

Good morning. My name is Jim Stone. I am the Director of Public Health for the Sangamon County Department of Public Health. I have held that position for the last 26 ½ years. I am a former President of the Illinois Association of Public Health Administrators. Thank you for the opportunity to present testimony today in support of the Governor's request for a Federal 1115 Waiver.

The primary reason the public health community supports the 1115 Waiver request is the hope and belief there will be a strong new focus on primary prevention by including resources and strategies for prevention and public health.

Any effort to improve behavioral health must address the social determinants of health and the impact of traumatic experiences in childhood on behavioral and emotional health. Since "half of all diagnoses of mental illness are made by the time a person is 14, and three-quarters are made by the age of 24," prevention efforts must focus on children and youth. This was noted in the 2011 publication Primary Prevention in Behavioral Health: Investing in our Nation's Future, by the National Association of State Mental Health Program Directors.

Best practices for behavioral health promotion and risk reduction have been identified by the Institute of Medicine, the federal Substance Abuse and Mental Health Services Administration, the National Association of State Mental Health Program Directors, as well as the Illinois Children's Mental Health Partnership.

I firmly believe that all strategies must have an explicit connection to local public health, health care, and human service systems. The transformation will affect the delivery of services by the state's community-based partners. A real commitment to community partnerships is essential for success.


The 1115 Waiver could provide the opportunity to expand the current Universal Newborn Support System demonstration that is being supported by federal Maternal, Infant, and Early Childhood Home Visitation Program funds. Furthermore, the waiver would also provide an opportunity to expand early childhood home visiting, including Healthy Families Illinois, Parents as Teachers, and the Nurse-Family Partnership, among other evidence-based models, by leveraging additional Medicaid revenues to match current investments of precious state funds.

It is also possible the 1115 Waiver could help to expand school-based approaches to prevention, early intervention, and access to care, through the expansion of school-based health centers.

Lastly, the waiver could also provide an opportunity to invest in primary prevention strategies to address opioid addiction, which has been identified as an epidemic by the Centers for Disease Control. According to the CDC, the number of overdose deaths involving opioids (including prescription opioid pain relievers and heroin) nearly quadrupled since 1999. More people died from drug overdoses in 2014 than in any year on record. The majority of drug overdose deaths (more than six out of ten) involve an opioid. 78 Americans die every day from an opioid overdose.

For these reasons, and many more than time allows for me to elaborate, I support the Governor's vision in seeking the 1115 Waiver which places emphasis on prevention and public health by introducing strategies that are designed to improve maternal and child health, as well as address our Country's opioid overdose epidemic.

Thank you for the opportunity to speak today.



# SIU School of Medicine

Good afternoon.


My name is Dr. Kari Wolf. I am a practicing psychiatrist and the new Chair of Psychiatry at the Southern Illinois University School of Medicine (SIU-SOM). As you know, the SIU School of Medicine exists to improve the health of all the people of central and southern Illinois through education, patient care, research, and service to the community. SIU-SOM is unique in that it serves the 67 counties in central and southern Illinois that represent both rural and urban communities. With more than 2,000 graduates practicing in Illinois coupled with 350 full-time faculty members and 1,700 academic and clinical staff, SIU's commitment to the community can be felt throughout the region.

This summer, I moved from Austin, Texas, to Springfield to join the SIU School of Medicine. In Texas, I wrote and implemented five 1115 Waiver projects and was involved in the implementation of several more. Illinois' development of the 1115 Waiver program was a major factor that led to my taking this position because I know first-hand the impact this program can have to improve care and reduce costs. I am excited to be able to apply my learnings from the Texas 1115 Waiver program to this state.

We at the SIU School of Medicine are excited to see the focus on behavioral health in the Illinois 1115 Waiver Program. I have personal experience with 1115 Waiver projects that focus on several of IL's priority areas:

- First I created a workforce development project that expanded psychiatry GME positions and created a fellowship focused on integrated behavioral health care. We know that nationally, 68% of doctors practice within 100 miles of where they did residency or fellowship (AAMC). However, with our project, more than 90% of our graduates stayed within 25 miles so expanding those residency spots had tremendous impact on access to care locally. Our project also included post-graduate training for pharmacists to assist primary care physicians in prescribing psychiatric medications. In Illinois, I see the opportunity for similar project that could be expanded to also train psychiatric nurse practitioners, physician assistants, licensed clinical social workers and psychologists.
- Another priority area where I have significant experience is in creating integrated behavioral health care. Our 1115 Waiver projects created 16 integrated clinics which served patients both through in-person care as well as wrap-around telemedicine for times when our provider was not physically in the clinic. We developed protocols for the local safety-net clinics to provide early recognition of depression and anxiety as well as treatment algorithms that could be carried out by the primary care physicians. With the Illinois 1115 Waiver project, I see significant opportunities to build integrated behavioral health clinics and to create systems of care through protocols and education so that primary care

Kari M. Wolf, MD  
Department of Psychiatry



# SIU School of Medicine

physicians are equipped to comfortably manage basic psychiatric care and preserve psychiatric expertise for more complicated cases

- My experience with the creation of 14 school-based behavioral health clinics aligns with Illinois' priority around youth prevention efforts. In our project, we placed a full-time therapist on each school campus to provide direct care to students individually and in groups as well as their families. But another, significant component of this project was the educational curriculum developed by these therapists. The therapists trained school staff in mental health first aid as well as other aspects of identification and management of students with behavioral health conditions. They also developed curriculum that was delivered to the students to prevent bullying, substance abuse, and to help with stress management. We saw a significant reduction in school absences and disciplinary referrals as well as improvement in behavioral health of the students. With the Illinois 1115 Waiver, we have the opportunity to build similar projects to improve the health of our youth.
- The final area I would like to discuss today is telepsychiatry. We built an 1115 Waiver project that created telemedicine network to 10 area hospitals in addition to more than 2 dozen primary/specialty care clinics. The limitation we experienced in Texas with our telemedicine project was the way the RHP boundaries were drawn. Had they aligned with the patient referral pathways, we could have had a much greater impact on getting patients the right care in the right place and avoided numerous patient transfers into the region where the service was available. I encourage you to take this experience into consideration as you define the rules for the Illinois 1115 Waiver project.

In closing, I want to applaud you for your efforts to bring the Illinois 1115 Waiver program to fruition. And I, as well as the SIU School of Medicine, stand ready to assist you as you develop the details of the program and as we collectively transform the healthcare delivery system. Thank you.

Kari M. Wolf, MD  
Department of Psychiatry

# Macomb Police Department

120 S. McArthur Street  
Macomb, Illinois 61455

Curt W. Barker  
Chief of Police

(309) 833-4505  
Fax (309) 836-2765

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September 8, 2016

To Whom It May Concern:

I have been a police officer for the city of Macomb for over 22 years. I am here today in support of Illinois' Behavioral Health Transformation & 1115 waiver. Since 2013 I have seen mental health calls for service increase each year from 36 in 2013 to 98 in 2015. As of yesterday, we have received 106 and we are on pace to exceed 150 mental health calls for service this year. That will be a 53% increase in mental health calls for service from last year. Of those calls for service, 43 required services at our local hospital. Those numbers may not seem high to larger cities, but we are a small rural community with a population of 20,000. We don't have a behavioral health center with inpatient services. The only option for officers if they believe the person is a risk to themselves or others is to take them to our local emergency room or to the county jail if they committed a crime. Blessing Hospital in Quincy does have inpatient services, but they are approximately 70 miles from Macomb. Any time an officer is required to take a person to the hospital who is suffering from mental illness he is required to stay with them until he is released by a doctor. This sometimes takes hours. If the individual is combative, this call for service will require two officers. If the individual needs to be transported to Quincy, two officers are taken out of the rotation for at least 4 hours. In almost every case I will need to hire back additional officers to cover while those officers either transport or monitor individuals at the emergency room. Individuals taken to our local emergency room which does not have the facilities for inpatient mental health services are usually medicated and released. Temporarily boarding individuals at our emergency room is not a solution.

"Boarding" individuals suffering from mental illness in our local jail is not a practical option either. In our rural area, it is extremely difficult to find a mental health specialist who can prescribe medication that is willing to see patients in a jail setting. If you are unable to provide the treatment in-house, the inmate must be transported to the hospital to see a mental health specialist and be prescribed their medication. The costs associated with transport and medical treatment for the jail is extremely high. Confinement in a jail setting in some cases will make an individual's mental health issues even worse.

I believe the waiver is an opportunity to improve access to behavioral health services and prevent the "boarding" of individuals with mental health problems in our emergency rooms and local jails. I believe this transformation can increase the capacity for community-based behavioral health services so officers have other options and that this practice does not continue.

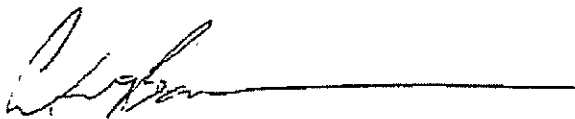
I also believe the waiver creates an opportunity to address the support services that behavioral health patients need once they are released into the community. They need help with housing services, employment services, and ensuring that they stay somewhere in the mental health services continuum. Someone must also ensure that they are receiving "Maintenance" and "Community Support". We do that by increasing the capacity for community-based behavioral health services at the local level with a

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*Pride in Policing*

focus on "Maintenance" and "Community Support". The waiver and transformation will give us the opportunity to make this happen.

Thank you for giving me this opportunity. If you need any additional information or have questions I can be contacted at (309) 833-4505 or via e-mail at [cbarker@macombpolice.com](mailto:cbarker@macombpolice.com).

A handwritten signature in black ink, appearing to read "C. Barker", followed by a long horizontal line extending to the right.

Curt W. Barker  
Chief of Police



**Statement: Illinois' Behavioral Health Transformation 1115 Waiver**

**September 9, 2016**

**Submitted by: Emily Gelber-Maturo, Health & Disability Advocates**

HDA applauds the long-term vision the state has for the behavioral health system, and the commitment to addressing social determinants of health, such as housing and supportive employment, and expanding the Medicaid benefit package for people with serious mental illness and substance use disorders.

However, with any great system transformation, we need to contend with the realities of the short term. In order to implement many of the benefits and initiatives proposed in this waiver, we need to address systemic capacity, clarify roles of payers and providers, as well as improve infrastructure and accountability.

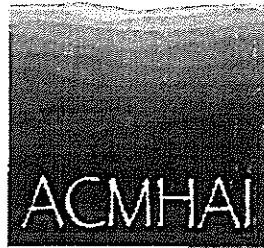
**HDA urges Illinois to use the waiver to make much needed strategic investments in workforce and infrastructure in the short and long term.** In order to enhance access to services and reduce unnecessary expenditures, we have to prioritize the assessment and diagnosis of mental illness and substance use disorders outside of the Emergency Department, the most expensive entry point to the health system. Assessment and diagnosis should happen in the community. Without adequately addressing our workforce challenges, we can't do that, and we can't take full advantage of services delivered through this waiver since eligibility for services is closely tied to diagnosis.

Further, while the services are critical to proposed cost savings; we will need enough providers, who are paid enough to cover their costs. That's not the current reality. We need rate reform. Loan forgiveness and training are not enough. Though the waiver does reference expanding telehealth which will likely help increase access to care, we will still need adequate rates to pay a provider on the other end of the screen.

HDA recommends that the state incorporate Medicaid infrastructure dollars to allow providers to keep pace, build capacity to bill, contract, and hire to provide services. We need to make sure that we are arming them to do what is expected and best within their roles by **investing in our infrastructure.**

In addition, HDA believes the waiver needs **greater clarity on the roles of Managed Care Organizations vs. the roles of providers.**

With how the waiver is crafted, it appears the State is outsourcing a good deal of responsibility to MCOs. It looks like Managed Care Organizations will be expected to implement service delivery. But the problem is that MCOs are payers, not providers. When the waiver addresses implementation of health homes and subsequent creation of a state plan amendment, we need to make sure that providers and other stakeholders are at the forefront of designing these. We don't call our MCO when we need care, we call our doctor.



Association of  
Community  
Mental Health  
Authorities  
of Illinois

## ACMHAI Recommendations

### Illinois' Health and Human Services Transformation

August 10, 2016

In addition to the items identified below in this document, the Association of Community Mental Health Authorities (ACMHAI) also supports the recommendations of CBHA, IARF and IPHA.

1. **What are Community Mental Health Authorities:** Community Mental Health Authorities are one such local funder and operate under the Illinois Compiled Statutes, MENTAL HEALTH, (405 ILCS 20/) Community Mental Health Act, as amended by Public Act 95-0336, August 21, 2007. They are commonly called 708 Boards. They have been formed by local citizens via referendum and provide over \$62 Million Dollars for mental health, developmental disability and substance abuse services in their community. They are designed and structured to work in tandem with the State Department of Human Services. Powers granted in the Act include:

*Sec. 3e. Board's powers and duties.*

*(i) Consult with other appropriate private and public agencies in the development of local plans for the most efficient delivery of mental health, developmental disabilities and substance use disorder services. The Board is authorized to join and to participate in the activities of associations organized for the purpose of promoting more efficient and effective services and programs;*

*(j) Have the authority to review and comment on all applications for grants by any person, corporation, or governmental unit providing services within the geographical area of the board which provides mental health facilities and services, including services for the person with a mental illness, a developmental disability or a substance use disorder. The board may require funding applicants to send a copy of their funding application to the board at the time such application is submitted to the Department of Human Services or to any other local, State or federal funding source or governmental agency. Within 60 days of the receipt of any application, the board shall submit its review and comments to the Department of Human*

ACMHAI/PO Box 935, Aurora, IL 60507/217-369-

5168/cdurkin@acmhai.org/www.acmhai.org

*Services or to any other appropriate local, State or federal funding source or governmental agency. A copy of the review and comments shall be submitted to the funding applicant. Within 60 days thereafter, the Department of Human Services or any other appropriate local or State governmental agency shall issue a written response to the board and the funding applicant. The Department of Human Services shall supply any community mental health board such information about purchase-of-care funds, State facility utilization, and costs in its geographical area as the board may request provided that the information requested is for the purpose of the Community Mental Health Board complying with the requirements of Section 3f, subsection (f) of this Act;*

2. **Local System of Care Stakeholders:** The Transformation Team has properly included a wide range of State public serving Departments such as DHS, HFS, DCFS, Corrections, IBE, DOA, IDPH, Juvenile Justice and more. For the Transformation to have the greatest impact and chance of success, it is critical to recognize that local communities have similar entities that must be taken into account when building a local system of care. There are schools, police departments, courts, health departments, community foundations, hospitals, Federally Qualified Health Clinics, etc., as well as local funding bodies that work in concert with each other and the State of Illinois in addressing the needs of their communities. Otherwise, the State of Illinois might make unilateral decisions that will have serious unintended consequences on the local network, diminish the impact of the local service network, increase costs, and cause the State's efforts to be unsuccessful.
3. **Other Community Funding Sources for Behavioral Health and Intellectual/Developmental Disability Supports:** In addition to the Community Mental Health Boards, when making provider and funding decisions, the Transformation Team cannot disregard other funding resources that are contributing to the communities' Behavioral Health System of Care. Local Matching and enhancement funds include:
  - Governmental Units such as Community Mental Health Authorities, Public Health Departments, Counties, Townships, and Municipalities general revenue
  - Boards for the Care and Treatment of Persons with a Developmental Disability (377) and Health Departments (553)
  - Federal Grants for homeless, Juvenile Justice, Corrections, etc.
  - Community Foundations
  - United Way
  - Civic Associations
4. **Preservation of Community Assets and Investments by Community Mental Health Authorities and other Local Funders:** The Transformation Team should consider the preservation of community assets and investments, where significant resources time and



efforts have been devoted to building and developing behavioral health services. When making decisions on providers and projecting costs versus community impact and outcomes, one does not want to “throw the baby out with the bath water”. What may seem like a cost effective move to a less expensive provider may seriously damage or eliminate programs that are being funded by sources other than the State. The other funding sources may have invested significant dollars in strengthening a number of areas; and may be anticipating future results and outcomes that redirecting state resources may destroy if it is not done working in concert with them. These outside resources that may not appear in the State’s budget include:

- System of care networks and relationships
  - Local planning boards, community partnerships, etc. such as Drug Free Communities or Continuum of Care
- Infrastructure, (buildings, IT, transportation, etc.)
- Staff development and training

For example, one wouldn’t want to remove the State’s Behavioral Health program funds from a provider that may have just received Community Foundation Funds for Staff Training and Development, Telepsychiatry Infrastructure Funds and services for uninsured from the Community Mental Health Authority, ancillary wrap around services fund by the Township or County Welfare Budget; correctional programing funds from the local court or Federal Justice Department, etc.

5. **Do no harm to Community Partnership Efforts:** Many community providers partner with local funders on planning councils, community collaborations, and shared service contracts. A currently funded community mental health agency may be contracted to have staff in a local Federally Qualified Health Center or a homeless shelter. They may also be the local response to the police for runaway and locked out youth. Again, many unintended consequence could occur resulting in overburdening other entities in the community, such as police departments, hospitals, clinics, shelters and crisis response programs.
6. **Coordinate with Existing Community Impact and Performance Measure Targets:** It is important to consider the following when contracting with community service providers. In designing successful treatment plans that will meet performance measurement targets and produce the desired outcomes of all their funders, it is necessary for the provider’s staff to have in-depth knowledge of community needs and assets and to have developed relationships with the other entities in the community necessary for the client/patient and their care managers to successfully access needed services and resources to improve their quality of life. Continued communication between all members of the service team is required to ensure that there is a safety net in place for when the most complicated cases require rapid response. Training and developing this knowledge and the necessary relationships takes considerable time, and the recent history of MCO’s has demonstrated that there is a high rate of turnover in care managers, care

resources and networks, and developed limited relationships with local community providers.

7. **Funds should be made available to nonprofit providers for expansion and infrastructure development:** CMHAs primarily fund nonprofit community based organizations. Community based nonprofit agencies are at a disadvantage compared to for profit providers in that they typically do not have venture, start-up or expansion funds available. This has become increasingly the case as more and more funds have moved from grants to fee-for-service reimbursements; and is particularly true with the delay in state payments resulting from the budget impasse. For-profit service providers have the venture capital to flock to new sources of revenue, and can expand rapidly when there is a new opportunity for rapid growth in revenue. Once revenue matures and growth slows, a for-profit firm will often reduce the quality of service to maintain growth and profit margins, otherwise its stock prices will drop. Some have even been caught cycling patients or fraudulently billing to keep profits up. Nonprofits are mission driven and respond at those times when the market fails and for-profits abandon the service. The State should make available additional funds for nonprofit providers for this expansion of community services. This is particularly important given the movement to deinstitutionalize state services that will increase the demand on community based providers. Local funders do not have enough resources for the kinds of infrastructure improvements that may be required.
8. **Rate structure is unsustainable for service provision:** Since the transfer of Behavioral Health Services to Managed Care, there has been some communications from HFS staff that MCOs will be allowed to negotiate the rates on separate provider contracts without being bound by Rule 132 or established rate structures. ACMHAI recommends against this.  
Rates need to be increased not negotiated down. As other state associations have noted in their responses to the 1115 Waiver, the rates have historically been too low to sustain viable programs. If rates aren't increased there will be fewer and fewer providers out there and any "new" ones (such as LCSWs who can now bill Medicaid) won't be interested.
9. **Supplementation:** In addition, do not anticipate other funding sources such as 708 boards to supplement lower than sustainable Medicaid rates. There is the problem of supplementation. Local funding sources cannot fill in this gap in funding to make the service viable. The provider is prohibited from seeking additional funding from us to make the program viable. A Medicaid rate is supposed to be all inclusive and once billed any attempt on the part of the provider to also use that unit of service to secure additional funding from, for example, the 708 Board, would constitute double billing.

**Prepared by:**

**Ron Melka, Executive Director, Lyons Township Mental Health Commission**



August 3, 2016

Ms. Felicia Norwood  
Director  
Illinois Department of Healthcare and Family Services  
401 South Clinton Street  
Chicago, IL 60607

Mr. George H. Sheldon  
Director  
Illinois Department of Children and Family Services  
100 West Randolph Street  
Suite 6-100  
Chicago, IL 60601

Dear Director Norwood and Director Sheldon:

Ann & Robert H. Lurie Children's is pleased to be engaged in the Health Human Services (HHS) Transformation Initiative led by Governor Rauner. We understand that the immediate priorities of the HHS Transformation initiative will focus on behavioral health. The purpose of this letter is to put forward Lurie Children's recommendations related to behavioral health as well as recommendations for consideration as the scope of the HHS Transformation expands.

**Behavioral Health Recommendations**

For over 60 years, the Department of Child and Adolescent Psychiatry at Lurie Children's has provided psychiatric and psychological services to families and their children of all ages from every social economic background. This year our specialists have provided mental health evaluation and care in more than 28,000 visits; 490 inpatient psychiatric admissions; 254 children served in the Partial Hospitalization Program; and more than 500 consultations each in the emergency department and the hospital inpatient and surgical services.

Currently, Lurie Children's has more than 874 children on its waiting list for outpatient child psychiatry services. Our waiting list has doubled during the State budget crisis due to the significant reduction in community based mental health services and inadequate reimbursement for outpatient mental health services.

Patrick M. Magoon  
August 3, 2016

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Director Norwood and Director Sheldon  
August 3, 2016

4. Remove barriers for prescribing psychiatric medications; for example under Medicaid managed care or other policies:
  - a. For pediatricians that are willing to manage lower acuity children.
  - b. For providers who struggle to get their kids the clinically appropriate drugs because of "step therapy" where you must start with one drug in the formulary before getting to the one that may be best.
5. Increase outpatient Medicaid rates for behavioral health to expand capacity.
6. Create policies and practices that enforce state and federal mental health and substance abuse parity provisions.
7. Since Illinois is a carve-in state with behavioral health carved into managed care, all policies need to have some way to operationalize them through MCOs; for example, establishing performance expectations for the MCOs to push care management functions out to clinical environments rather than centralizing them and providing CM through the MCO. Or creating incentives for MCOs to contract with integrated Behavioral Health/Primary Care clinics.

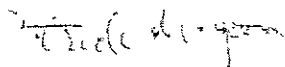
#### Other Recommendations

*Medically Complex Children:* Nationally, Lurie Children's leads a comprehensive health care reform effort for children with medical complexity through the Children's Hospital Association's federal Medicaid proposal for children with medical complexity. We believe that the federal Medicaid proposal is the best care delivery model for children with medical complexity. We ask that the State include its intention to join a national Medicaid initiative focused on children with medical complexity, if implemented, in its waiver. This program transforms health care delivery for children with medical complexity by assuring access to needed health care services and reducing overall costs of care for children with medical complexity. Attached is language we would like included in any vehicle that the state employs to pursue transformation.

*Non-Mandatory Populations:* Allow opportunities for qualified providers to manage care or take risk for non-mandatory Medicaid populations of children such as those enrolled in DCFS, DSCC, and SSI.

Thank you for your consideration of these recommendations. We look forward to continuing our work with you on behalf of improving the health and well-being of Illinois children.

Sincerely,



Patrick M. Magoon  
President & CEO

cc: AJ Wilhelmi, President & CEO, Illinois Health and Hospital Association

Attachment

The State of Illinois intends to pursue through this 1115 Waiver Project expenditure authorities related to the care coordination and special needs of medically complex children that could be implemented consistent with the State's focus on service delivery through managed care. This program would include flexibility in benefit design and the provision of care to meet the unique needs of this fragile population. The State will be developing innovative service delivery systems such as pediatric networks capable of delivering complex medical care to improve outcomes, increase efficiency and reduce costs for this special population of children. Such authorities may include variation on the amount, duration, and scope of benefits and comparability than those offered to other beneficiaries under the plan as well as other potential design components necessitating a waiver from statewideness and freedom of choice requirements of Title XIX.

**Colleen Cicchetti, PhD  
Child Psychologist  
Ann & Robert H. Lurie Children's Hospital of Chicago**

**Statement of Record on the Illinois Department of Healthcare and Family  
Services proposed Section 1115 Research and Demonstration Waiver**

**Friday, September 9, 2016  
James R. Thompson Center  
100 W. Randolph Street  
Chicago, Illinois 60601  
10:30 a.m.**

Good morning. My name is Dr. Colleen Cicchetti. I am a Pediatric Psychologist at Ann & Robert H. Lurie Children's Hospital of Chicago where I lead the Center for Childhood Resilience. I am also an Assistant Professor at Northwestern University Feinberg School of Medicine. In addition to my role at Lurie Children's, I serve as Co-Chair of the School Age Practices and Policies Committee of the *Illinois Children's Mental Health Partnership (ICMHP)* and am the Clinical Director of the Illinois Childhood Trauma Coalition (ICTC).

Thank you for hosting this hearing on the Illinois Department of Healthcare and Family Services (HFS) proposed Section 1115 Demonstration and for the opportunity to offer testimony that represents the perspective of children. Children are not miniature adults and they have different mental health needs.

For almost 60 years, the Department of Child and Adolescent Psychiatry at Lurie Children's has provided psychiatric and psychological services to families and children of all ages, from every social and economic background. The need for this waiver and the timing of this waiver is evidenced by the situation at our hospital. Currently we have more than 800 children on a waiting list for outpatient child psychiatry services, double our typical waitlist. This year our specialists provided mental health evaluation and care in more than 28,000 outpatient visits; in 490 inpatient psychiatric admissions; 254 children served in the Partial Hospitalization Program; and more than 500 consultations each in the emergency department and the hospital inpatient pediatric and surgical services. The need for our services far exceeds our capacity and this situation is replicated throughout our state.

It is critically important for the state to expand workforce capacity for behavioral health. Under workforce strengthening initiatives in the waiver, there is mention of developing training and learning collaboratives for smaller community providers to support to their capacity to work effectively with Managed Care Organizations. This need is absolutely critical, but no details are provided on how this will be accomplished. Specifically, there is a significant shortage of child psychiatrists, nurses, and other mental health specialists trained to deliver early intervention strategies in educational and community settings and hospital-based services. It is critical that Professional Learning Collaborative and pediatric consultation model pilots developed by ICMHP and others be expanded to address this critical shortage and build evidence-based treatment options for children, youth and families. It is also imperative that we develop incentives to encourage the next generation of pediatric mental health specialists.

#### **Relationship to Medicaid Managed Care**

The 1115 waiver notes that the State is migrating Department of Children and Family Service (DCFS) children to a “specialized managed care product.” There are no additional details about the timeframe or development of this specialized product. We applaud the effort and look forward to a more detailed explanation of the program and would appreciate any opportunity or forum to meet and discuss the complex issues surrounding the vulnerable population.

#### **Inclusion of Children**

Lurie Children’s is pleased that so many of the demonstration benefits apply to children and youth, and that there are some much needed additional benefits for this unique population. The initiatives in the waiver around infant/early childhood mental health consultation and first episode psychosis are excellent.

Services to ensure successful transitions from Illinois Department of Corrections and Cook County Jail are included. We strongly urge that counterpart services be included for Illinois Department of Juvenile Justice, and the Cook County and other Juvenile Temporary Detention Centers. Supporting youth involved in the juvenile justice system in these transitional programs is essential given high rates of exposure to trauma and significant behavioral health needs. In addition, this meets key goal of rehabilitation and successful re-integration back into the community: the earlier these needs can be addressed, the less likely it is that the young person will later be involved in adult corrections.

#### **Implications for Violence Prevention**

Lurie Children’s is very happy to see that crisis intervention training for police officers and mental health first aid training for volunteers and social service and health care professionals are included as part of initiatives to prepare the workforce for behavioral and physical health

## Testimony on Illinois' Behavioral Health Transformation

(Section 1115 Demonstration Waiver)

September 9, 2016

Good Morning. My name is Dr. Jennifer Stelter. I'm the Operations Director of Clinical Programs for Alden Management Services. I'll be speaking today on behalf of the 300 skilled facility members of the Health Care Council of Illinois.

Although Illinois' Behavioral Health Transformation (Section 1115 Demonstration Waiver) plan is pertinent for people suffering with mental illness who can function independently in the community, it fails to detail plans for those who either aren't ready to function independently or aren't able to, long-term.

The plan discusses de-institutionalizing all patients and, in essence, discharging patients from hospital settings right to the community, which sets the patient up for failure when shortcutting a step-down approach to care that we all know works the best for long-term recovery. We believe this will lead to more relapses and an increased need for crisis level of care causing further use of hospital settings or jail to provide services for those suffering with mental illness.

This is the problem that the Demonstration Waiver claims to resolve but will actually heighten.

Alden's Behavioral Health Program is a residential rehabilitation program for those suffering with mental illness. Our program resides in skilled long-term care settings that allow not only the patient to engage in therapeutic mental health rehabilitation but also to care for often prevalent, comorbid medical problems (e.g., Diabetes, Type II, COPD, Hypertension, etc.). We offer short-term and long-term stays, depending on where the patient is at in their recovery and ability to keep themselves safe. We provide 24-7 monitoring, as the patients learn coping skills and medication management needed to sustain stability out in the community.

Additionally, to fund the Waiver program, the plan is to take away \$200 million dollars away from Medicaid Programs, i.e., taking money away from



residential care needed for patients that require this level of care. Taking this money away and closing programs like Alden's Behavioral Health Program can lead to this... one of our programs had 6 residents that were discharged to the community through Money Follows the Person, the state's latest quick fix to take patients out of long-term care settings and support them in the community. These patients required our level of care – now, 2 are in jail, 1 died, and 4 returned to the facility.

There are numerous examples of patients that are with us or were with us and have returned to our setting because they did not sustain stability in the community and needed a higher level of care. I have detailed some of those examples below and will review a few as part of my comments.

Examples:

1. Male, Caucasian, 41 years of age with Paranoid Schizophrenia. His voices give him strong commands and he is genuinely afraid of the repercussions if he doesn't do just as the voices tell him. The voices tell him at times to wash his hands, over and over, as people are dying from his germs. He will then scrub his hands with soap till they are raw and bleeding. The voices will also tell him not to eat and if he does, people will die and it will be his fault. So he will go days or longer without eating. It has gotten so bad that he now has to receive ECT every few months. He requires constant supervision to prevent serious self-harm from the commands. His family has been very pleased with how stable he has been since coming to us and starting ECT. They have said they believe it is because we are able to provide constant supervision and interventions that his family was not capable of doing and this keeps him much safer and healthier. He has been with us for two years.

2. Male, Caucasian, 68 years of age with Schizoaffective Disorder. He came to us after an ICU stay due to being found unresponsive in his apartment having not eaten or taken any medications for a few weeks. He seemed to do well with us and after a while insisted on going home again. We had him show us, for a 6 month period, that he could shower every day, keep his room clean, do his laundry, keep his bedding clean, take all his meds as prescribed, etc., all the things he would have to do to live on his own. He did very well over those 6 months and went home again to live on his own with outpatient psych and medical care all set up. Within a few weeks, we got a call from a local hospital saying he was back in the ICU

and was not expected to live after having not taken any medication since his discharge, including meds for hypertension as well as psych meds, and having not drank or eaten since his discharge. Miraculously he did survive and returned to us. He has acknowledged that this happens every time he tries to live on his own and he now states he does not believe he can ever live on his own and is afraid he will die if he tries this again. He takes all his meds when he is with us and is generally stable overall while at our facility. He has been with us for a total of seven years.

3. Female, Caucasian, 53 years of age, with Paranoid Schizophrenia. This resident came to us after she was arrested for assault. She was living with family but would often times believe that her meds, including the insulin for her very difficult to manage Diabetes, were poison and she would not take the meds. Her family had little if any success at getting her to take her meds when her paranoia was present. She had not been taking her psychotropic meds when she was in line to pay at a store and thought a customer in line behind her was talking bad about her (the other customer was not talking about her at all). She hit the other customer. The court allowed her to come to us as they felt she needed treatment instead of jail. She has very severe auditory hallucinations as well as very serious political and religiously themed delusions, and these only ramp up her paranoia even further. With constant staff interventions we can generally get her to take all of her meds, even her insulin. Her family was frightened of her when she lived with them, but they feel very comfortable to visit her at the facility and will take her out for short passes no longer than a couple hours. Her family, especially her mother who now is becoming pretty elderly, has said that they were not able to manage her when she lived with them before and don't believe they could manage her at any point in the future. But they feel that, due to the constant staff supervision and interventions, she is managed well at our facility and they would like her to remain with us. She has been with us now for eight years and is doing well. She has shown no physical aggression in those eight years.

4. Female admitted to us on May 27, 2016. Diagnoses include: Schizophrenia, unspecified, Major Depression Disorder, Recurrent, and Hypertension. Patient is 63 y/o AA and has been married once, but is currently divorced. She stated that she has been receiving mental health services for years. When she left another residential placement, she moved to an apartment near the city through the program called Money Follows the Person. She lived there for four years; and received services

through MFP. MFP provided her with assistance in managing her funds, taking classes which she attended two days a week plus field trips, and regular appointments with a physician and psychiatrist. Per the patient, living independently became stressful. She stated she had mental relapses, frequently. She says stress was the culprit. Stressful matters included: memory setbacks, reduced contact with family (afraid to be involved with family), being left alone often, and many medication adjustments. After one hospitalization and her stay with us thereafter, the new medication has her stabilized, less anxious, and she has built a network of friendships on the unit. She states she prefers living in a supervised environment. It appears that having a routine is the key to stabilization. She further stated that she does not want to return to the community to live independently at this time.

5. Female is currently 59 y/o AA with a diagnosis of Schizoaffective d/o, Major Depressive d/o, Single episode, Heart Failure, DM, HTN and Glaucoma. She was admitted to us in November of 2014 from another long-term care setting. She was married in her teens to her husband who passed away in 1979. To this union was born four children from 1975 to 1978. After this tragedy, she felt alone, and had little contact with her family. She expressed that she prefers to be in rehabilitation because, "it's so lonely out there." She went on to say, "I don't want to move from here." She said, she was afraid to make friends in the community, and to go to the laundromat because she might get robbed or hurt. She further stated that people would take advantage of her by asking for money or to borrow the TV, etc. She felt like no one valued her. She expresses that she loves living in this environment because she says no one here is trying to take advantage of her. "I have a place to be, with people I see every day, and I can tolerate people better."

6. Female is a 64 y/o AA with dx of Schizophrenia, Depressive episodes, DM type 2, Anemia, Chronic Embolism and Thrombosis of unspecified vein. She reports living in a one-bedroom apartment in the past (dates she cannot recall at this time). From what we've been told, twin daughters have taken advantage of her financially. What brought the patient back to living on a specialized behavior health unit was "...getting up depressed and talking to myself." She has lived with us since July 2010. She often inquires about living independently, but does not meet the requirements of the Money Follows the Person housing program. She needs assistance with medication administration, reminder to shower, and managing her

anger. She has been advised by the MFP that she would be in need of a supervised setting versus independent living.

7. 52 yr. old AA male with a diagnosis of Schizoaffective and HTN. He was moved out of our SNF by Thresholds into the community in May 2015 and was in and out of the hospital over seven times due to medication noncompliance during the time he lived in the community. In early 2016, Thresholds moved him into an ICF where he did not do well and in April 2016 Thresholds asked that he be readmitted to our SNF. When he returned to our SNF he was off his baseline and is still not back to the level of functioning he was at before he moved into the community.

8. 60 year old Caucasian male with a diagnosis of Bipolar D/O, Chronic pain syndrome, and osteoarthritis. He was living in the community working with Thresholds and he was unable to function, could not manage his medication and was in and out of the hospital. Thresholds moved him into an ICF where he did not do well and then moved him into our SNF.

9. 63 year old AA male with a diagnosis of Schizophrenia and HTN. He states that he does not want to move out into the community; he feels he would be taken advantage of and would not stay on his medication.

In conclusion, the examples I have presented demonstrate that not all individuals with mental illness with comorbid issues are able to function independently in the community. It is our recommendation that the 1115 waiver plan include accommodations for individuals who either aren't ready to function independently or aren't able to, long-term.

Thanks you for the opportunity to speak today. I am available to answer any questions you may have.

Testimony on Illinois' Behavioral Health Transformation  
(Section 1115 Demonstration Waiver)  
September 9, 2016

Good Morning. My name is Fred Berkovits and I am the Regional Director and Corporate Compliance Officer for Bria Health Services. I am also a member of HCCI and speak on behalf of all of our members serving the population covered under the 1115 waiver proposal. Like Dr. Stelter, I work with residents that have demonstrated an inability to function effectively in the community.

I have identified a number of cases where individuals have been returned to the community as part of the Money Follows the Person program without positive outcomes.

RESIDENT #1 (J.C.)

This resident was a brittle diabetic who was non compliant with his medications. We explained this to the MFP folks but they insisted that they would manage his diabetes. During the time he was out of the facility (9 months) he was hospitalized 5 times for uncontrolled diabetes. The resident called us to ask if he could come back because he was not doing well in the community. Since being back his diabetes is under control.

RESIDENT #2 (V.S.)

This resident had a history of substance abuse. This was explained to the MFP folks but they discharged her into the community. She was in the community for less than 5 months when she was found by the police wandering the streets and back using drugs.

RESIDENT #3 (E.P.)

This resident had a history of mental illness and medical issues. She was discharged into an apartment and during that time had multiple hospitalizations. She was referred back to the facility by the hospital.

RESIDENT #4 (A.J.)

This resident was discharged with MFP and within 5 days we received a call from an ICU because the resident was there and they needed medical history information.

Current residents: (A.B. and N.T.)

We have 2 current residents who are being pursued by MFP who have told MFP that they are afraid to live in the community because they like the structure that the facility provides and both have said that they consider this their home. However, the group is still pursuing them when they are in the facility.

Again, we request your consideration of preserving the current program for residents unable to return to the community.

Thank you for the opportunity to share our experiences.



**Proposed Section 1115 Demonstration Public Hearing**

**Illinois Department of Healthcare and Family Services**

**September 9, 2016**

**Testimony Submitted by Christina LePage, Managing Director of the Illinois Children's Mental Health Partnership**

Thank you for the opportunity to speak before you today as Illinois prepares to submit its 1115 Demonstration Waiver application. The Illinois Children's Mental Health Partnership (Partnership) applauds the leadership and efforts of the Administration to transform children's mental health services, recognizing the urgency for Illinois to prioritize this critical public health issue.

The Illinois Children's Mental Health Partnership is the only statewide, public/private partnership in Illinois comprised of representatives from families, policymakers, legislators, advocates and child-serving systems that is committed to improving the scope, quality, and access of mental health programs, services, and supports for children and their families.

Illinois leaders took bold steps when they passed the Children's Mental Health (CMH) Act in 2003 and created the Partnership. For over twelve years, the Partnership has worked closely with its partners to address the need for a more comprehensive continuum of care for children and families. The Partnership is encouraged by Illinois' Waiver application, as it continues to move Illinois in the direction of system integration and delivery of services in natural settings. Targeted efforts to accelerate Illinois' integration of physical and behavioral health services will help increase prevention, early identification and intervention, and treatment for children before mental health concerns become more severe, and more costly to the State. An integrated approach will also help address the stigma that is often associated with mental health services, as it will promote the understanding that mental health is equally as important as physical health.

Additionally, the Partnership supports Illinois' shift to outcome-based reimbursement practices, clearly prioritizing quality over quantity. As Illinois makes this shift in practice, the Partnership strongly cautions the State to remain mindful of the complexities involved with defining and measuring mental health outcomes, especially among children. We remind the State of the importance of adopting a child developmental approach when establishing outcome measures; an approach that takes into account the changing needs of children and adolescents, and their families, as youth age. It is also critical that families and consumers are involved in the creation of outcome measurements to ensure that their individual characteristics, needs, preferences, and circumstances are accurately represented. In addition, to further support providers with the transition to outcome-based reimbursement models,

funding for behavioral health services needs to be consistent and sustainable in order to prevent service disruptions, staff turnover, and program cuts that negatively impact child and family outcomes.

We are also pleased to see the inclusion of crisis beds, respite care and intensive home-based services in the Waiver, which align with previous recommendations made by the Partnership's Children's Behavioral Health Integration Initiative (CBHII). Through CBHII, the Partnership worked with the Department of Healthcare and Family Services (HFS), the Division of Mental Health, and the Department of Children and Family Services to develop recommendations and service descriptors for HFS regarding additional services that should be included in the array of behavioral health services available to children.

Lastly, the Partnership enthusiastically supports the inclusion of infant/early childhood mental health consultation (mental health consultation) in the Waiver as a cost-effective strategy to support young children and their families. Mental health consultation is not a new concept for the State of Illinois; Illinois has been a leader in the nation for the work we have done across systems to support infant/early childhood mental health.

The Partnership is currently leading a Mental Health Consultation initiative in close collaboration with the Irving Harris Foundation and numerous public and private stakeholders, to create a comprehensive framework and infrastructure to embed mental health consultation in all child-serving systems in Illinois. The inclusion of mental health consultation in the Waiver is a major step forward in the expansion and sustainability of this valuable support. Moreover, the Waiver will allow the State to further demonstrate the evidence-base for the use of mental health consultation to improve outcomes for systems, programs, providers, and most importantly, children and families in Illinois.

There is an urgency and necessity to respond to the mental health needs of Illinois' children in ways that challenge the status quo and maximize Illinois' very limited resources. The Partnership commends the Administration's leadership and clear commitment to improve the mental health system for Illinois children and their families. By working together, we can support children's mental health so that all Illinois children can live healthier, happier lives and contribute positively to the social and economic fabric of Illinois. Thank you for your time.

For more information about the Illinois Children's Mental Health Partnership contact Christina LePage, Managing Director, at [clepage@voices4kids.org](mailto:clepage@voices4kids.org) or 312-516-5569.





Illinois Health and Hospital Association

Statement of the  
**ILLINOIS HEALTH  
AND HOSPITAL  
ASSOCIATION**

**Friday, September 9, 2016**

**Patrick Gallagher  
Group Vice President  
Health Policy and Finance  
Illinois Health and Hospital Association**

**State of Illinois  
Public Hearing on Proposed Section 1115  
Demonstration**

**James R. Thompson Center  
Chicago, IL**

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Illinois Health and Hospital Association

**Testimony of Patrick Gallagher  
Group Vice President, Health Policy and Finance  
Illinois Health and Hospital Association**

**State of Illinois  
Public Hearing on Proposed Section 1115 Demonstration**

**James R. Thompson Center  
Chicago, IL**

**Friday, September 9, 2016**

Good Morning, Directors Baldwin, Norwood and Sheldon and Secretary Dimas, I am Patrick Gallagher, Group Vice President of Health Policy and Finance at the Illinois Health and Hospital Association (IHA). On behalf of the over 200 hospitals and over 50 health systems that are members of IHA, I would like to thank you for your focus on transforming the behavioral healthcare delivery system in Illinois. With your leadership, the state has outlined an ambitious plan to address the numerous issues surrounding behavioral health. IHA looks forward to learning more of the details of the proposal and working with you to improve the lives of individuals living with mental illness and addiction. There are a several components of the waiver I would like to highlight as important to the hospital community as well as point out several questions and comments.

IHA has been examining priority behavioral health interventions that can improve access to care and we are pleased to see many of these included in the waiver. IHA's Behavioral Health Advisory Forum, made up of a diverse group of administrators and providers from across the state, developed recommendations with specific emphasis on evidence-based interventions that can be replicated across Illinois and that can improve the delivery of and payment for behavioral healthcare. We feel these are meaningful recommendations that will make a significant improvement across the state. Many of these align with the primary waiver initiatives of greater integration and workforce development.

In particular, IHA supports:

- (1) Enhancing emergency and community-based crisis stabilization services. We want to stress that these services can be provided in a variety of settings, not just in an IMD. Colocation within or near a hospital's emergency department is an optimal setting, as it meets the patient where they often present in crisis for intervention and de-escalation;

TESTIMONY BY  
Patrick Gallagher  
Group Vice President  
Illinois Health and Hospital Association  
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(2) Using behavioral health homes to integrate behavioral and physical health, which is key to meeting all the health care needs of individuals with behavioral health conditions;

(3) Expanding telehealth capacity to serve individuals in both rural and urban communities. Currently, the primary impediment appears to be the low reimbursement that does not make the service a sustainable model to deliver care; and

(4) Enhancing the behavioral health workforce, including enabling providers to practice at the tops of their license.

All of these are important provisions of the waiver. There are other proposals in the waiver that hold significant promise, including those related to addressing homelessness, providing employment supports and enhancing the capacity of community behavioral health services.

While the details of the waiver implementation will be necessary to provide a final evaluation of the proposal, there are several issues we would like to raise at this time. Since health homes will play a foundational role in coordinating care, we would like to point out that providers are in the best position to provide services like patient and family support, comprehensive care management, health promotion and wellness. The role of the MCOs in coordinating care needs to be clearly articulated so the health homes achieve true outreach and coordination, rather than acting as a gatekeeper. As providers are challenged with complying with numerous new MCO policies and procedures, it will be important to strike a balance between achieving innovation and uniformity in designing the criteria for the medical homes. We request the state develop appropriate criteria with significant provider input to better inform future strategies. Similarly, the role of MCOs in the waiver needs to be clarified not only in terms of care coordination, but also in terms of achieving the goal of value based reimbursements. Value based contracts need to be mutually agreeable between providers and the MCOs, where incentives are aligned around realistic savings expectations. Therefore, continued oversight of the MCOs will be necessary to not only gain provider participation, but also to inspire confidence in the process.

The financial component of the waiver is critical, especially obtaining a better understanding of the distribution of funding as well as the expected savings. While achieving budget neutrality is central to a waiver, a meaningful transformation of services for persons with behavioral health conditions will require an increase in funding. Illinois' average spending per Medicaid enrollee ranks 49th in the nation – substantially lower than every surrounding state in the Midwest and lower than our peer states of California, New York, Texas and Florida. In some cases this will

TESTIMONY BY  
Patrick Gallagher  
Group Vice President  
Illinois Health and Hospital Association  
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mean increasing rates for services in order to provide adequate access to care, such as those for telehealth.

Enhancing access to behavioral health in Illinois and addressing workforce shortages are necessary components to ensure there is sufficient care to coordinate. Every day patients arrive in hospital emergency departments where compassionate care is delivered but all too often there is inadequate capacity to place the patient in an inpatient or community setting where ongoing treatment can occur. Developing the integrated health homes will also require funding to build capacity and the reimbursement model will need to provide sufficient incentives for providers to make the necessary investments for care coordination infrastructure.

Enhanced capacity, incentives to coordinate care, and an increased and fully utilized workforce will have positive repercussions throughout the health care system. I would like to leave you with just one example. More timely placement from the ED in the most appropriate level of care would occur with effective care coordination and use of crisis stabilization. We continue to hear from our members that patients are presenting in the ED at a higher level of acuity than in recent years and this not only has implications for the unmet health care needs of the patient, but also safety concerns for staff providing the treatment.

The time has come for a comprehensive plan to address these numerous behavioral health issues. We look forward to our continued dialogue on these important issues, and we appreciate your leadership on this initiative.

# Health & Medicine

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September 9, 2016

Thank you for the opportunity to comment on the Illinois Behavioral Health Transformation Section 1115 Demonstration Waiver. The Center for Long-Term Care Reform at Health & Medicine Policy Research Group launched a Behavioral Health-Primary Care Integration Learning Collaborative in 2015 and we are beginning our second year working with 12 providers, consumers, and payers to operationalize goals that are very similar to those of the 1115 waiver.

The Learning Collaborative has identified Health Homes as a major source of lessons for current practices and an opportunity for Illinois to move toward high quality, financially sustainable, integrated health services. We, therefore, welcome the central role that Integrated Health Homes occupy in the Administration's 1115 Waiver and its broader plan for the behavioral health sector in Illinois. As a policy organization that deliberately sought out the expertise of people who provide and receive services in the existing, highly dysfunctional behavioral health system, Health & Medicine would like to share the following comments regarding the 1115 waiver and Integrated Health Homes.

The waiver refers to an "evolution of Illinois' payment and delivery system" and also an intention to "allow for flexibility for multiple models to emerge" that address diverse needs and create space for continuing innovation. If Illinois' behavioral health system is to evolve into a thriving ecosystem rather than sinking into "Darwin's nightmare" of predatory lionfish and life choking algae, we note two barriers that must be overcome: (1) data systems and business models that align with value-based payment and health home models are costly to develop and to effectively deploy, and (2) measuring quality in behavioral healthcare has been a historical and trending challenge for the state. In addition, we note that community-based integrated care with enhanced access to short-term residential treatment would be a major step forward, but that an integrated service plan can fall apart when a person is admitted to an inpatient hospital.

### 1) Data and business systems infrastructure

Infrastructure investment and baseline interoperability is necessary, along with training to prepare providers to implement data exchange and analysis that coordinates care and shifts to value-based payment. Contract rate development, financial oversight of per-member-per-month payments, and coordinating workflows in a team-based, outcomes-oriented payment and delivery model requires more significant changes to data systems and business operations than can be achieved through training alone. In the development of the IHH SPA and other waivers and rule changes, as well as the initiatives that could be funded by the Integration Funds described in the 1115 waiver, we urge you to consult with providers in Illinois and health homes in other states about the infrastructural and operational needs to adapt to value-based designs.

For example, outreach and engagement in particular are the biggest challenges cited by health home programs with many years of experience in Missouri and those in Washington State, and managing the PMPM payments that allow for expanding and improving outreach is an operational challenge. The providers that can perform the difficult work of identifying and engaging people at-risk or people experiencing serious mental illness (SMI) or substance use disorders (SUD) also take on the added challenge of coordinating new benefits such as supported housing and employment. Those providers may not necessarily be the same providers that can adapt quickly to incentives for new business models.

Developing nimble business models that can maximize the benefits of value-based payment is an important component of health system transformation that we do not want to minimize or vilify. However, supporting the providers who excel at the *core work* of person-centered engagement and recovery to create financially-sustainable business models is a far better investment than attempting to teach providers that have savvy business models for new financial incentives, but do not have the skill set or inclination to provide person-centered care, which moves the dial on both prevention and recovery. The risk of incentives going awry and rewarding entities that are more revenue-savvy than person-centered appears to be acknowledged in the waiver when it calls for a third party pre-authorization and audits for SUD treatment in IMDs.

## 2) Acknowledging deficiencies in quality measurement

Gaps in quality measurement for SMI and SUD are a challenge for developing outcomes- or value-based payments and identifying those providers most likely to leverage integration funds to create innovative, effective health homes. The preliminary evaluation plan included in the waiver demonstrates this problem. Most of the proposed measures are for utilization, consumer self-reports of satisfaction with services, and costs. These are all important metrics, but the fact that it is difficult to identify validated and reliable quality measures that have been shown to be associated with improved health outcomes for people with serious mental illness<sup>1,2</sup>, should be acknowledged as a challenge that will require creative and adaptable solutions. Measures of success in reaching members assigned to a health home and conducting assessments, as well as utilization measures that indicate engagement in community-based services and reduction in avoidable hospitalizations may serve as intermediary indicators of quality practice until more robust outcome measures are available.

## 3) Hospital transitional care as part of integrated care

One final lesson to share from the Learning Collaborative is that integration needs to address transitions between settings, including hospital discharge to the community and transitions

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<sup>1</sup> Gaynes, Bradley et al. "Relationship Between Use of Quality Measures and Improved Outcomes In Serious Mental Illness," Agency for Healthcare Research and Quality Technical Brief Number 18, January 2015.

<sup>2</sup> Pincus, Harold Alan et al. "Quality Measures for Mental Health And Substance Use: Gaps, Opportunities, And Challenges," *Health Affairs* 35, no. 6 (2016): 1000 – 1008 doi:10.1377/hlthaff.2016.0027

between residential care, hospitals, and community-based care. The waiver cites statistics on hospital readmissions and over-utilization of inpatient care, but does not specifically address a major stress point for patients and providers—hospital admission and discharge. Post-hospital discharge transitions arose as a particular concern in the Learning Collaborative, and we plan to work more to identify practical, effective solutions in the coming year of our work together. Health & Medicine is also a partner with hospitals and community-based organizations across the country in a hospital transitional care program, The Bridge Model. The Bridge Model is a person-centered, social work-led, interdisciplinary transitional care intervention that helps older adults and high utilizers safely transition from the hospital back to their homes and communities.

We would be happy to share more of our experience with the Learning Collaborative and the Bridge Model as the Administration continues its efforts to transform the behavioral health system in Illinois.

Sincerely,

A handwritten signature in black ink, appearing to read 'S Post', with a long horizontal flourish extending to the right.

Sharon Post  
Director, Center for Long-Term Care Reform  
Health & Medicine Policy Research Group



ORAL TESTIMONY FOR ACCESS LIVING ON 1115 WAIVER  
APPLICATION  
September 9, 2016

Thank you for the opportunity to provide testimony today on the HFS 1115 waiver application. Our comments today stem from our core values of consumer control and self-direction, which in the area of mental health prioritize consumer-centered care and consumer-engaged goal setting.

We have long been in favor of rebalancing Illinois' Medicaid long term care dollars, which to us means moving the needle on this area of spending so that we spend more on home and community based supports, as opposed to institutional settings. We are pleased that the State recognizes that investing in home and community based services can actually result in cost savings to the State. We believe that actuarial analysis for the *Williams* consent decree will demonstrate those cost savings, as it has for the *Colbert* consent decree. It remains, however, extremely important to do rebalancing well and by centering consumer-centered care and consumer-engaged goal-setting.

We believe that in order to provide real, fully-informed integrated care for persons with both behavioral health needs and other health needs, it is vital to develop a trained physician workforce that understands how to interpret possible linkages between mental health and symptoms of other health issues. Currently we are not confident that most physicians in Illinois have secured this training.

Access Living agrees that the State badly needs supportive housing services for individuals with serious mental illness. We encourage the State to fund, at the very least, a pilot project utilizing the "Housing First" concept in supportive housing for this target group. Housing First provides housing without mandating treatment for addiction or the receipt of services in financial literacy and basic self-care. We would urge the State to exercise some caution where Housing First has been linked with Assertive Community Treatment (ACT). ACT is team-based and multidisciplinary, providing individualized treatment and support to people with mental illness. This can often be very good for people with mental illness, but it can sometimes lead to a coercive setting that strips away the person's self-determination.

Access Living commends the proposal to fund supported employment services. Research has clearly shown that people with mental illness or substance use disorders fare well when provided this service. We further commend the State's choice of Individual Placement and Support (IPS) services as its model program. The client-centered approach of this model allows people to play an active role in defining the type of work they want and strategies in job-seeking, consistent with Access Living's philosophy that places primacy on consumer engagement and choice.

We urge the State to exercise caution about the maintenance of community supports for people with mental illness who are placed in IMDs, since they need to be able to keep what housing supports are already in place. It is critical to have a mechanism to ensure their housing is not lost.

Illinois also seeks Medicaid funds for individuals in need of stabilization due to crisis but without needs acute enough to require inpatient hospitalization. We encourage the State to



consider as “first responders” such centers as “The Living Room” in Skokie, Illinois. The Living Room, which opened in September 2011, is a residential room staffed by a trained peer counselor and with a psychologist and nurse available if needed. People in crisis can simply walk in, be evaluated by a psychiatric nurse to rule out a medical emergency, and talk about what is troubling them or just rest and relax in a nonthreatening environment. In its first year of operation, the Living Room handled 228 visits that resulted in only 15 emergency room referrals – a deflection rate of 93% that saved Illinois an estimated \$550,000 in Medicaid costs. The great majority (84%) of deflections resulted in a return to the community.

For workforce-strengthening initiatives, Access Living recommends inclusion of certified recovery support specialists (CRSSs) in strengthening the workforce. Medicaid has recognized peer support services as evidenced-based practices since at least 2007. Illinois has created a CRSS credential for persons who have experienced their own personal recovery. These professionals offer a unique contribution, the insights that come from personal experience and personal recovery, and the message to others that recovery and personal empowerment are real and possible

The credential is earned in a rigorous and extensive educational program requiring 100 hours of training, a lengthy period of supervised practical and work experience, and a successful score on a CRSS written examination. Maintaining certification thereafter requires completion of 40 continuing education units every two years.

We recommend not only inclusion of CRSS professionals as an enhancement to the workforce but the same financial assistance to these individuals as that given other professionals. Obtaining a CRSS credential is a costly endeavor and considerable financial investment. We recommend that the expansion of the Illinois workforce include a tuition reimbursement mechanism for CRSS professionals who commit to serving Medicaid populations similar to loan forgiveness or other incentives provided other mental health and alcohol and drug use professionals.

In the area of first episode psychosis (FEP) programs, Access Living strongly supports the goal to develop a workforce and infrastructure sufficient to fund 13 teams statewide. Access Living recommends that the FEP team be expanded to include peer support specialists who have the lived experience of psychosis and can add unique value to the recovery-oriented program.<sup>1</sup>

Thank you for the opportunity to provide comments at today’s hearing.

Contact:  
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<sup>1</sup> This approach is recommended by the National Institute of Mental Health in a 2014 white paper. [http://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep\\_147096.pdf](http://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf)