in IMDs to ensure individuals have access to the right type of care at the right time in the right setting
	Crisis beds	▪ Diversion beds to serve as alternative destination for individuals fulfilling medical necessity requirements but without acute or high enough needs to warrant inpatient care
6	Intensive in-home services	▪ Time-limited, intensive, home-based crisis intervention services to allow families of children with mental health conditions to improve youth and family functioning and prevent out-of-home placement in inpatient settings
	Respite care	▪ Services to provide children and their caregivers supportive time apart to reduce stress and keep children in their communities

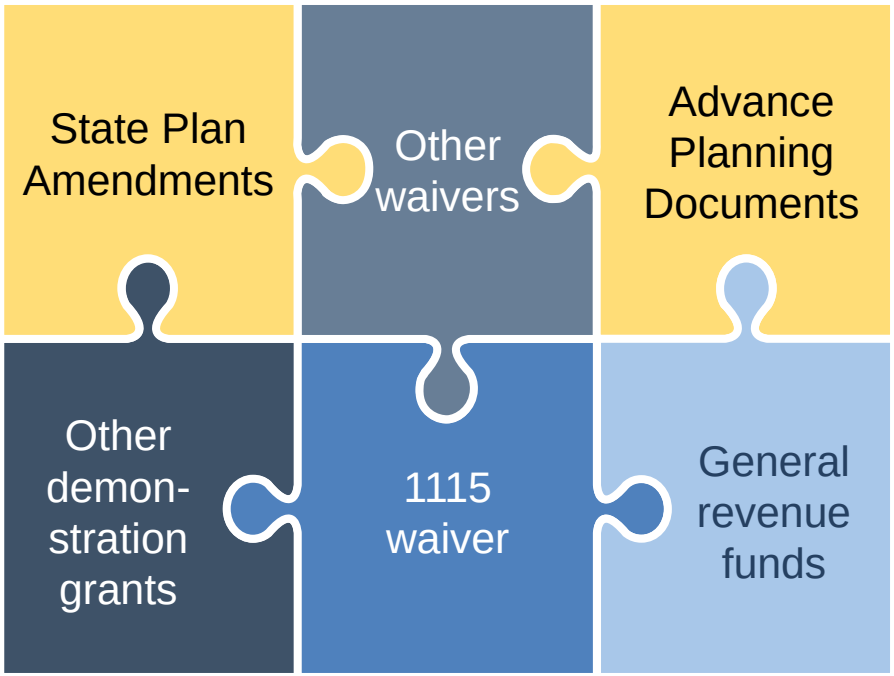
C The State also seeks to pursue a set of initiatives that will complement the benefits and maximize their effectiveness

Demonstration waiver benefits

#	Initiative	Description
1	Behavioral and physical health integration activities	▪ Investment funds for the State, MCOs, and providers to promote integration of behavioral and physical health (e.g., development of team-based care partnerships between providers, workforce cross-training to ensure competence in both physical and behavioral health, etc.)
2	Infant/Early childhood mental health consultation	▪ Consultations to teach professionals who have frequent contact with young children (e.g., teachers, care providers) ways to improve the socio-emotional and behavioral health and development of at-risk children
3	Workforce-strengthening initiatives	▪ Investment funds for the State and providers to support behavioral health workforce-strengthening initiatives (e.g., creation of a loan repayment program, continuing education, and telemedicine infrastructure)
4	First episode psychosis (FEP) programs	▪ Programs that address individuals in the initial onset of a psychotic episode, stopping the usual trajectory into disability

The State will also pursue initiatives outside the waiver to advance its behavioral health strategy

Non-waiver initiatives covered here



Other initiatives

- State Plan Amendments (SPAs), including, but not limited to:
  - Integrated physical and behavioral health homes
  - Crisis stabilization and mobile crisis response
  - Uniform Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA)
- Advance Planning Documents (APDs)
  - Data interoperability through 360-degree view of behavioral health member

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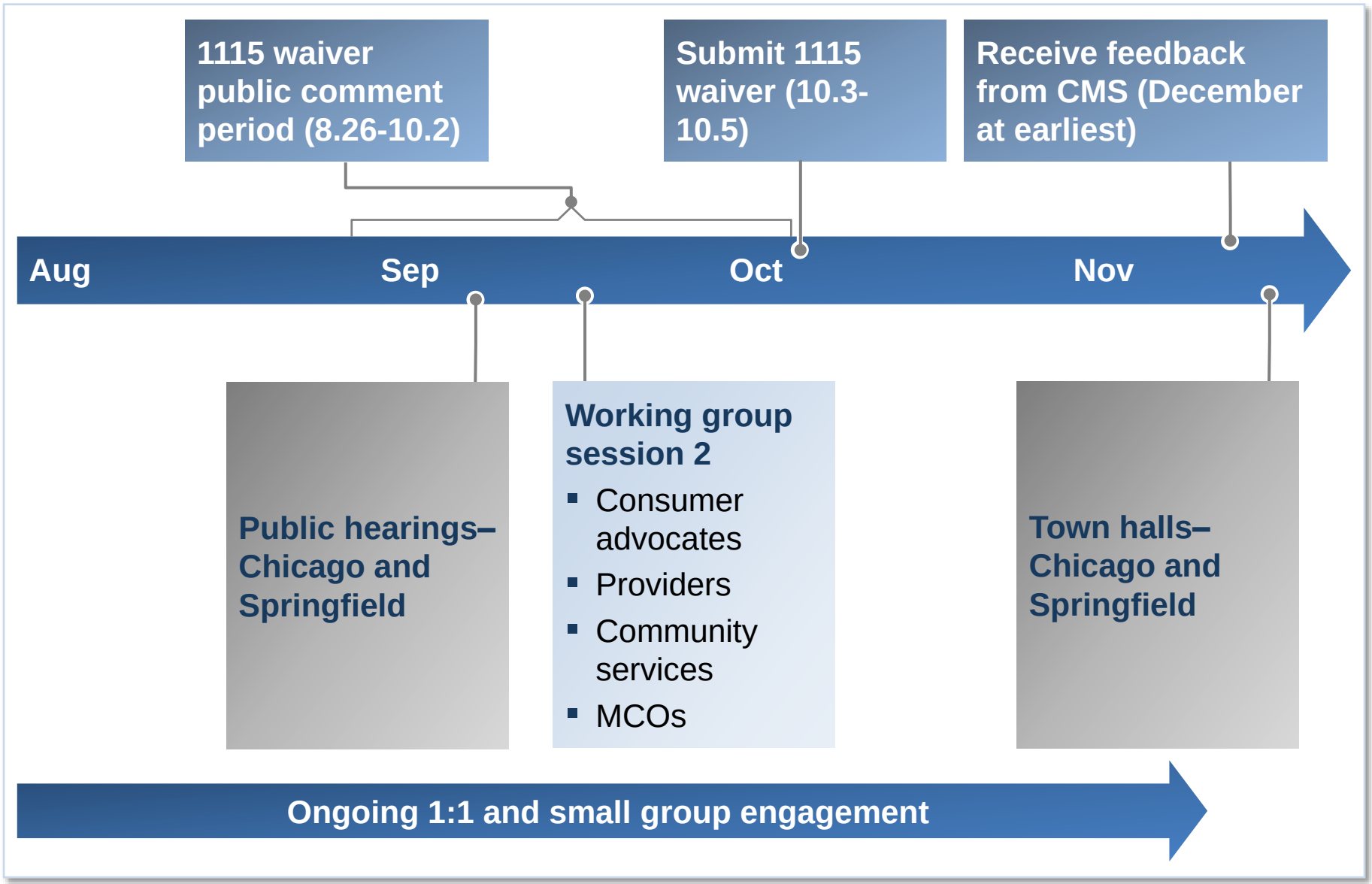
The Transformation will continue to seek out stakeholder input going forward



Any questions or comments

Thank you for your support

Learn more at http://www.illinois.gov/hfs/

Submit written comments to hfs.bpra@illinois.gov

Or by mail to:
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Division of Medical Programs
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