

# Illinois' Behavioral Health Transformation

## Section 1115 Demonstration Waiver

Prepared by  
Illinois Department of  
Healthcare and Family Services

September 2, 2016  
Draft for Public Comment



## Contents

|  |           |
|--|-----------|
| <b>Section 1: Program Description</b>  | <b>1</b>  |
| Section 1.1: Overview and introduction   | 1         |
| Section 1.2: Context for 1115 waiver demonstration   | 5         |
| Section 1.2.1: Overview of Medicaid in Illinois  | 5         |
| Section 1.2.2: Overview of behavioral health in Illinois   | 6         |
| Section 1.2.3: Illinois' vision for an integrated behavioral and physical health delivery system | 10        |
| Section 1.2.4: The Illinois behavioral health aspiration and strategy                            | 11        |
| Section 1.2.5: Alignment of ongoing state initiatives  | 16        |
| Section 1.2.6: Stakeholder engagement  | 17        |
| Section 1.3: Waiver demonstration plan   | 18        |
| Section 1.3.1: Demonstration goals   | 19        |
| Section 1.3.2: Demonstration benefits  | 20        |
| Section 1.3.3: Demonstration initiatives   | 21        |
| Section 1.3.4: Savings to enable demonstration benefits and initiatives                          | 21        |
| Section 1.3.5: Designated State Health Programs (DSHPs)  | 22        |
| Section 1.4: Demonstration hypotheses and evaluation   | 22        |
| Section 1.5: Demonstration location and timeframe  | 26        |
| <b>Section 2: Demonstration Eligibility</b>  | <b>27</b> |
| Section 2.1: Eligibility groups affected by the demonstration                                    | 27        |
| Section 2.2: Eligibility groups excluded from the demonstration                                  | 27        |
| <b>Section 3: Demonstration Benefits and Cost-Sharing Requirements</b>                           | <b>28</b> |
| Section 3.1: Demonstration benefits  | 28        |
| Section 3.1.1: Supportive housing services   | 30        |
| Section 3.1.2: Supported employment services   | 34        |

|  |           |
|--|-----------|
| Section 3.1.3: Services to ensure successful transitions from Illinois Department of Corrections (IDOC) and Cook County Jail (CCJ) incarceration | 38        |
| Section 3.1.4: Redesign of substance use disorder service continuum  | 42        |
| Section 3.1.5: Optimization of the mental health service continuum   | 53        |
| Section 3.1.6: Additional benefits for children and youth with behavioral health conditions and/or serious emotional disturbance                 | 54        |
| Section 3.2: Cost-sharing requirements   | 57        |
| <b>Section 4: Other Waiver Initiatives</b>   | <b>58</b> |
| Section 4.1: Behavioral and physical health integration activities   | 58        |
| Section 4.2: Infant/early childhood mental health consultation   | 63        |
| Section 4.3: Workforce-strengthening initiatives   | 65        |
| Section 4.4: First episode psychosis (FEP) programs  | 68        |
| <b>Section 5: List of Proposed Waivers and Expenditure Authorities</b>   | <b>70</b> |
| <b>Section 6: Demonstration Financing and Budget Neutrality</b>  | <b>73</b> |
| <b>Section 7: Stakeholder engagement and public notice</b>   | <b>75</b> |
| <b>Section 8: Demonstration administration</b>   | <b>76</b> |
| <b>Appendix</b>  | <b>77</b> |
| Appendix A: Evolution of Illinois' behavioral health ecosystem   | 78        |
| Appendix B: Proposed Designated State Health Programs (DSHPs)  | 80        |

# Section 1: Program Description

## Section 1.1: Overview and introduction

Illinois is one of the largest funders of health and human services (HHS) in the country. With \$32 billion spent across its HHS agencies,<sup>1</sup> amounting to more than 40% of its total budget, the State is deeply invested in the health and well-being of its 12.9 million residents and 3.2 million Medicaid members.<sup>2,3</sup> There is an urgent need to get more from this investment: the State must improve health outcomes for residents while slowing the growth of healthcare costs and putting the State on a more sustainable financial trajectory.

To this end, Illinois has embarked on a transformation of its HHS system. The transformation, which was announced by Governor Bruce Rauner in his 2016 State of the State address, *“puts a strong new focus on prevention and public health; pays for value and outcomes rather than volume and services; makes evidence-based and data-driven decisions; and moves individuals from institutions to community care to keep them more closely connected with their families and communities.”*

Consistent with the Triple Aim, the HHS transformation seeks to improve population health, improve experience of care, and reduce costs. It is grounded in five themes:

- Prevention and population health
- Paying for value, quality, and outcomes
- Rebalancing from institutional to community care
- Data integration and predictive analytics
- Education and self sufficiency

To move the transformation plan from theory to practice, Illinois has assembled a broad cross-agency transformation team from the Governor’s Office and 12 state agencies ([Exhibit 1](#)).

*Exhibit 1: Cross-agency transformation team members*

| 13 ILLINOIS ENTITIES ARE INVESTED IN HHS TRANSFORMATION |  |
|---|--|
| Abbreviation  | Name of entity participating in behavioral health transformation |
| GO  | Governor’s Office  |
| DHFS  | Illinois Department of Healthcare and Family Services            |
| DCFS  | Illinois Department of Children and Family Services              |
| IDHS  | Illinois Department of Human Services                            |
| IDJJ  | Illinois Department of Juvenile Justice                          |
| IDOC  | Illinois Department of Corrections                               |
| IDoA  | Illinois Department on Aging                                     |

1 Based on SFY 2015 and includes DHFS, IDHS, DCFS, IDoA, IDOC, IDES (Illinois Department of Employment Security), IDPH, IDVA

2 State Fiscal Year 2015 Illinois DHFS claims data

3 From this point forward Medicaid will refer to both Title XIX and Title XXI of the Social Security Act.

|       |  |
|-------|--|
| IDPH  | Illinois Department of Public Health             |
| IDVA  | Illinois Department of Veterans' Affairs         |
| IHDA  | Illinois Housing Development Authority           |
| DoIT  | Illinois Department of Innovation and Technology |
| ISBE  | Illinois State Board of Education                |
| ICJIA | Illinois Criminal Justice Information Authority  |

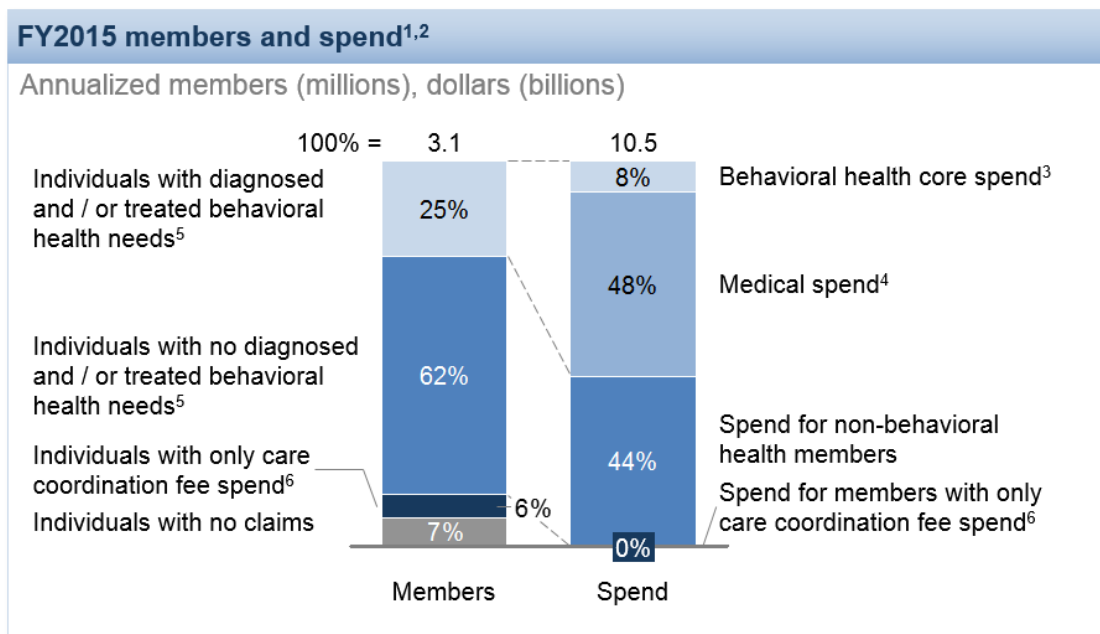
The initial focus of the transformation effort is on behavioral health (mental health and substance use) and specifically the integration of behavioral and physical health service delivery. Behavioral health was chosen due to the urgency of the issue as well as the potential financial and human impact. Building a nation-leading behavioral health strategy will not only help bend the healthcare cost curve in Illinois but also help turn the tide of the opioid epidemic, reduce violent crime and violent encounters with police, and improve maternal and child health. There is also a large financial payoff in improving behavioral health: Medicaid members with behavioral health needs (referred to henceforth as “behavioral health members”) represent 25% of Illinois Medicaid members but account for 56% of all Medicaid spending ([Exhibit 2](#)).<sup>4</sup>

---

<sup>4</sup> State Fiscal Year 2015 Illinois DHFS claims data

Exhibit 2: Behavioral health members as proportion of Medicaid population

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



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.  
 3 Behavioral health core spend defined as all spend with a behavioral health primary diagnosis or behavioral health-specific procedure, revenue, or HIC3 pharmacy code.  
 4 Behavioral health core spend is defined as spend on behavioral health care for individuals with behavioral health needs  
 5 Medical spend is defined as all other spend for individuals with behavioral health needs. See appendix for additional methodology notes  
 6 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  
 7 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 focus on behavioral health has been informed by the State’s *Healthy Illinois 2021* plan, which encompasses the State Health Assessment (SHA), the State Innovation Model (SIM) grant awards, and the State Health Improvement Plan (SHIP). Together, these initiatives aim to align plans, processes, and resources to improve the health of Illinois residents. Illinois’ two State Innovation Model (SIM) design grant awards from the Center for Medicare and Medicaid Innovation - a Round One award in 2013 and a Round Two award in 2015 – helped the State to create focused and measurable health improvement strategies and identify behavioral health as a priority. Together, the SHA, SIM, and SHIP work have been foundational to the Illinois’ HHS transformation and to the requests in this waiver.

The SIM work was led by the Governor’s Office and the Illinois Department of Public Health, with input from key stakeholders including other State agencies, provider associations, community organizations, payers, advocacy groups, and educational institutions. An executive committee and four SIM workgroups (consumer needs, data and technology, physical and behavioral health integration, and quality measure alignment) met monthly over five months to provide recommendations for key strategies of the *Healthy Illinois 2021 Plan*.

These stakeholders identified several priorities for transformation efforts, including the need to reduce siloes in behavioral health care to enable a more efficient system with greater integration of physical and behavioral health. This waiver demonstration proposes critical next steps to accomplish this mission, aiming to achieve six main goals:

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 lower needs
4. Support 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 members, such as housing and employment services
6. Create an enabling environment to move behavioral health providers toward outcomes- and value-based payments

This 1115 waiver application is only one component of a broader strategy to help achieve the above goals. The State has already started to integrate physical and behavioral health by carving-in behavioral health into the managed care system and developing a set of proposed State Plan Amendments (SPAs) that support integration. The waiver proposals in this application build on this work to lay the foundation for a truly integrated physical and behavioral health system, centered on members, their families, and their communities. The waiver proposals seek to test new ideas that catalyze innovation in integration and value-based payments. They also seek to test a combination of services that may have been pursued in isolation but promise to be more effective together, tailored more precisely to member needs.

Illinois Medicaid is committing to producing federal savings of \$1.2 billion over the life of the waiver and re-investing these savings to help achieve the demonstration goals. The State believes that the benefits and initiatives authorized by this waiver demonstration are fundamental components to bring Illinois' vision to fruition.

Greater detail is provided in the following subsections:

- [Section 1.2](#): Context for Illinois' 1115 waiver demonstration
- [Section 1.3](#): Illinois' waiver demonstration plan
- [Section 1.4](#): Demonstration hypotheses and evaluation approach
- [Section 1.5](#): Demonstration location and timeframe

## Section 1.2: Context for 1115 waiver demonstration

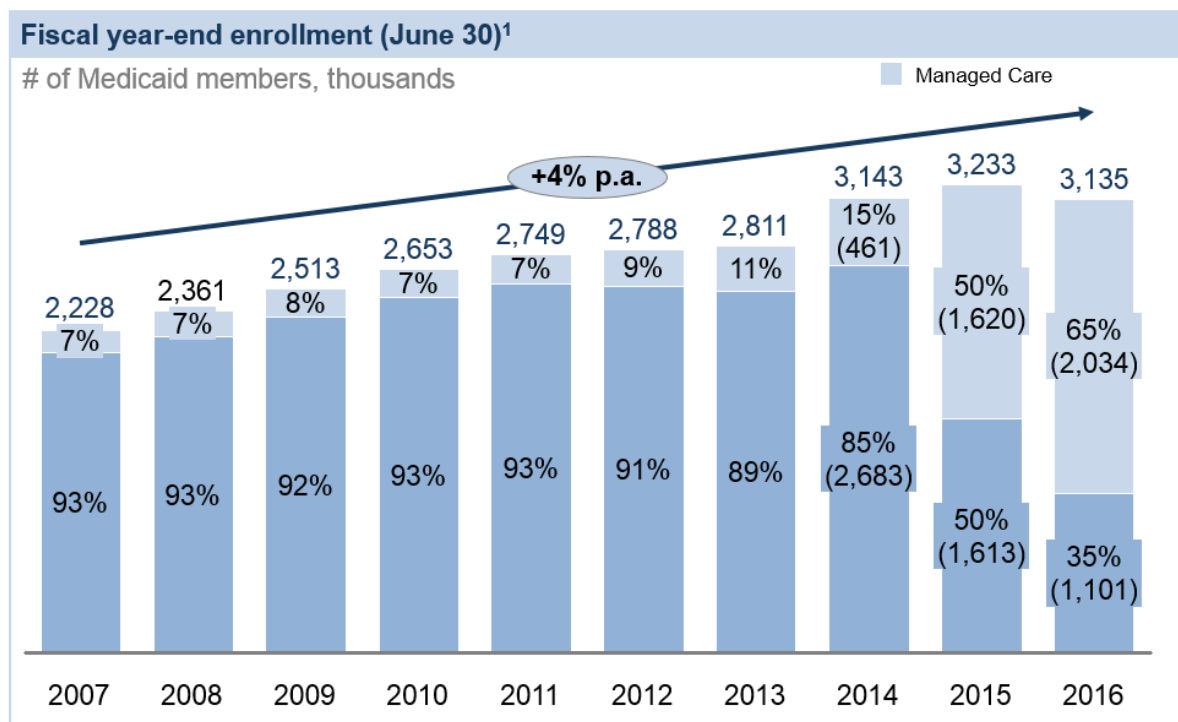
Illinois and its Medicaid program have undergone significant changes over the past few years and now approach its behavioral health strategy and this waiver demonstration with a heightened sense of urgency.

### Section 1.2.1: Overview of Medicaid in Illinois

Illinois spends more than \$18 billion on the approximately 3.2 million Medicaid members in the State.<sup>5</sup> With Medicaid expansion under the Affordable Care Act (ACA), approximately 600,000 members were added to the Medicaid rolls, shifting Illinois' Medicaid population from mostly children to mostly adults.<sup>6</sup> Furthermore, 65% of Illinois' Medicaid population is now enrolled in capitated managed care, up dramatically from 15% in 2014 ([Exhibit 3](#)).<sup>7</sup> This amounts to seismic and purposeful change in the Medicaid landscape in the State that will continue to unfold.

Exhibit 3: Medicaid, MCO enrollment growth

**Medicaid enrollment has grown ~4% annually since 2007; capitated managed care enrollment has more than quadrupled in the past three years**



<sup>1</sup> Excludes partial eligibility

SOURCE: Healthcare and Family Services Bureau of Rate Development and Analysis

<sup>5</sup> State Fiscal Year 2015 Illinois DHFS claims data

<sup>6</sup> DHFS eligibility

<sup>7</sup> DHFS Bureau of Rate Development and Analysis



Adapting to this new reality has been a challenge for both the State government and the State's healthcare delivery system. Since many rules and practices were tailored to a pre-ACA world with limited capitated managed care, Illinois is now "catching up" by updating them. For example, proposed changes to Illinois' administrative rules aim to ease the burden on providers and break down barriers to the integration of behavioral and physical health, such as requiring that all services provided by CMHCs be tied back to a mental health need.

Providers have also faced challenges. In mandatory managed care regions, the primary relationships for providers have shifted from those with the State to ones with managed care organizations (MCOs), a transition that has not been without growing pains (e.g., adapting to the billing practices and systems of multiple MCOs). Providers are working to adapt to a predominantly managed Medicaid environment, and managed care organizations have begun to form partnerships with provider coordination entities to improve care. These partnerships are in their infancy, so there are substantial opportunities to enhance their impact.

The Illinois budget situation has exacerbated challenges in the healthcare delivery system. Because the State only achieved a stop-gap budget on the last day of the 2016 fiscal year (June 30, 2016), the healthcare ecosystem faces uncertainty for the months ahead.

### *Section 1.2.2: Overview of behavioral health in Illinois*

Illinois aspires to nation-leading behavioral health outcomes yet today outcomes vary widely. On some indicators, Illinois performs better than many of its state peers. For example, Illinois ranks 11<sup>th</sup> among states for rates of youth substance abuse or dependency problems (5.8%)<sup>8</sup> and 14<sup>th</sup> for drug deaths per 100,000 (11.9).<sup>9</sup> On other measures, the State performs below the national average. Illinois ranks 30<sup>th</sup> in mental health workforce availability with 844 people per mental health worker compared to the national median of 752 and the 25<sup>th</sup> percentile of 520.<sup>10</sup> Illinois ranks 32<sup>nd</sup> and 31<sup>st</sup> in the nation in pre-term birth and violent crime rates, respectively, both of which have links to behavioral health.<sup>11</sup> Lastly, Illinois ranks 41<sup>st</sup> in the nation in mental health service coverage for children, with just 45% of children who need services receiving them.<sup>12</sup> Given the State's overall spending on the behavioral health population, these results demonstrate clear room for improvement.

The Illinois behavioral health ecosystem is heavily reliant on deep-end, institutional care rather than upstream, community-based care. Approximately 40% of Illinois Medicaid behavioral health spend is dedicated to inpatient or residential care<sup>13</sup> and utilization of state psychiatric

---

8 *America's Health Rankings 2015*, United Health Foundation

9 *Parity or Disparity: The State of Mental Health in America 2015*, Mental Health America

10 *Ibid.* Ratio includes psychiatrists, psychologists, licensed clinical social workers, counselors, and advanced practice nurses specializing in mental health care.

11 *America's Health Rankings 2015*, United Health Foundation

12 *America's Health Rankings 2015*, United Health Foundation








13 State Fiscal Year 2015 Illinois DHFS claims data.; does not include supplemental payments to hospitals

hospitals per 1,000 residents is 44% higher than the national average. This stands in sharp contrast to utilization of lower-cost community care facilities, which is less than half the national average.<sup>14</sup> This over-reliance on institutional care has significant implications for behavioral health members, who may experience additional stress due to removal from their communities and treatment in more restrictive institutional settings.

To understand what drives this high spend and poor outcomes, Illinois has conducted quantitative and qualitative analyses and sought extensive stakeholder input through dozens interviews, multiple town halls, and review of more than 200 written recommendations. In addition, to understand the behavioral health system from a member-centric perspective, the State devised 14 representative member archetypes. The archetypes reflect the diversity of Illinois’ behavioral health population and illuminate the many clinical and non-clinical factors that can influence behavioral health outcomes. The archetypes are displayed in [Exhibit 4](#)

*Exhibit 4: Behavioral health member archetypes*

**The strategy has been informed by pain points experienced by 14 customer archetypes that vary by age, living situation, and behavioral health condition**

| Lenses  |             |                                 |   |
|---|-------------|---------------------------------|---|
| Archetype   | Age         | Living situation                | Behavioral health condition                   |
|  Jerry    | Toddler     | In at-risk home                 | At-risk                                       |
|  Jane    | Child       | Foster home                     | ADHD/ODD                                      |
|  Connor  | Teenager    | Transferring to congregate care | Severe aggression                             |
|  Brice   | Teenager    | Urban home                      | Major depression                              |
|  Mike    | Teenager    | Juvenile institution            | Bipolar disorder/ alcohol and marijuana abuse |
|  Mia     | Teenager    | Rural home                      | Opioid abuse                                  |
|  Jenn    | Young Adult | Rural home                      | Anxiety                                       |
|  Greg    | Young Adult | Correctional facility           | Schizophrenia                                 |
|  Stephen | Adult       | Experiencing homelessness       | Actively psychotic/ opioid abuse              |
|  Darnell | Adult       | Experiencing homelessness       | Post-traumatic stress                         |
|  Ashley  | Adult       | Permanent supportive housing    | Schizophrenia                                 |
|  Tom     | Adult       | Friend's couch                  | Alcohol and heroin abuse                      |
|  William | Adult       | Rural home                      | Alcohol abuse                                 |
|  Cynthia | Aged        | Skilled nursing facility        | Moderate anxiety and depression               |

**The State is taking a fully multigenerational approach to behavioral health**

Through the member archetypes, quantitative and qualitative analyses, and stakeholder input, Illinois has identified six primary pain points ([Exhibit 5](#)) the State must address to maximize the effectiveness of its behavioral health system.

*Exhibit 5: Key pain points in behavioral health system*

| SIX PAIN POINTS FOR BEHAVIORAL HEALTH MEMBERS                         |  |
|---|--|
| Pain point  | Description  |
| Lack of coordination of behavioral health services                    | <ul style="list-style-type: none"> <li>• Currently no designated point of accountability for whole-person needs (medical and behavioral health care)</li> <li>• Services often delivered in siloes, resulting in gaps and interruptions in service, particularly during transitions between care settings and during major life changes (such as being released from incarceration; aging out of the Department of Child and Family Services, or DCFS, system; loss of housing)</li> <li>• Lack of coordination results in care deficiencies and sub-optimal care allocation</li> <li>• Evidence:               <ul style="list-style-type: none"> <li>– At 23.5%, Illinois ranks 42<sup>nd</sup> in the nation in state psychiatric hospital 180-day readmission<sup>15</sup></li> <li>– Behavioral health population has 80 admissions per 1,000 and 14 readmissions per 1,000<sup>16</sup></li> </ul> </li> </ul> |
| Challenges in identifying and accessing those with the greatest needs | <ul style="list-style-type: none"> <li>• No evidence-based approach to identify need and target care</li> <li>• Limited funding for identification and prevention services</li> <li>• Un-integrated, disparate access points for key subpopulations such as homeless individuals and parolees</li> <li>• Care tends to be reactive, rather than preventative</li> <li>• Evidence:               <ul style="list-style-type: none"> <li>– More than 40% of core behavioral care spend is inpatient care, indicating failure to assess and intervene early<sup>17</sup></li> </ul> </li> </ul>   |
| Insufficient community behavioral health services capacity            | <ul style="list-style-type: none"> <li>• Limited community capacity prohibits behavioral health services from being provided in the most appropriate, lowest-acuity settings possible, such as in members’ homes and in less intensive outpatient settings</li> <li>• Community capacity has not expanded to meet the needs of an expanded and more heavily adult Medicaid population</li> <li>• Evidence:</li> </ul>  |

<sup>15</sup> *Parity or Disparity: The State of Mental Health in America 2015*, Mental Health America

<sup>16</sup> State Fiscal Year 2015 Illinois DHFS claims data

<sup>17</sup> Ibid.

|  |   |
|--|---|
|  | <ul style="list-style-type: none"> <li>– Illinois ranks 30<sup>th</sup> in the nation in mental health workforce availability<sup>18</sup></li> <li>– Wait times for new psychiatrist appointments can be as long as 3 months</li> </ul>  |
| Limited support services to address “whole-person” needs                       | <ul style="list-style-type: none"> <li>• Limited assistance in supportive housing, transport, and job training</li> <li>• Existing services are poorly coordinated</li> <li>• Evidence: <ul style="list-style-type: none"> <li>– ~40,000 individuals in Illinois have housing needs, ~25% of whom have serious mental illness (SMI); only 17,500 of those 40,000 are receiving the services they need<sup>19</sup></li> <li>– Only 29% of adults with known mental health conditions who are served in the community are employed, vs. 39% nationally<sup>20</sup></li> </ul> </li> </ul>   |
| Duplication and gaps in behavioral health services across agencies raise costs | <ul style="list-style-type: none"> <li>• Duplication due to lack of cross-agency procurement strategy for common purchases</li> <li>• Gaps and interruptions in services arise because many programs and services lack a “natural owner” to provide them</li> <li>• Program-centric (rather than member-centric) orientation of behavioral health system leads to duplication and gaps</li> <li>• Evidence: <ul style="list-style-type: none"> <li>– 42.2% of members served by the Division of Alcoholism and Substance Abuse (DASA) are criminal-justice referrals without direct coordination between entities<sup>21</sup></li> <li>– Agencies occasionally offer same or similar services without capturing synergies</li> </ul> </li> </ul> |
| Deficiencies in data, analytics, and transparency                              | <p>Illinois has submitted an Implementation Advance Planning Document (IAPD) to address the following pain point:</p> <ul style="list-style-type: none"> <li>• Information often not shared across state agencies and providers, making it difficult to draw critical insights</li> <li>• Evidence: <ul style="list-style-type: none"> <li>– No single view of the behavioral health member exists, making it difficult to understand member history and tailor service packages based on what is most likely to drive positive outcomes</li> </ul> </li> </ul>   |

18 Parity or Disparity: The State of Mental Health in America 2015, Mental Health America

19 Illinois Supportive Housing working group, 2016

20 SAMHSA Uniform Reporting System – 2014 State Mental Health Measures

21 DASA Provider Performance and Outcomes Reports – SFY 2015

### *Section 1.2.3: Illinois' vision for an integrated behavioral and physical health delivery system*

Although the lack of coordination of behavioral health services is one of the largest behavioral health system pain points, Illinois believes merely resolving this pain point and promoting coordination of behavioral health services do not go far enough. Rather, the State aspires to full-scale integration of behavioral and physical health services, ensuring team-based care and seamless communication across and between medical and “social service neighborhoods.” Building upon a managed care system that carves behavioral health into the medical program, the State, in collaboration with its managed care partners, aims to enhance true integration of behavioral and physical healthcare through an ambitious integrated behavioral and physical health home program that promotes accountability, rewards team-based integrated care, and shifts away from fee-for-service (FFS) towards a system that pays for value and outcomes. Henceforth, these will be referred to as “integrated health homes” or “IHHs.”

Agencies involved in the HHS transformation have collectively defined integration as “the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.”

Illinois' vision for integration is ambitious, and the current provider delivery system is not structured to support it. Today, behavioral and physical healthcare providers often operate in siloes and fail to exchange information, let alone collaborate as part of a seamlessly integrated care team.

The development of integrated behavioral and physical health homes and the payment model to sustainably support them will be a significant step in realigning the Illinois delivery system. The State envisions that these IHH providers and teams will have:

- Access to enhanced integration funding to facilitate the creation of these health homes (to be discussed in [Section 4.1](#))
- Reimbursement (e.g., PMPM payments) for care coordination activities that promote whole-person care for eligible populations in need
- Outcomes-based payment models that reward measurable, positive outcomes associated with integrated care (across behavioral and physical health indicators)

Illinois recognizes that these IHHs will not materialize without considerable planning; both further design and development processes are required. The State therefore intends to progress the design of these health homes with significant stakeholder input, building upon and furthering other demonstrations across the country. It also intends to allow flexibility for

multiple models to emerge across the State to address the needs of different segments of the population and allow for continued provider innovation.

Further, the State appreciates that different providers are at different stages in their evolutions toward becoming integrated health homes. Therefore, the model will likely follow a phased approach under which all providers are encouraged to make progress. This approach will also create greater incentives for those providers that are able to move more quickly towards a higher degree of integration. An evolution of Illinois' payment and delivery system can be found in [Appendix A](#).

#### *Section 1.2.4: The Illinois behavioral health aspiration and strategy*

Illinois' vision for an integrated behavioral and physical health delivery system is part of a broader and comprehensive behavioral health strategy. In seeking to transform its behavioral health system, the State has solicited input from a wide range of stakeholders representing a diversity of geographic and socioeconomic perspectives. This stakeholder engagement is further discussed in [Section 1.2.6](#).

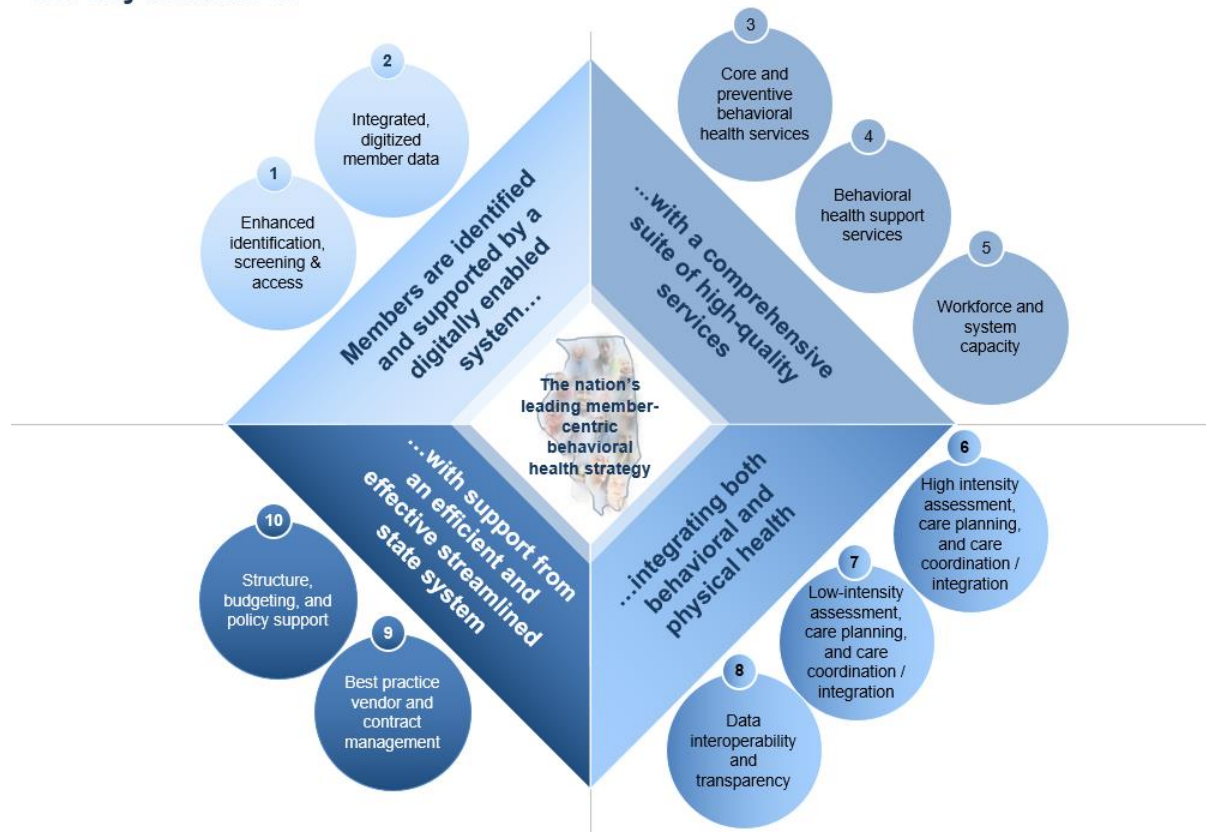
Building on stakeholder input, the State and the stakeholder community envision a future behavioral health system in which:

- Members are identified and supported through a digitally enabled system
- Members have access to a comprehensive suite of high-quality services
- Behavioral and physical health services are integrated
- A streamlined state administrative system provides effective and efficient support

[Exhibit 6](#) depicts these four central approaches and ten initiatives to support them. In the following four subsections, these approaches are described in depth.

Exhibit 6: Four central approaches and ten initiatives of Illinois' behavioral health strategy

**Illinois envisions a member-centric behavioral health system enabled by ten key initiatives**



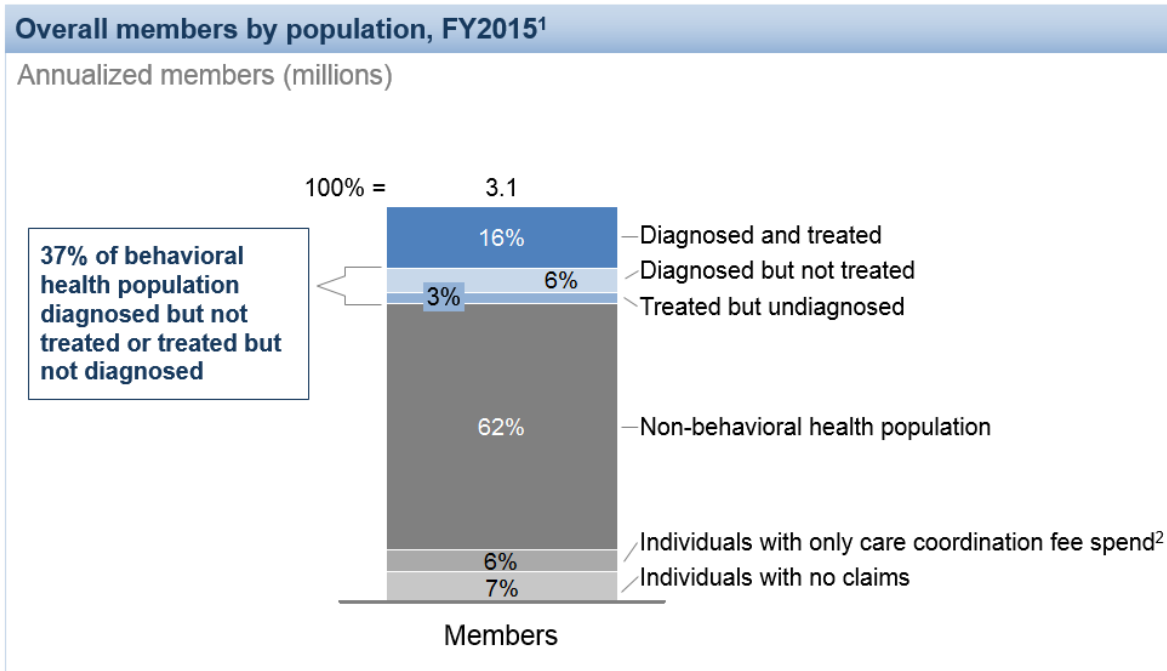
*Section 1.2.4.1: Members are identified and supported by a digitally enabled system*

Today, many behavioral health members fall through the cracks: nearly a quarter of this population receives a behavioral health diagnosis in any given year but does not receive any behavioral health services, and more than 10% receive behavioral health services, largely medications, without a corresponding behavioral health diagnosis ([Exhibit 7](#)).<sup>22</sup> To address this issue, the State first aims to enhance identification, screening, and access by meeting members “where they are” and using uniform screening and assessment tools for earlier diagnosis, more proactive care, and improved provider communications.

22 State Fiscal Year 2015 Illinois DHFS claims data

Exhibit 7: Treated but undiagnosed and diagnosed but untreated subpopulations

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



<sup>1</sup> Annualized members (not unique members) shown here with no exclusions made on population or spend. Annualized member count = Sum of member months/12

<sup>2</sup> 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

Second, the State will integrate digitized member data to facilitate unified, non-duplicative approaches to addressing member needs, which will help optimize service allocation and direct services to where they can be most effective. Illinois plans to submit an Implementation Advanced Planning Document (IAPD) to build a 360-degree member view that can provide a comprehensive picture of needs across the HHS system.

*Section 1.2.4.2: Members have access to a comprehensive suite of high-quality services*

The current behavioral health system concentrates care in institutional settings and lacks sufficient community-based alternatives to deliver care where it can often be more effective and less costly. The State aims to address the over-reliance on institutional care in several ways.

First, Illinois aims to strengthen community-based behavioral health services, both core (dedicated behavioral health services) and preventative (upstream interventions to prevent behavioral health conditions from arising or mitigate their impact through early identification and immediate treatment). It also seeks to optimize its use of higher-acuity services, providing appropriate oversight to ensure that they occupy the appropriate position in the continuum of care, mapping directly to members' needs.



Second, the State seeks to strengthen support services, such as housing and employment assistance, to augment and reinforce core and preventative behavioral health services. Illinois believes supportive services are essential for meeting whole-person needs, enhancing the effectiveness of core services, and enabling members to improve their own outcomes.

Finally, these services must be delivered by a workforce that is up to the task. To this end, Illinois aims to expand the supply of highly trained mental health professionals and enhance the efficiency and effectiveness of the existing workforce through increased access to training opportunities and system design that encourages professionals to practice at the “top of their license.” Illinois envisions technology-enabled services such as tele-psychiatry as a central component of this workforce strategy, particularly for bringing high-quality care to residents in underserved areas of the State.

#### *Section 1.2.4.3: Behavioral and physical health services are integrated*

The State sees three pillars in its mission to integrate physical and behavioral health:

1. *High-intensity assessment, care planning, and care coordination and integration:* As outlined in [Section 1.2.3](#), Illinois intends to build a system of integrated health homes to manage members with complex behavioral health needs (e.g., serious mental illness, substance use disorder (SUD)) and hold providers accountable for outcomes.<sup>23</sup> Illinois will submit an updated SPA for these IHHs, which will align financial incentives around a comprehensive approach to behavioral and physical health services, uniform assessment, evidence-based practices, and wellness promotion. Illinois believes that IHHs targeted at members with the highest needs will have a significant impact on outcomes and healthcare spending because the costliest 10% of Medicaid behavioral health members account for more than 70% of all Medicaid spending on behavioral health in the State ([Exhibit 8](#)).<sup>24</sup> These IHHs will ensure that the needs of this highly complex population are met.

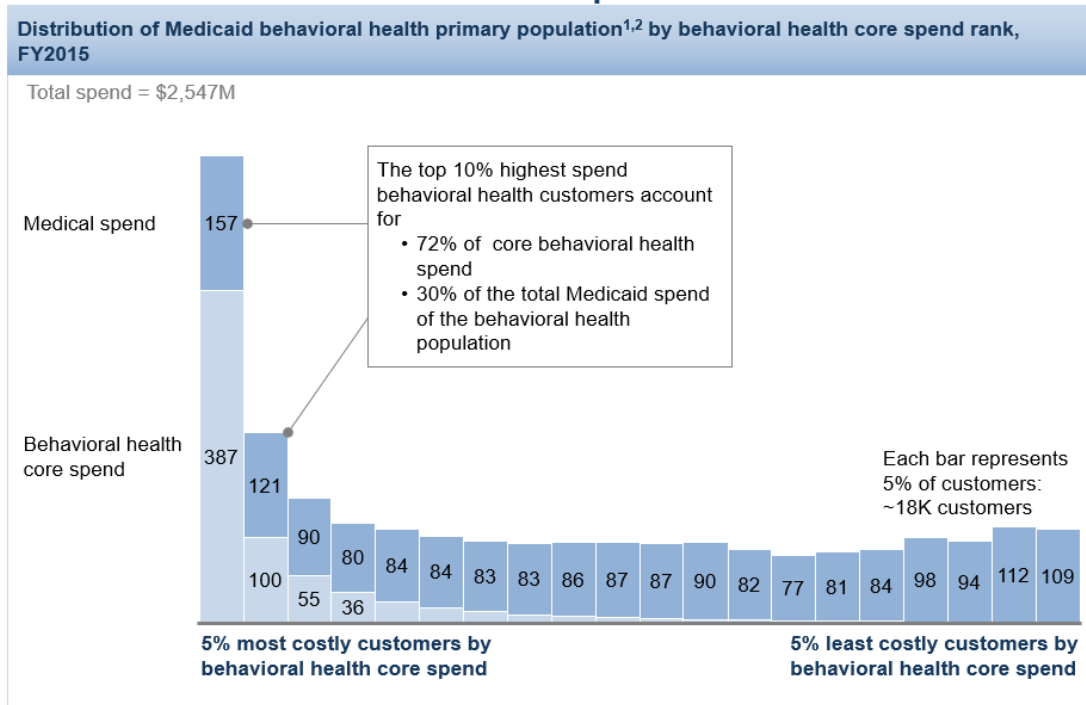
---

<sup>23</sup> Health homes traditionally defined as providers who “integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.” Services include comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow-up, patient and family support, and referrals to community and social support services.

<sup>24</sup> State Fiscal Year 2015 Illinois DHFS claims data

Exhibit 8: The costliest 10% of Medicaid behavioral health members

## The costliest 10% of Medicaid behavioral health members account for more than 70% of all behavioral health spend



<sup>1</sup> Distribution of unique members shown here

<sup>2</sup> 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

2. *Low-intensity assessment, care planning, and care coordination and integration:* Illinois' IHHs will also integrate behavioral health into primary care to serve members with lower behavioral health needs. This integrated approach is expected to have a significant payoff: many members with behavioral health problems also have chronic medical conditions or use primary care as their preferred point of contact. As shown earlier, many members either receive behavioral health services without a formal diagnosis or receive a behavioral diagnosis but no behavioral health services. To address these gaps, Illinois believes it can promote assessment, care planning, care coordination, and integration of physical and behavioral health at the primary care level as part of broader IHHs. These IHHs can be held accountable for outcomes and total cost of care, making whole-person care a necessity. Behavioral health integration into primary care through IHHs is expected to reduce barriers to access to behavioral health for lower-needs members and help ensure they receive services in the most appropriate setting.
3. *Data interoperability and transparency:* Enhanced data interoperability and transparency will be critical to enable full integration of physical and behavioral health. Data interoperability can ensure care team members have the most up-to-date information on a member to inform critical decisions. It can also help providers

communicate more easily and more effectively, thus facilitating care integration. Meanwhile, greater transparency will give providers insight into their own performance as well as the performance of peers with whom they collaborate. For example, a primary care provider who suspects a member is on the verge of a behavioral health crisis should know which behavioral care providers are best-suited to serve that member. Furthermore, greater transparency will empower members themselves to make more informed decisions about the care they receive.

*Section 1.2.4.4: A streamlined state administrative system provides effective and efficient support*

To enhance the efficiency and effectiveness of the State system, Illinois plans to focus on two key areas: vendor/contract management and organizational effectiveness. By ensuring best practices for managing vendors and contracts, with an emphasis on outcomes and continuous improvement, Illinois will ensure system-wide accountability and strengthen relationships between providers, vendors, and the State. Enhancing this function will improve outcomes and enhance cost-effectiveness of state spending.

With the launch of the HHS transformation, Illinois has renewed its focus on organizational effectiveness and capacity building. New agency leadership has been assembled from both the private and public sectors, many of whom have successful records of transformation in other states. The transformation leadership team aims to ensure that the system is designed to achieve behavioral health objectives not only in the short-term, but also on an ongoing basis.

In search of additional efficiency and effectiveness measures, the State will revise outdated administrative rules that hinder the behavioral health system. Rules that were developed for a different time (e.g., Rule 132, which governs mental health, and Rules 2060 and 2090, which cover substance-use disorder) may now inhibit progress toward the outcomes Illinois seeks. For example, these rules may deter integration of behavioral and physical health rather than promote it. This process is expected to enhance behavioral health system capacity and remove structural barriers to integration.

*Section 1.2.5: Alignment of ongoing state initiatives*

The behavioral health strategy is aligned with a broad set of state efforts. It builds on the SIM work and aims to fulfill the behavioral health goals of the most recent SHIP initiative, which include integrating behavioral and physical health, reducing deaths caused by behavioral health crises, and rebalancing treatment from institutional to community settings. The strategy is also aligned with and expands upon recent state legislation “Public Act 099-0480,” which aims to address the opioid crisis.

The State has also submitted a series of six Advance Planning Documents (APDs) on the data and analytics infrastructure to support the behavioral health strategy. These APDs help ensure compliance of Illinois Medicaid programs with new electronic healthcare standards and would

update the State’s Medicaid Management Information System (MMIS) and Medicaid Statistical Information System (MSIS). The component of the strategy addressing integrated, digitized member data will be pursued through a recently submitted IAPD, which focuses on building a shared interoperability platform that can provide a comprehensive view of each member, including service eligibility, provider interactions, and State agency relationships. This view will help enable physical and behavioral health integration and provide common data where no direct relationships between providers exist today.

Finally, the State’s participation in two CMS Medicaid Innovation Accelerator Programs (IAPs) provides access to technical assistance to guide Illinois’ pursuit of the core components of its behavioral health strategy. The State’s emphasis on supportive services such as housing is strengthened by its participation in “Promoting Community Integration through Long-Term Services and Supports” (on the “State Medicaid-Housing Agency Partnership” track). Additionally, integration is directly supported by the “Physical and Mental Health Integration” IAP.

The research, planning, and stakeholder engagement funded by CMS have served as foundational inputs into the behavioral health strategy and stakeholder support. Each of these efforts fits within the broader HHS transformation as well as the State’s behavioral health strategy. This waiver demonstration seeks to add to and build upon this portfolio of efforts and further advance healthcare transformation in Illinois.

#### *Section 1.2.6: Stakeholder engagement*

Stakeholder engagement and input have been critical in both informing the State’s focus on behavioral health and the design of the strategy detailed above. Throughout the SHA, SIM Rounds One and Two, the creation of the SHIP, and the HHS transformation, more than 2,000 stakeholders collectively emphasized the urgency of behavioral health transformation in Illinois. In HHS transformation town halls, DCFS town halls, and dozens of meetings and surveys, stakeholders shared insights about pain points in the behavioral health system and suggested strategies to address them.

Stakeholders across the State provided detailed input into the SHA process during which 400 organizational leaders were engaged and 11 organizational presentations were held both in person and via webinar. These sessions provided an overview of *Healthy Illinois 2021* and solicited feedback on preliminary priorities; suggestions for additional priorities; examples of successful health improvement work; and perceived statewide assets, barriers, and opportunities. The State also held 11 focus groups with citizens in five counties from different regions across Illinois: Champaign, Cook, Lee, St. Clair, and Sangamon. Each focus group included no more than 15 participants and met for two hours. The limited group size fostered deeper discussions and more actionable recommendations.

During the SIM rounds, the Governor’s Office convened three working groups that met

regularly ([Exhibit 9](#)).

*Exhibit 9: SIM workgroups*

| <b>SIM Workgroup</b>                              | <b>Purpose</b>   |
|---|--|
| <b>Consumer Needs</b>                             | To inform SIM recommendations from the perspective of consumers and their families   |
| <b>Data and Technology</b>                        | To recommend solutions (including those using existing resources) that enhance the secure and timely exchange of actionable clinical behavioral health data consistent with defined standards and to recommend opportunities for provider technical assistance |
| <b>Physical and Behavioral Health Integration</b> | To provide recommendations to support best practices for payers and providers, enhance care coordination, and develop collaborative practices and service linkages   |

Working group members included state agency staff, provider association representatives, behavioral health advocates, behavioral health providers, physical health providers, payers, and consumers from across Illinois. Recommendations by the physical and behavioral health integration working group, in particular, helped inform both the broad behavioral health strategy and the components of this 1115 waiver.

Most recently, four stakeholder-specific working groups were convened with consumer advocates, community services providers, behavioral health providers, and managed care organizations to obtain focused feedback on the emerging behavioral health strategy and components of this waiver application.

All channels of stakeholder engagement have informed the behavioral health strategy. Some components of the strategy are included and described in this waiver request. Other components are being pursued through other mechanisms (e.g., the IAPD; State Plan Amendments, or SPAs; etc.).

### **Section 1.3: Waiver demonstration plan**

Illinois strongly believes this 1115 waiver is critical to the successful implementation of its behavioral health strategy. The proposed waiver elements seek to test new ideas that lay the foundation for innovation in integration and value-based payments. They also seek to test a combination of services that may have been pursued in isolation but promise to be more effective together.

Illinois believes the strategy, supported by the waiver, will have substantial impact on the lives of Medicaid members with behavioral health conditions, offering them a more comprehensive suite of services delivered in a way that is tailored more precisely to their needs. Additionally, Illinois believes that the strategy will have a positive financial impact over the life of the waiver. The State seeks approval for the initial investments needed to secure these savings and further

promote the behavioral health transformation. The federal savings will come from implementing value-generating measures in the early years of the waiver, which would result in substantial savings by the last year of the demonstration.

Under this waiver demonstration, the State asks CMS to invest federal savings in a set of benefits and initiatives to advance its behavioral health strategy, which are outlined in [Sections 1.3.2](#) and [1.3.3](#). All eligibility groups will continue to receive all State Plan benefits; the additional initiatives will maximize the impact of these benefits. In addition, the State asks CMS to fund a set of Designated State Health Programs (DSHPs) to enable further investment in its behavioral health strategy. The State will continue to fund its share of waiver benefits and initiatives as well as reinvest some of its savings in the behavioral health system through a set of SPAs that the State will submit for approval. The Illinois budget situation makes this demonstration a critical step on the path to offering a comprehensive continuum of behavioral health and supportive services for residents with behavioral health needs.

In aggregate, these measures will help Illinois create a value-based, member-centric payment and delivery system that not only fulfills the behavioral health strategy but also delivers member-centric care to all State-supported Illinois residents.

#### *Section 1.3.1: Demonstration goals*

This demonstration, which seeks to provide residents of Illinois with a full complement of well-integrated services, is integral to realizing two foundational components of the State's behavioral health strategy: providing a comprehensive suite of high-quality services and integrating physical and behavioral health.

This demonstration has six overarching goals, as mentioned previously:

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 lower needs
4. Support 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 members, such as housing and employment services
6. Create an enabling environment to move behavioral health providers toward outcomes- and value-based payments

Goals 1, 2, and 3 are the State's primary objectives - effective integration and coordination and the correct balance of community-based and institutional care are critical to improving population health, improving experience of care, and reducing costs. The State is exploring ways to integrate behavioral and physical health through value-based payment and delivery models, IHHs for behavioral health members with high needs, and integrated primary care and behavioral health services management for behavioral health members with lower needs. This waiver will be essential for enabling Illinois care providers to transition to these models.

Goals 4 and 5 lay the foundation for the first three goals. To promote integration, re-balance the behavioral health system, expand the availability of community care, and reduce overreliance on institutional care, the State must build appropriate core, preventative, and supportive services. Without these services, outcomes will not improve significantly regardless of how well integrated behavioral health is with other healthcare and supportive services. As Illinois seeks to shift from an institutional care model to a more community-based one, a broader array of services is critical. Therefore, goals 4 and 5 underpin the success of goals 1, 2, and 3.

Together, these five goals will enable significant progress toward achieving goal 6: the shift to outcomes- and value-based payment models. This shift is instrumental for achieving true transformation of Illinois' healthcare delivery system and ensuring the system is restructured with the member at the center. Meeting these goals will improve the quality of behavioral health care across the State and set the stage for payment models that reward providers for outcomes rather than volume.

To meet these six goals, Illinois proposes a set of benefits and initiatives to be tested under this waiver. Illinois will also submit a set of SPAs for services that are inextricably linked and complementary to the behavioral health strategy.

### *Section 1.3.2: Demonstration benefits*

Illinois requests approval to implement a priority set of benefits and initiatives. In keeping with the spirit of 1115 demonstrations, many of the proposed benefits and initiatives are to be conducted in pilot form. The waiver initiatives are described in [Section 1.3.3](#). As will be noted in [Section 3](#), all eligibility groups will continue to receive all State Plan benefits.

The following list includes six benefits that the State seeks to pursue through this waiver demonstration. These benefits are further detailed in [Section 3](#).

- Supportive housing services
- Supported employment services
- Services to ensure successful transitions for individuals incarcerated at the Illinois Department of Corrections (IDOC) and the Cook County Jail (CCJ)
- Redesign of the substance use disorder service continuum

- Optimization of the mental health service continuum
- Additional benefits for children and youth with significant mental health needs

*Section 1.3.3: Demonstration initiatives*

The State also requests approval to pursue a set of initiatives to complement the benefits and maximize their effectiveness.

The following table ([Exhibit 10](#)) is an overview of the additional initiatives that the State seeks to pursue through this demonstration. They are detailed further in [Section 4](#).

*Exhibit 10: Overview of demonstration waiver initiatives*

| <b>DEMONSTRATION WAIVER INITIATIVES</b> |   |  |
|---|---|--|
| <b>#</b>                                | <b>Initiative</b>                                     | <b>Description</b>   |
| 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 behavioral and physical health)   |
| 2                                       | Infant/Early childhood mental health interventions    | Intervention to teach professionals who have frequent contact with young children (e.g., teachers, care providers) ways to improve the social-emotional and behavioral health and development of at-risk children<br><br>In addition, regular, planned home visits to coach parents on approaches to improving family health |
| 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, curriculum redesign to promote integration, continuing education, training to work with justice-involved populations, and telemedicine infrastructure)            |
| 4                                       | First episode psychosis (FEP) programs                | Programs that address individuals in the initial onset of a Schizophrenia Spectrum Disorder, aimed at avoiding the usual trajectory into disability  |

*Section 1.3.4: Savings to enable demonstration benefits and initiatives*

The State believes that the rebalancing of behavioral health services and the integration of physical and behavioral healthcare will produce substantial savings to the federal government. To ensure that the demonstration project is budget-neutral, the State will place all of its full-benefit Medicaid population under the waiver and commit to generating federal savings of \$1.2 billion over the five-year life of the waiver, a 2% reduction in spending compared to what spending would be without the waiver.



Much of these savings will be generated by the design and implementation of value-based payment and delivery models that will integrate physical and behavioral health. To that end, Illinois intends to pursue IHHs at scale. These IHHs will be pursued through a SPA, but this waiver demonstration seeks to prepare providers to become IHHs through the integration activities described in [Section 4.1](#) as well as a more comprehensive suite of available services through the waiver benefits and proposed SPAs. Collectively, with these value-based payment models and the support of other initiatives, Illinois will be able to achieve its trend reduction target.

By improving the delivery of behavioral health services across the state and creating an infrastructure for continued improvement, the benefits and initiatives to be funded by this waiver will continue to generate federal and state savings well beyond the five-year demonstration period.

#### *Section 1.3.5: Designated State Health Programs (DSHPs)*

Illinois also seeks to fund DSHPs through this waiver demonstration. These DSHPs include state health services provided by a variety of agencies, including the Department of Juvenile Justice (DJJ), the Division of Alcoholism and Substance Abuse (DASA), and the Illinois State Board of Education (ISBE). The DSHPs will enable greater investment by Illinois in its behavioral healthcare system through the initiatives in this waiver as well as through a complementary set of SPAs that the State will submit for approval. These funds will be used to fill critical gaps in current behavioral health services and strengthen the delivery and effectiveness of these services.

[Appendix B](#) contains a list of the DSHPs that the State seeks to pursue through this waiver.

#### **Section 1.4: Demonstration hypotheses and evaluation**

The table below ([Exhibit 11](#)) presents an overview of the preliminary plan to evaluate the services funded by this waiver. It is subject to change and will be further defined as the program is implemented. The example measures are not final and do not represent an exhaustive list of measures that could be used to test each hypothesis.

Exhibit 11: Demonstration hypotheses, broken down by demonstration goal

| PRELIMINARY EVALUATION PLAN   |  |   |
|---|--|---|
| Hypothesis  | Example measures (not final)   | Data sources  |
| <i>Goal 1: Rebalance the behavioral health ecosystem, reducing overreliance on institutional care and shifting to community-based care</i>                                    |  |   |
| Rebalancing the behavioral health ecosystem will reduce total cost of care and optimize utilization (increasing appropriate utilization and reducing unnecessary utilization) | <ul style="list-style-type: none"> <li>• Risk-adjusted total cost of care</li> <li>• Inpatient utilization/1,000</li> <li>• Community mental health utilization/1,000</li> </ul>   | <ul style="list-style-type: none"> <li>• Claims data</li> </ul>   |
| Helping members to stay in their communities will improve satisfaction  | <ul style="list-style-type: none"> <li>• Health Plan CAHPS scores<sup>25</sup> <ul style="list-style-type: none"> <li>– Overall rating of health care received in last 6 months</li> <li>– Overall health plan rating</li> </ul> </li> </ul>   | <ul style="list-style-type: none"> <li>• Health Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey</li> </ul>                            |
| <i>Goal 2: Promote integrated delivery of behavioral and physical health care for behavioral health members with high needs</i>   |  |   |
| Integration of behavioral and physical health care will improve the quality of care for members with high needs (costliest 10% of members)                                    | <ul style="list-style-type: none"> <li>• Health Plan CAHPS scores <ul style="list-style-type: none"> <li>– Percentage of people who rate overall mental or emotional health as very good or excellent (for top 10%)</li> </ul> </li> <li>• HEDIS quality measures <ul style="list-style-type: none"> <li>– Follow-up within 7 days for behavioral health hospitalization</li> <li>– Diabetes screening in members with diabetes and schizophrenia</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Health Plan CAHPS</li> <li>• Claims data</li> <li>• Healthcare Effectiveness Data and Information Set (HEDIS)</li> </ul> |
| Integration will reduce unnecessary utilization and total cost of care for members with high-needs  | <ul style="list-style-type: none"> <li>• Differential in member spend for chronic conditions between behavioral health and non-behavioral health populations</li> </ul>  | <ul style="list-style-type: none"> <li>• Claims data</li> <li>• HEDIS</li> </ul>  |

25 Can substitute with CAHPS Clinician and Group survey results (CG-CAHPS) if available

|  |  |  |
|--|--|--|
|  | <ul style="list-style-type: none"> <li>• Rate of plan all-cause readmissions (PCR) Mental health inpatient utilization</li> </ul>  |  |
| <p><i>Goal 3: Promote integration of behavioral health and primary care for behavioral health members with lower needs</i></p>   |  |  |
| Integration of behavioral health and physical health will improve access to services for members with lower-needs  | <ul style="list-style-type: none"> <li>• Number and percent of diagnosed but untreated individuals with depression, anxiety, and substance use disorder</li> <li>• Number of initial behavioral health diagnoses in primary care settings</li> <li>• Antidepressant medication management</li> </ul>                               | <ul style="list-style-type: none"> <li>• Claims data</li> <li>• HEDIS</li> </ul> |
| Integration of behavioral health and physical health will reduce unnecessary utilization and total cost of care for lower-needs members  | <ul style="list-style-type: none"> <li>• Risk-adjusted total cost of care</li> <li>• Emergency room visits/1,000</li> <li>• Hospitalizations/1,000</li> </ul>  | <ul style="list-style-type: none"> <li>• Claims data</li> </ul>                  |
| Integration of behavioral health and physical health will improve quality of care for lower-needs members  | <ul style="list-style-type: none"> <li>• HEDIS quality measures <ul style="list-style-type: none"> <li>– PHQ-9 scores at follow-up</li> <li>– Percentage of members receiving eye screenings for diabetic retinal disease</li> <li>– Initiation and engagement of substance abuse treatment after diagnosis</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Claims data</li> <li>• HEDIS</li> </ul> |
| <p><i>Goal 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</i></p> |  |  |
| Preventative measures will reduce prevalence of mental health and substance use diagnoses over time  | <ul style="list-style-type: none"> <li>• Prevalence of mental health diagnoses</li> <li>• Prevalence of SUD diagnoses</li> </ul>   | <ul style="list-style-type: none"> <li>• Claims data</li> </ul>                  |
| More robust behavioral health services will decrease the ratio of inpatient vs. outpatient utilization and spend for   | <ul style="list-style-type: none"> <li>• Ratio of risk-adjusted total cost of care for inpatient care to that for outpatient care</li> </ul>   | <ul style="list-style-type: none"> <li>• Claims data</li> </ul>                  |

|  |  |   |
|--|--|---|
| the behavioral health population   | <ul style="list-style-type: none"> <li>• Ratio of inpatient utilization per 1,000 to outpatient utilization per 1,000</li> </ul>   |   |
| Better behavioral health services will increase member satisfaction  | <ul style="list-style-type: none"> <li>• Health Plan CAHPS scores <ul style="list-style-type: none"> <li>– Ease of getting care and treatment</li> <li>– Overall rating of health care received in last 6 months</li> <li>– Overall health plan rating</li> </ul> </li> </ul>  | <ul style="list-style-type: none"> <li>• Health Plan CAHPS</li> </ul>   |
| <i>Goal 5: Invest in support services to address the larger needs of behavioral health patients, such as housing and employment services</i>   |  |   |
| Supportive services provision will reduce inpatient admissions and lengths of stay   | <ul style="list-style-type: none"> <li>• Inpatient admissions with a primary diagnosis of a behavioral health condition per 1,000</li> <li>• Members with behavioral health diagnosis in residential mental health facilities (per 1,000)</li> <li>• Average length of stay in residential treatment facilities</li> </ul> | <ul style="list-style-type: none"> <li>• Claims data</li> </ul>   |
| Supportive services provision will enhance behavioral health member independence, reducing the total cost of care while also increasing rates of stable living conditions and employment | <ul style="list-style-type: none"> <li>• Risk-adjusted total cost of care</li> <li>• Employment status of adult mental health members in the community</li> </ul>  | <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Substance Abuse and Mental Health Services Administration (SAMHSA)</li> </ul> |
| <i>Goal 6: Create an enabling environment to move behavioral health providers toward outcomes- and value-based payments</i>  |  |   |
| Creating an enabling environment will increase outcomes- and value-based payments  | <ul style="list-style-type: none"> <li>• Percentage of Medicaid spending through outcomes- and value-based payment models</li> <li>• Percentage of eligible providers participating in health home payment model</li> </ul>  | <ul style="list-style-type: none"> <li>• Claims data</li> </ul>   |
| Outcomes- and value-based payment models will  | <ul style="list-style-type: none"> <li>• Health Plan CAHPS scores <ul style="list-style-type: none"> <li>– Percentage of people who rate overall mental or</li> </ul> </li> </ul>  | <ul style="list-style-type: none"> <li>• Health Plan CAHPS</li> <li>• Claims data</li> <li>• HEDIS</li> </ul>                                 |

|  |   |  |
|--|---|--|
| improve outcomes for behavioral health members | <p>emotional health as very good or excellent</p> <ul style="list-style-type: none"> <li>• HEDIS quality measures <ul style="list-style-type: none"> <li>– Follow-up within 7 days for behavioral health hospitalization</li> <li>– Percentage of members getting annual wellness visits</li> </ul> </li> </ul> |  |
|--|---|--|

To test these hypotheses and evaluate the performance of the demonstration project initiatives, the State will compare measures including but not limited to those listed above before, during, and after the demonstration.

**Section 1.5: Demonstration location and timeframe**

The demonstration will take place throughout the State of Illinois over the next five years, with the aspiration to start on July 1, 2017.

This demonstration is the first step in Illinois’ statewide, cross-agency HHS transformation. It focuses on creating change in the Illinois behavioral healthcare system that is sustainable beyond the life of the waiver. Despite undertaking it during a time of great challenges in the State, Illinois believes that this approach to transformation, based on statewide collaboration and member-centric design in behavioral health, can provide a model for the nation to address a long-neglected health issue. We look forward to our discussions and welcome your feedback.

## **Section 2: Demonstration Eligibility**

Under the demonstration, there is no change to Medicaid eligibility. The standards for eligibility set forth under the State Plan remain in effect.

### **Section 2.1: Eligibility groups affected by the demonstration**

The demonstration will enhance behavioral health benefits and integrate behavioral and physical health benefits, in both fee-for-service and managed care, for all child and adult full-benefit Medicaid beneficiaries. All affected groups derive their eligibility through the Medicaid State Plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan. All Medicaid eligibility standards and methodologies for determining eligibility of these groups remain applicable. Expenditures for all groups (other than those specifically excluded) are subject to the demonstration budget neutrality calculation.

### **Section 2.2: Eligibility groups excluded from the demonstration**

The demonstration does not include the groups or benefits described in 42 C.F.R. § 440.255 (limited services available to certain aliens); or individuals who are eligible only for payment of Medicare premiums and cost-sharing including those enrolled in the Specified Low Income Medicare Beneficiaries; the Qualified Individual (QI) program; or the Qualified Disabled Working Individual (QDWI) program.

## Section 3: Demonstration Benefits and Cost-Sharing Requirements

### Section 3.1: Demonstration benefits

Under the 1115 waiver, Illinois requests coverage of six groups of benefits. Each benefit is designed to enable Illinois to provide a higher-value, higher-quality behavioral health system. The benefits, however, do not create optimal impact in isolation. They are critical elements in supporting fully integrated behavioral and physical health homes, which will be most effective when they have the right core, preventative, supportive behavioral health services with which to integrate.

Illinois has designed each of benefits based on strong evidence showing improvements in cost and quality of care through similar initiatives across the country. Illinois recognizes the importance, however, of tailoring programs to geographic and population-specific variations and of undergoing continuous data analysis and performance review to monitor and improve the program to optimize outcomes.

In this vein, for many benefits, Illinois has identified pilot target populations most in need of the proposed benefits and for whom the benefits will most likely decrease total cost of care and increase quality of care. As the waiver progresses and the benefits demonstrate significant cost and quality outcomes, benefits will be scaled to reach a broader population where appropriate.

All eligibility groups will continue to receive all State Plan benefits. The benefits described in [Exhibit 12](#) may be available to any individual in any eligibility group who meets the criteria for the target group on a pilot basis.

*Exhibit 12: Benefit populations and limits*

| Section | Benefit   | Target group   |
|---------|---|--|
| 3.1.1   | Supportive housing services   | Individuals with serious mental illness (SMI) who are either at risk of institutionalization or homelessness or currently reside in institutions or permanent supportive housing     |
| 3.1.2   | Supported employment services   | Individuals aged 14 years and up with serious and persistent mental illness (SPMI), SUD, or serious emotional disturbance (SED) needing ongoing support to obtain and maintain a job |
| 3.1.3   | Services to ensure successful transitions for IDOC- and Cook County Jail (CCJ) justice-involved individuals | Medicaid-eligible IDOC-justice-involved individuals within 30 days of release to the community   |

|       |   |  |
|-------|---|--|
|       |   | Cook County detainees eligible for managed care not previously enrolled in CountyCare  |
|       | Medicaid coverage for extended-release injectable naltrexone MAT services for targeted individuals within 30 days pre-release | Medicaid-eligible individuals incarcerated at the Illinois Department of Corrections (IDOC) appropriate for MAT therapy within 30 days of release to the community |
| 3.1.4 | Short-term residential treatment in an institution for mental diseases (IMD) treating substance use disorder                  | Individuals with SUD in need of short-term residential treatment as part of a continuum of care  |
|       | Substance use disorder case management  | Individuals with substance use disorders receiving any ASAM treatment level of care but not receiving case management from other sources (e.g., IHHs)              |
|       | Withdrawal management   | Individuals with substance use disorders who meet the medical necessity ASAM criteria for withdrawal management  |
|       | Recovery coaching for substance use disorder  | Individuals who have already initiated recovery and are seeking support for long-term recovery   |
| 3.1.5 | Short-term residential treatment in a mental health IMD   | Individuals with mental health disorders in need of short-term residential treatment as part of a continuum of care  |
|       | Crisis beds   | Individuals who require psychiatric treatment but without sufficiently high or acute needs to require inpatient stay   |
| 3.1.6 | Intensive in-home services  | Families and children with high behavioral health needs and/or SED at risk of transition to higher level of care<br><br>Limited to children 5-21 years of age      |
|       | Respite care  | Families and children with high behavioral health needs and/or SED at risk of transition to higher level of care<br><br>Limited to children 5-21 years of age      |

The following subsections describe each benefit outlined in [Exhibit 12](#), providing more detailed benefit descriptions, rationales, lists of included elements, and delivery structures. While described as individual benefits for the sake of clarity, these asks form part of a robust HHS continuum designed to deliver key services in an integrated way to meet the needs of



behavioral health members and support them and their families to live healthy lives in the lowest-intensity setting suitable for their needs.

### *Section 3.1.1: Supportive housing services*

For many individuals with behavioral health conditions, housing instability can be the most significant barrier to health care access, leading to excessive use of emergency department care, inpatient treatment, and crisis services. In Illinois, an estimated 46% of adults using emergency shelters or living on the street have a chronic substance abuse problem and/or serious mental illness.<sup>26</sup> For these individuals, supportive housing offers a lifeline: a stable living situation that serves as a base from which they can access services and pursue their own efforts to improve their behavioral health.

By coupling stable housing and pre-tenancy and tenancy supports and services with behavioral and physical health services, the chances of mental health recovery and reduced alcohol and drug use among persons with mental illness and/or SUD experiencing homelessness or housing instability greatly improve.

Illinois recognizes the value of developing and funding supportive housing services in helping members avoid inappropriate re-institutionalization and costly inpatient and acute services, and it currently funds a limited array of supportive housing services through a mix of federal grants and state general revenue funds from state agencies. However, it currently has no defined Medicaid service package to support individuals to find, obtain, and retain supportive housing.

To design the supportive housing benefit package, Illinois takes guidance from the June 2015 CMS Informational Bulletin, “Coverage for Housing-Related Activities and Services for Individuals with Disabilities,” to “assist states in designing Medicaid benefits” and to “clarify the circumstances under which Medicaid reimburses for certain housing-related activities.” To facilitate development of services in this area across the states, CMS offered a competitive Medicaid Innovation Accelerator Program (IAP) intensive technical assistance opportunity to eight states, including Illinois, to explore how best to incorporate pre-tenancy and tenancy support services within the Medicaid program. This IAP technical assistance has shaped the following waiver ask as well as the broader strategic approach to covering housing support services under Medicaid in Illinois.

Through the 1115 waiver, Illinois seeks to pilot a funding and delivery model for pre-tenancy services and tenancy support services for individuals with high behavioral health needs who are at risk of homelessness or inappropriate institutionalization. There are currently no 1915c waivers serving the Illinois behavioral health population. The 1115 waiver offers the best option to ensure provision of services to this vulnerable population.

---

26 U.S. Department of Housing and Urban Development, Office of Community Planning and Development, 2011

Illinois envisions the supportive housing service package created through this waiver as critical to enabling IHHs to truly take accountability for members and serve them with a “whole-person” approach. Direct supportive housing service provision and the linkage to supportive housing services will be some of the critical activities of an integrated health home.

Details on the pilot’s proposed delivery system, services, and eligible members are outlined in [Exhibit 13](#).

*Exhibit 13: Supportive housing services details*

| SUPPORTIVE HOUSING SERVICES |  |
|-----------------------------|--|
| <b>Service details</b>      | <p><b>Pre-tenancy services</b> support an individual’s ability to prepare for and transition to housing.</p> <p><b><u>Category: Person-Centered Assessment</u></b></p> <ul style="list-style-type: none"> <li>• Screening and assessment of housing preferences/barriers related to successful tenancy               <ul style="list-style-type: none"> <li>– Working with an individual to assess the type of housing, location, and other factors that could meet their needs that they prefer</li> <li>– Identifying possible housing transition and retention barriers, such as accessibility needs, criminal background, ability to pay rent (including SSI/SSDI eligibility and benefits), tenancy problems that have led to prior housing loss and needed supports (including Medicaid/Medicare eligibility and benefits)</li> </ul> </li> <li>• Developing an individualized housing support plan based on assessment               <ul style="list-style-type: none"> <li>– Identifying the types of housing-related services and supports an individual will need based on the assessment</li> <li>– Defining short- and long-term measurable goals, interventions to address identified barriers/needs, and roles and responsibilities for the tenant and support staff</li> </ul> </li> <li>• Developing an individualized housing support crisis plan               <ul style="list-style-type: none"> <li>– Identifying situations and behavioral risk factors that could jeopardize housing placement and appropriate early interventions to prevent or address crisis and related roles and responsibilities</li> </ul> </li> </ul> <p><b><u>Category: Housing Search Services</u></b></p> <ul style="list-style-type: none"> <li>• Assisting with rent subsidy application/certification and housing application process</li> </ul> |

- Assisting individuals with obtaining, completing, and submitting applications to secure rental assistance and apply for housing (e.g., apartment rental applications)
- Assisting individuals to collect required documentation to apply and be eligible for housing, including personal identification, proof of income, and credit history
- Requesting a reasonable accommodation or modification related from a landlord/property manager for individuals with disabilities (e.g., waiving restriction on pets for service animals, requesting a first floor apartment or installation of automatic door openers)
- Assisting with housing search
  - Assisting in search, including reviews of housing resources (e.g., newspapers, rental databases), accompanying individual on inspection of potential housing, and helping make selection)

**Category: Move-In Preparation Services**

- Identifying resources to cover start-up expenses, moving costs, and other one-time expenses
  - Assisting individuals to identify expenses related to move-in and start-up, such as security and utility deposits, covering unpaid utility bills, purchasing adaptive aids and environmental modifications, moving costs, purchases of furniture/furnishings and supplies, and identifying financial and other resources to facilitate move-in
- Community transition/household set-up services
  - Assistance with security deposit if necessary; set-up fees for utilities or service access, including telephone, electricity, heating and water; essential household furnishings and moving expenses, including furniture, window coverings, food preparation items and bed/bath linens. The housing support plan development process should determine what set-up services qualify as reasonable and necessary; community set-up services should be provided only when the person is unable to meet such expenses or when these services cannot be obtained from other sources
- Ensuring housing unit is safe and ready for move in
  - Conducting or facilitating an inspection to ensure that housing meets standards for federal, state, or other rental assistance programs and related quality/safety standards
- Assisting in arranging for and supporting move-in

- Assisting individuals to schedule move-in activities, such as movers, utilities, change of address, and helping individuals purchase furniture, furnishings, and household supplies

**Tenancy Support Services** assist qualified individuals in maintaining tenancy once housing is secured. These services are made available to individuals with identified risks for housing instability and eviction. Ongoing housing-related services promote housing success, foster community integration and inclusion, and help members develop natural support networks.

**Category: Relations with property management and community members**

- Education/training on the roles, rights, and responsibilities of tenants and landlords
  - Includes periodic review of leases and related documents that establish the rights and responsibilities of the tenant and landlord and ongoing training regarding the consequences of not meeting lease obligations
- Coaching on developing/maintaining relationships with landlords/property managers
  - Coaching and assisting individuals to advocate for themselves with the landlord/property manager, to maintain positive relationships, and to foster successful tenancy
- Continuing training on being a good tenant and lease compliance
  - Ongoing support, coaching, motivational interviewing, and links to behavioral interventions to help an individual be a good tenant. Includes ongoing support to master household management and life skills (e.g., laundry, maintaining a clean apartment, minimizing fire and other safety hazards, money management including budgeting and paying rent and utilities)

**Category: Housing Retention Services**

- Providing support in order to maximize housing retention
  - Working with individuals to manage and reduce behaviors that jeopardize housing, such as late rent payments or other lease violations, like use of illicit substances, excessive noise, problems with cleanliness, not seeking treatment for the exacerbation of mental health symptoms, etc.

|                         |  |
|-------------------------|--|
|                         | <ul style="list-style-type: none"> <li>– Providing or coordinating necessary crisis or other interventions as necessary</li> <li>• Providing advocacy/linkage with community resources to prevent eviction <ul style="list-style-type: none"> <li>– Assisting individuals to secure a reasonable accommodation, to engage legal services, or to apply for resources to pay rent or utility arrears to prevent eviction</li> </ul> </li> <li>• Assisting with the housing recertification process <ul style="list-style-type: none"> <li>– Identifying and helping to secure necessary paperwork for completing a housing recertification</li> <li>– Assisting in completing applications in a timely manner to avoid loss of housing</li> </ul> </li> <li>• Coordinating with tenants to review/update/modify housing support and crisis plans <ul style="list-style-type: none"> <li>– Regularly reviewing and updating housing and crisis support plans to reflect current needs and address new or recurring barriers to housing retention</li> </ul> </li> </ul> |
| <b>Service delivery</b> | Services will be provided to eligible members as authorized by their payers (MCO or FFS). Service units will be proportionally allocated to each FFS and MCO, based on applicable populations.   |
| <b>Eligible members</b> | Individuals with serious mental illness (SMI) who are either at risk of inappropriate institutionalization or homelessness or currently reside in an institution or permanent supportive housing   |

### *Section 3.1.2: Supported employment services*

Stable employment, like stable housing, plays a critical role in helping individuals with behavioral health issues prevent hospitalizations and support their journey to recovery. Stable employment has been shown to aid recovery, reduce the likelihood of crisis reoccurrence, and lead to better overall health outcomes for individuals with mental illness. In addition, employment services have been found to reduce community mental health treatment costs, psychiatric hospitalization days, and emergency room usage.

In Illinois, 22% of individuals served by community mental health programs are employed, this is slightly above the national average of 19%. However, 48% of the individuals served are unemployed, and the remaining 30% are not in the labor force.<sup>27</sup> For these unemployed individuals, services to help obtain and maintain employment may improve outcomes.

A growing body of research supports the Individual Placement and Support (IPS) employment approach. IPS supported employment services provide intensive ongoing support to obtain and maintain a job or to find self-employment outside sheltered workshops and other non-competitive situations for individuals needing assistance due to their mental health challenges.

---

<sup>27</sup> SAMHSA Uniform Reporting System, 2015

IPS supported employment services are integrated with mental health services, chemical dependency services, and clinical/support services.

Illinois has more mental health patients participating in IPS-supported job programs (2.8%) than the national average (1.8%). However, compared to the number of individuals with mental illness who desire work, this coverage remains far too low. This waiver seeks to expand existing IPS supported employment services to address a greater percentage of the 78% of members served by community mental health centers (CMHCs) and substance use agencies who are unemployed or out of the workforce.

Currently, 51 IPS teams in Illinois are supported by braided funding through the Division of Mental Health (DMH) and the Division of Rehabilitation Services (DRS). However, Illinois has identified some core challenges to the implementation of the IPS model, including a lack of collaboration across a fragmented system.

Through the 1115 waiver, Illinois seeks to pilot a funding and delivery model of supported employment for a targeted group of behavioral health members with high needs that unifies the current fragmented system. The delivery model will be designed to be seamlessly unified with the IHHs as Illinois envisions supported employment services to be a critical activity offered by (either directly or through a coordinated referral) the IHH.

Details on the pilot’s proposed delivery system, services, and eligible members are outlined in [Exhibit 14](#).

*Exhibit 14: Supported employment services details*

| SUPPORTED EMPLOYMENT SERVICES |  |
|-------------------------------|--|
| <b>Service details</b>        | <p>IPS supported employment services provide ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain a job in competitive or customized employment in an integrated work setting.</p> <ul style="list-style-type: none"> <li>• An average of 20 hours of service per month are provided, based on the needs of the individual and his/her phase of placement and employment (on a limited basis, additional hours can be authorized for members with demonstrated need for more intensive services)</li> <li>• IPS services may also include support to establish or maintain self-employment, including home-based self-employment</li> <li>• Supported employment services are individualized and may include any combination of the following services:               <ul style="list-style-type: none"> <li>– Vocational/job-related discovery or assessment, person-centered employment planning, job placement, extensive job development with and without the presence of the</li> </ul> </li> </ul> |

member, identifying employer needs and developing collaborative relationships to make sure they are addressed in ways to facilitate both employee and employer success

- Assessing potential and actual natural supports in the workplace, partnership building and negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, development of natural supports, benefits support, transportation, asset development and career advancement services
- Other workplace support services, including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting (these services may be made within the waiver or under the authority of State Plan mental health services)

IPS supported employment services are provided in conjunction with mental health services and may include:

- An assessment of work history, skills, training, education, and career goals
- Ensuring accurate information about how employment will affect income and disability supports
- Preparation skills, such as résumé development, interview skills, and disclosure discussions
- Helping create and update individualized job and career development plans, listing member strengths, abilities, preferences, and goals
- Assistance in locating employment opportunities that are consistent with the member’s strengths, abilities, preferences, and goals
- Finding integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required
- Coaching, mentoring, and encouraging the use of illness self-management tools and strategies utilized in the work setting to increase positive presentation to potential employers and to increase job sustainability
- Exploration of community-based resources to increase job placement likelihood (interview outfits, transportation assistance, GED courses/educational programs) and assistance accessing such resources

|                         |  |
|-------------------------|--|
|                         | <ul style="list-style-type: none"> <li>• Helping members prepare for performance evaluations, increasing their self-advocacy skills, advancing soft-skills development, and assisting with career advancement through links to certificate-granting programs</li> <li>• Assistance in properly terminating employment where desired and/or necessary to increase likelihood of re-employment</li> </ul>  |
| <b>Service delivery</b> | <p>Medicaid funds under the 1115 waiver would enable providers will employ a service team consisting of IPS staff and clinical staff (in both mental health and substance abuse).</p> <p>All clinical and medical services provided would be billed separately from the per capita fee.</p> <p>The providers would receive outcomes-based rates per participant that will be determined by defined milestones. Example milestones include:</p> <ul style="list-style-type: none"> <li>• Completion of individual assessment of employment interests, skills, preferences, strengths, and challenges</li> <li>• Preparation for employment (e.g., development of résumé, attendance at available work-related skill-building activities, enrollment into an educational program)</li> <li>• Completing steps in job search process (e.g., development of a job search plan, number of job search appointments maintained, number of face-to-face employer contacts made within first three months of enrollment, number of interviews completed)</li> <li>• Job placement (e.g., payment after five days on the job)</li> <li>• Job retention (e.g., payments at 15, 45 and 90 days, 6 months and 12 months on the job; increase in the number of hours/week employed)</li> </ul> |
| <b>Eligible members</b> | <p>Working-age (14 years and older) Medicaid enrollees who, because of their behavioral health challenges, need intensive ongoing support to obtain and maintain a job in a competitive work environment or in self-employment that pays more than minimum wage.</p> <p>Members who meet the following criteria may be eligible:</p> <ul style="list-style-type: none"> <li>• Serious and persistent mental illness, substance use disorder, or serious emotional disturbance</li> <li>• Express a desire to be employed</li> </ul>  |



### *Section 3.1.3: Services to ensure successful transitions from Illinois Department of Corrections (IDOC) and Cook County Jail (CCJ) incarceration*

Each year, approximately 10,000 people are released from IDOC correctional facilities and 60,000 individuals are released from CCJ. Many of these individuals have behavioral health conditions: national estimates suggest 56% of state correctional populations are dealing with mental health issues<sup>28</sup>, DOC estimates approximately 80% of its population has SUD, and the Cook County Health and Hospital system (CCHHS) estimates that approximately one-third of these individuals have some sort of mental illness.

SUDs are a particularly severe problem among the justice-involved population. According to the Illinois Department of Corrections, 9,237 inmates, who comprise 19 percent of the prison population, were incarcerated for violations of the Controlled Substance Act or the Cannabis Control Act in 2014. Another 7,782 Illinois parolees, or 28 percent of the total 2014 parolee population, were on parole for violations of those Acts.<sup>29</sup> Furthermore, the opioid epidemic has hit the justice-involved population particularly hard. In one Illinois facility, the Sheridan Correctional Center, heroin and other opiates were reported as the primary substances for 22% of the inmates.<sup>30</sup> Overall, in state fiscal year 2015, IDOC reported that 1,413 individuals entered a DOC correctional facility with a SUD involving heroin or other opioids as the primary substance and an additional 366 individuals entered DOC with a SUD diagnosis with heroin/other opioids as a secondary substance (IDOC).

The justice-involved population has historically had high rates of mental health and substance use disorders. What is unprecedented is the ability of Medicaid programs to address these issues. IDOC estimates that due to the Affordable Care Act, about 90% of its population is eligible for Medicaid. The ACA Medicaid expansion offers Illinois the first opportunities to comprehensively connect justice-involved individuals with Medicaid services. The magnitude of both the need for Medicaid services and the lack of coordination within this system is large, and offering the proper mental health and SUD services and pre-release linkages could potentially reduce costs and improve outcomes both within the behavioral health system and within the justice system.

Today in Illinois mental health and SUD needs often go unaddressed after release. Transitions to the community are disjointed, and there is limited oversight to connect former inmates to necessary SUD and mental health treatment services upon release. These flawed transitions can have dire consequences for the health of these individuals and can lead to further criminal activity and recidivism.

---

28 Urban Institute, 2015

29 Illinois Department of Corrections, Fiscal year 2014 Annual Report

30 Illinois Criminal Justice Information Authority, 2011

- National research has shown that a former inmate’s risk of dying from a drug overdose is 129 times greater in the two weeks following release from prison than for the general public<sup>31</sup>
- As of 2011, former IDOC inmates had the fifth-highest recidivism rate in the nation: 51.7%, compared with a national average of 43.3%<sup>32</sup>
- IDOC estimates that approximately 1,000 recidivists each year have serious mental illness

Pre-release planning and effective hand-off procedures are needed to improve health outcomes for this population, address gaps in care, and reduce recidivism. To ensure that the IDOC and CCJ populations are linked to the appropriate services upon release and have access to the SUD and mental health treatment they need, IDOC, DHFS, CCJ, and CCHHS are pursuing initiatives to restructure intake, pre-discharge, and discharge processes to ensure all Medicaid-eligible individuals are enrolled upon release.

Through the 1115 waiver, Illinois seeks to further these initiatives and ensure a seamless transition for justice-involved individuals back into their communities. In particular, Illinois intends to ensure this population is linked to and has relationships with their integrated health homes pre-release.

To do this, Illinois requests:

- **Medicaid coverage for behavioral health screening and, if indicated, assessment, 30 days prior to release:** These services would be administered by trained clinical staff inside the correctional facility
- **Medicaid coverage for identifying Illinois licensed and/or certified behavioral health providers to be accountable for these individuals post-release:** This will only be needed for fee-for-service providers, as MCOs will be responsible for the managed care population
- **Medicaid coverage for outpatient behavioral health (both mental health and SUD) services provided to justice-involved individuals 30 days prior to release.** These services would be administered by either the contracted in-facility provider or, where feasible, by Illinois licensed and/or certified providers who will also be accountable for these individuals post-release (often via telemedicine). These visits would provide a foundation for improved mental health and SUD treatment before transition to the community
- **Pilot Medicaid coverage for extended-release, injectable naltrexone medication-assisted treatment (MAT) services for targeted individuals incarcerated at IDOC within 30 days pre-release:** Individuals with SUD will receive pre-release MAT education, MAT

---

31 Binswanger, I.A., Stern, M.F., Deyo, R.A., Heagerty, P.J., Cheadle, A., Elmore, J.G., & Koepsell, T.D. (2007). Release from prison a high risk of death for former inmates. *New England Journal of Medicine*, 356

32 Pew Center for States, 2011

readiness assessment, counseling, and relapse/overdose prevention education. In addition, those appropriate may participate in a pilot to receive medication assisted treatment administered in the form of extended release injectable naltrexone to be continued after release in the community.

- **Waiver authority to allow justice-involved individuals to defer redeterminations for eligibility until after release:** This would ensure continued access to services during a period in which previously justice-involved individuals remain highly vulnerable to recidivism. By remaining Medicaid-eligible while incarcerated, these individuals are more likely to receive the care they need as they transition back into their communities. Redetermination would be delayed until 90 days post-release
- **Waiver authority to allow Illinois to auto-assign IDOC justice-involved individuals to an MCO at the earliest possible point:** Because the default enrollment process in health plans can take more than a month to become effective, auto-assignment needs to occur as early as possible
- **For the CCJ population, waiver authority to allow automatic and passive enrollment in CountyCare, a full-service MCO owned and operated by CCHHS:** Exceptions would be made for individuals who opt for another plan within 30 days or were enrolled in a different health plan at the time of incarceration and released in fewer than 60 days; these individuals can return to their original plans under the State’s “quick reinstatement” policy.

Details of the proposed delivery system, services, and eligible members for pre-release services are outlined in [Exhibit 15](#). Details of the proposed delivery system, services, and eligible members for pilot MAT services are outlined in [Exhibit 16](#).

*Exhibit 15: Details for transition services for IDOC- and CCJ justice-involved individuals*

| SERVICES FOR IDOC- AND CCJ JUSTICE-INVOLVED POPULATIONS PRE-RELEASE |  |
|---|--|
| <b>Service details</b>  | <p>The 1115 waiver requests Illinois to allow Medicaid coverage for behavioral health screenings and assessments administered in the 30 days prior to release from IDOC or CCJ facilities. It also requests that appropriately licensed and certified providers be permitted to bill Medicaid upon release for one outpatient behavioral health visit within 30 days before release for each justice-involved individual transitioning from IDOC and CCJ.</p> <ul style="list-style-type: none"> <li>• Services offered will not differ from behavioral health services offered under the State Plan (e.g., assessment, counseling, treatment, case management)</li> <li>• Services may be provided by the appropriate professional in person or via telemedicine and may be provided by both the contracted SUD/mental health provider within the facility, or, when possible, by the same providers who will be taking responsibility for that individual post-release; in either</li> </ul> |

|                         |   |
|-------------------------|---|
|                         | <p>circumstance, a smooth transition to accountable providers post-release must be assured</p> <ul style="list-style-type: none"> <li>Identifying providers who will be accountable post-release will be the responsibility of MCOs (or the State for the fee-for-service population)</li> </ul>  |
| <b>Service delivery</b> | <p>Screening and assessment will take place within correctional facilities to ensure behavioral health needs are fully recognized prior to release. If need for a behavioral health provider on the outside is clinically indicated, identification of the post-release accountable provider will follow.</p> <p>Provider reimbursement will be requested upon release and will be contingent upon demonstration of full and proper linkage to the behavioral health system (individual must have a care plan, a follow-up appointment within 2 weeks of release, and proof of medication dispensing)</p> |
| <b>Eligible members</b> | All Medicaid-eligible inmates who are within 30 days of release   |

*Exhibit 16: Details for MAT services for IDOC- justice-involved individuals*

| MAT SERVICES FOR IDOC JUSTICE-INVOLVED POPULATIONS PRE-RELEASE |   |
|--|---|
| <b>Service details</b>   | <p>The 1115 waiver requests Illinois to allow Medicaid coverage for medication-assisted treatment in the form of extended-release, injectable naltrexone administered within 30 days of release from pilot IDOC facilities.</p> <p>Opioid-agonist maintenance therapies (e.g., methadone, buprenorphine) for opioid use disorders are effective treatments, but use is often discouraged among the justice-involved population due to concern over diversion of medication. Extended-release injectable naltrexone, approved by the Food and Drug Administration in 2010 for the prevention of relapse to opioid disorders, however, has no known misuse or diversion potential and thus may be preferred within the correctional system. Most critically, because injectable naltrexone has an extended release, it may protect former inmates from overdose death within the critical one month post-release period.</p> <p>Furthermore, the controlled environment of the correctional facility is an appropriate setting to initiate extended release naltrexone as justice-involved individuals with opioid use disorders have a higher likelihood of abstaining from opioids for the required length of time prior to initiating treatment.</p> |

|                         |   |
|-------------------------|---|
|                         | <p>The MAT treatment offered in-facility will not differ from the services currently offered under the State Plan.</p> <p>Pre-release MAT services may be provided by the appropriate professional in person or via telemedicine and may be provided by both the contracted SUD/mental health provider within the facility, or, when possible, by the same providers who will be taking responsibility for that individual post-release</p>                     |
| <b>Service delivery</b> | <p>Provider reimbursement for medication assisted treatment will be requested upon release and will be contingent upon demonstration of full and proper linkage to an outpatient MAT provider</p> <p>The Pre-release injectable naltrexone pilot will be offered to ~200 individuals statewide. Over the 5 years of the waiver, as these services demonstrate significant cost and quality outcomes, services will be scaled to reach a broader population.</p> |
| <b>Eligible members</b> | <p>Medicaid-eligible inmates of IDOC appropriate for medication maintenance therapy who are within 30 days of release on a pilot basis</p>  |

*Section 3.1.4: Redesign of substance use disorder service continuum*

The nation, including Illinois, is experiencing a rapidly growing SUD crisis.

- In 2011, 928,000 Illinois residents ages 12 years or older met the DSM-IV criteria for a SUD<sup>33</sup>; of these 928,000 individuals:
  - Approximately 259,000 needed but did not receive treatment for SUD<sup>34</sup>
  - Approximately 731,000 individuals needed but did not receive treatment for alcohol abuse<sup>35</sup>
- In 2015, there were 43,591 unduplicated admissions to Illinois Division of Alcoholism and Substance Abuse (DASA)-funded treatment services, representing less than 5% of the Illinois over-12 population with SUD
- 29% of patients admitted to DASA-funded services in 2015 indicated opiates were their primary substance of abuse, a 32.8% increase from 2002

While Illinois has a strong track record of providing an expansive range of SUD treatment services for these individuals, its system, like those found across the rest of the nation, lacks strong coordination with the broader physical and mental health system. Furthermore, the

<sup>33</sup> National Survey on Drug Use and Health

<sup>34</sup> State Fiscal Year 2015 Illinois DHFS claims data

<sup>35</sup> This estimate is based on a somewhat broader definition of treatment need than past-year DSM-IV substance-related disorder; another, partially overlapping group of 731,000 Illinois residents 12 years and older needed but did not receive treatment for alcohol use in the past year

services that are provided today are not adequately matched to the level of acuity of the member's needs, resulting in dependence on high-cost, deep-end residential treatment rather than integration with community-based prevention, treatment, and recovery.

Through the design and development of IHHs, other elements of its broader behavioral health transformation, and through the relevant asks in this 1115 waiver, the State of Illinois will not only ensure individuals with substance use disorders have access to the full continuum of necessary services, both in the community and within inpatient facilities, but will also ensure these services are provided within a fully coordinated, integrated delivery model that incentivizes providers to care for individuals at the right time in the lowest-acuity setting possible.

To transition to this fully integrated and coordinated substance use system Illinois intends to develop:

- An integrated system in which providers and their teams take ownership for both physical and behavioral health
- Increased data transparency and outcome-based payment models to measure and reward high-quality care
- A comprehensive evidence-based service continuum
- Appropriate standards of care
- Benefit management and program integrity safeguards to ensure appropriate utilization
- A robust network development plan
- Initiatives that address and reduce the opioid use epidemic

Each of the above elements are described in the following subsections.

#### **Section 3.1.4.1: Integrated physical and behavioral health delivery system**

As described in [Section 1.2.3](#) IHHs will incentivize a single care delivery model that wraps around the members, ensures access to the appropriate suite of services provided in the lowest-acuity setting, and is provided by a coordinated behavioral and physical health team.

#### **Section 3.1.4.2: Data transparency and outcome-based payment**

Illinois has already taken steps toward data transparency with respect to SUD. The Illinois Division of Alcoholism and Substance Abuse (DASA) collects a set of National Outcomes Measures, developed by SAMHSA, on all members to track progress on a set of six goals:

- Increase the percentage of members reporting employment (or enrollment in school)
- Decrease the percentage of members arrested
- Decrease the percentage of members who report being homeless
- Increase the percentage of members reporting abstinence from alcohol
- Increase the percentage of members reporting abstinence from illegal drugs

- Increase the percentage of members experiencing “social connectedness” (measured as by participation in self-help groups)

Additionally, DASA has taken steps toward utilizing collected data to shift from paying for volume to paying for performance. The performance-based contracting goals are intended to improve the extent to which members are engaged in the initial phase of treatment, retained in treatment, and are linked to less intensive levels of service following completion of a SUD treatment program.

Marrying this system with the development of IHHs will enable providers to look beyond substance use and social indicators toward full integration, taking “paying for performance” to the next level and leveraging the power of teams to improve whole-person and whole-family outcomes.

### **Section 3.1.4.3: Comprehensive evidence-based design**

An integrated physical and behavioral health system to prevent and treat individuals with SUD is critical, and the availability of a continuum of services with which to coordinate is equally critical.

Today, the Illinois Medicaid program offers many but not all of the American Society of Addiction Medicine (ASAM) treatment levels of care. Through this 1115 waiver and a set of SPAs, Illinois seeks to expand the SUD treatment continuum benefit.

Through this 1115 waiver, Illinois requests Medicaid coverage for:

- Treatment within licensed ASAM level III.5 residential treatment services with more than 16 beds for up to 30 days for members enrolled in fee-for-service
- Treatment within licensed ASAM level III.5 residential treatment services with more than 16 beds for 15 to 30 days for members enrolled in managed care
- SUD case management for targeted populations on pilot basis
- Withdrawal management (level III.2) for targeted populations on pilot basis
- Recovery coaching for targeted populations on pilot basis

Through a SPA, Illinois will expand the SUD treatment continuum to also include MAT.

[Exhibit 17](#) displays the full spectrum of ASAM and non-ASAM services available today and how this treatment continuum will expand as a result of the 1115 waiver and proposed SPAs. It is critical to note that this expansion will occur not only within the context of a seismic shift toward a coordinated, integrated care delivery system with outcomes-based payment incentives but will also be coupled with clear standards of appropriate care, program integrity safeguards, and benefit management (as described in [Sections 3.1.4.4](#) and [3.1.4.5](#)).

Exhibit 17: ASAM services

| ASAM LEVEL OF CARE | SERVICE TITLE  | BRIEF DESCRIPTION  | CURRENT MEDICAID SERVICE  | FUTURE MEDICAID SERVICE | ENABLER                                       |
|--------------------|--|--|---|-------------------------|---|
| N/A                | SBIRT  | Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs | No (Limited provision under SAMHSA grant to Federally Qualified Health Centers, or FQHCs) | Yes                     | Integrated Health Homes                       |
| N/A                | Recovery coaching  | Non-clinical support to help individuals sustain recovery over time  | No  | Yes                     | 1115 waiver (pilot with targeted populations) |
| N/A                | SUD case management  | Activities designed to augment clinical services for a patient in treatment that include providing and coordinating ancillary services to support treatment and improve clinical outcomes                | No  | Yes                     | 1115 waiver (pilot with targeted populations) |
| N/A                | Medication-assisted treatment (MAT)<br>-Opioid Treatment (Methadone) | Physician-supervised opioid agonist medication (daily or several times weekly) and counseling to maintain multidimensional stability for those with severe opiate use disorder                           | No  | Yes                     | SPA   |
| I                  | Outpatient services  | Organized outpatient treatment services (fewer than 9 hours per week delivered in a variety of settings), including professionally directed screening, assessment, and counseling, and                   | Yes   | Yes                     | Current State Plan                            |



|       |  |   |  |                     |  |
|-------|--|---|--|---------------------|--|
|       |  | ongoing recovery and disease management services  |  |                     |  |
| II    | Intensive outpatient/<br>partial hospitalization       | Structured program delivering 9 or more hours per week of clinically intensive programming with a planned roster of individualized therapies                                  | Yes  | Yes                 | Current State Plan   |
| III.1 | Clinically Managed Low-Intensity Residential Services  | Supportive living environment (halfway house) with 24-hour staff and integration with clinical services; at least 5 hours of low-intensity treatment per week (Halfway House) | No - GRF funded  | No                  | State GRF as funded today                                  |
| III.5 | Clinically Managed High Intensity Residential Services | Residential treatment for adults or adolescents, providing at least 25 hours per week of high-intensity clinical services   | Only the treatment portion of the stay and only for those programs in compliance with the IMD exclusion. No coverage for domiciliary costs | Yes (up to 30 days) | 1115 waiver and SPA for managed care for less than 15 days |
| III.2 | Withdrawal Management – Clinically Managed Residential | Patients with moderate withdrawal needs, who require 24-hour support to complete withdrawal management and increase likelihood of continuing recovery                         | No   | Yes                 | 1115 waiver (pilot with targeted populations)              |

|       |   |   |     |     |                    |
|-------|---|---|-----|-----|--------------------|
| III.7 | Withdrawal Management – Medically Monitored | Patients with severe withdrawal needs, requiring 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical/ nursing monitoring | Yes | Yes | Current State Plan |
|-------|---|---|-----|-----|--------------------|

Illinois proposes under the 1115 waiver to cover level III.5 IMD services for all Medicaid-eligible individuals for up to 30 days but SUD case management, withdrawal management, and recovery coaching services for a targeted group on a pilot basis. [Exhibits 18](#) and [19](#) describe the SUD case management and withdrawal management services, as well as proposed delivery systems and eligible members. [Exhibit 20](#) describes the details for recovery coaching for individuals initiating recovery from substance use disorder.

*Exhibit 18: SUD case management service details*

| SUD CASE MANAGEMENT        |  |
|----------------------------|--|
| <b>Service description</b> | <p>SUD case management helps members handle aspects of their lives that are not necessarily related to a SUD but that might influence whether the patient remains in treatment or has successful treatment outcomes. Areas of needed assistance addressed by case management services include:</p> <ul style="list-style-type: none"> <li>• Health needs</li> <li>• Arrangement of transportation of members (not providing transportation)</li> <li>• Childcare</li> <li>• Management of family situations, living conditions, and school or work situations</li> </ul> <p>Case management services are individualized for patients in treatment, reflecting particular needs identified in the assessment process and those developed within the treatment plan. Examples include:</p> <ul style="list-style-type: none"> <li>• Inter- and intra-provider record review</li> <li>• Internal and/or external multidisciplinary clinical staffing</li> <li>• Telephone calls, letters, and other attempts to engage family members or “significant others” in the member’s treatment</li> <li>• Telephone calls, letters, and home visits to members to keep them engaged in treatment</li> <li>• Assistance with budgeting, meal planning, and housekeeping</li> <li>• Letters, telephone calls, and meetings with employers on behalf of a member</li> <li>• Assistance for members and their families in obtaining Medicaid, Social Security, cash grants, and WIC</li> <li>• Link Cards and other entitlements that they may need</li> </ul> |

|                         |  |
|-------------------------|--|
|                         | <ul style="list-style-type: none"> <li>Assistance for members and their families in obtaining medical, dental, mental health, educational, recreational, vocational, and social services as specified in the treatment plan</li> </ul> |
| <b>Delivery system</b>  | Authorized by a DASA treatment license in outpatient or residential setting or an approved off-site location   |
| <b>Eligible members</b> | Medicaid-eligible members receiving any ASAM treatment level of care who are not receiving case management services through any other provider on pilot basis  |

*Exhibit 19: Withdrawal management service details*

| <b>WITHDRAWAL MANAGEMENT (LEVEL III.2)</b> |  |
|--|--|
| <b>Service description</b>                 | <p>Withdrawal or “clinically managed detoxification” (level III.2) services are those provided in a non-medical or social detoxification setting. This level of care emphasizes peer and social support and is intended for members whose intoxication and/or withdrawal is sufficient to warrant 24-hour support.</p> <p>Services provided under level III.2 are administered by appropriately trained personnel and include 24-hour monitoring, observation, and support in a supervised environment for a member to achieve initial recovery from the effects of alcohol or another drug. This level is referred to as “social detoxification” because of its emphasis on peer and social support. It also can be used for members whose intoxication or withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support, but do not require medically monitored inpatient detoxification.</p> |
| <b>Delivery system</b>                     | Performed in a DASA-licensed residential treatment setting   |
| <b>Eligible members</b>                    | Medicaid-eligible members with SUD who meet the medical necessity ASAM criteria for withdrawal management on a pilot basis   |

*Exhibit 20: SUD recovery coaching service details*

| <b>SUD RECOVERY COACHING</b> |  |
|------------------------------|--|
| <b>Service description</b>   | <p>Recovery coaching aims to help members recovering from SUD sustain recovery over time. It focuses on non-clinical issues and utilizes evidence-based practices such as strengths-based case management, motivational interviewing, and contingency management.</p> <p>Issues addressed through coaching include but are not limited to proceeding through drug court; dealing with probation officers; and helping find resources for harm reduction, family support and education, and support groups, among other services.</p> |

|                         |  |
|-------------------------|--|
|                         | Recovery coaching can not only help members in addiction treatment acquire the resources and skills they need to sustain recovery over time but can also prevent members with SUD from requiring more intensive and expensive care.  |
| <b>Delivery system</b>  | <p>Recovery coaching will be provided by a “recovery coach” who does not diagnose or treat directly and instead focuses on non-clinical issues to assist members to sustain recovery. The coaches will be required to go through formal training and may be required to have “lived experience.”</p> <p>The coaches may practice in a wide range of settings including primary care practices, emergency departments, Federally Qualified Health Centers (FQHCs), CMHCs, schools, recovery community centers, faith and community-based organizations, recovery homes, jails and prisons, probation and parole programs, and other social service centers.</p> <p>Peer recovery services are delivered across the recovery process, from prior to treatment to post-treatment (or sometimes in lieu of treatment).</p> |
| <b>Eligible members</b> | Limited pilot of Medicaid eligible adults ages 18+ who have already initiated recovery and are seeking support for long-term recovery from addiction to alcohol and/or other drugs on a pilot basis  |

**Section 3.1.4.4: Appropriate standards of care, benefit management, and program integrity safeguards**

Defining appropriate standards of care will be critical to the successful implementation of the future substance use benefit package Illinois envisions. Illinois currently uses and will continue to use the ASAM Patient Placement Criteria standards. All providers are and will continue to be required to demonstrate compliance with these criteria and be periodically checked via on-site reviews.

In addition, to ensure the added services are utilized in an appropriate manner, Illinois will implement an independent third-party pre-authorization service for SUD assessment, level-of-care, and length-of-stay recommendations. This third party will pre-authorize services and perform chart audits and random site visits, among other functions, to ensure the fidelity of Illinois’ substance use model. Illinois recognizes the importance of such an unbiased review of compliance, especially as it seeks Medicaid funding for the SUD treatment continuum to cover ASAM level III.5 in an IMD. It anticipates this type of third-party pre-authorization process to be performed by MCOs or other appropriate entities for members not in managed care. Additionally, in order to ensure that expansion of level III.5 IMD services does not exceed the identified need, the State will implement a certificate of need requirement for any request for new residential services or for requests for additional beds to existing service facilities.

Further, to ensure the proposed benefit package is provided to individuals in accordance with clinical and other standards contained in administrative rule, DASA will conduct post-payment audits annually for each Medicaid-certified provider, based upon a subset of licensure rules. Any funds found to have been paid in a non-compliant manner will be recouped and if necessary, sanctions will be imposed on the license or Medicaid certification.

#### **Section 3.1.4.5: Network development plan**

Also critical to successful implementation of the proposed future substance use benefit package in [Exhibit 17](#) is a strong network development plan. To ensure providers are prepared to deliver the ASAM services, DASA will enhance its licensing and credentialing requirements regarding the ASAM criteria and providers' ability to follow this evidence-based protocol. In addition, providers will be required to undergo annual trainings unique to their professional credentials and additional trainings for providers wishing to perform new services to ensure they fully understand the ASAM evidence-based protocols and other regulatory requirements.

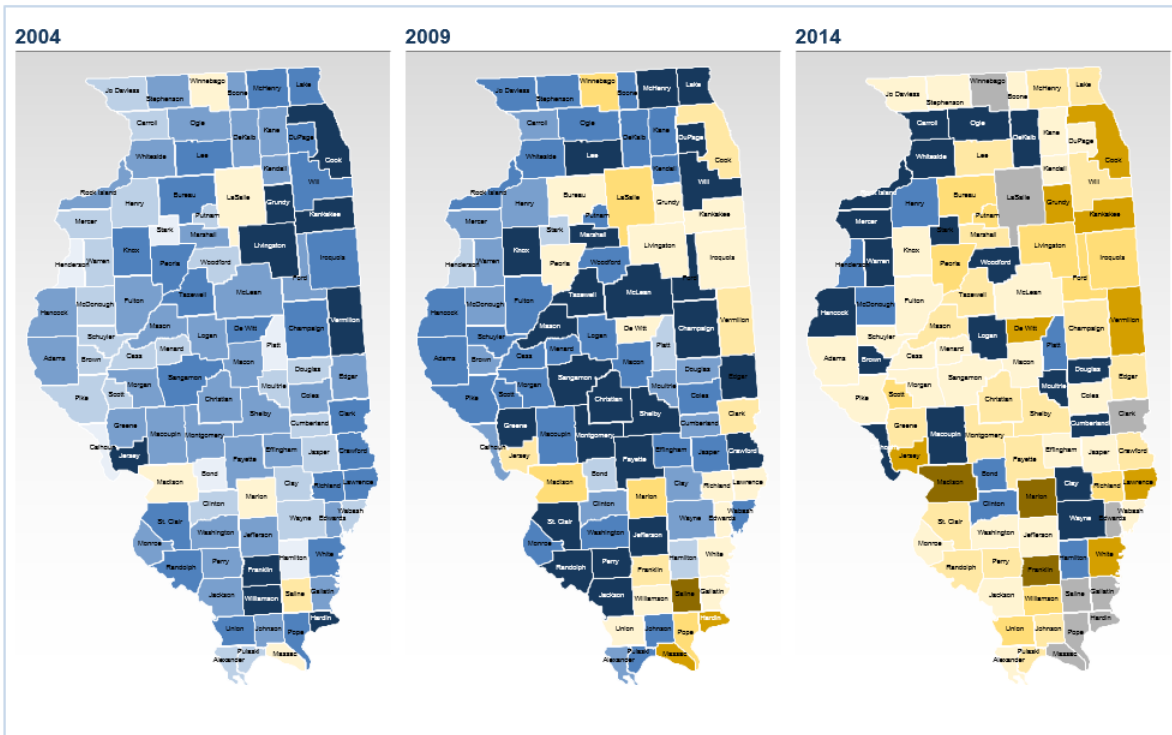
#### **Section 3.1.4.6: Strategies to address prescription drug abuse and opioid use disorder (OUD)**

Illinois, like the rest of the nation, is facing a rapidly growing opioid epidemic.

- Between 2008 and 2014, deaths in Illinois from opioid overdoses nearly tripled, and the proportion of drug overdose deaths attributable to opioids jumped from 31% to 68%
- 29% of patients who were admitted to DASA-funded services in 2015 indicated opiates as their primary substance, a 32.8% increase in such admissions from 2002
- Illinois treatment admissions for heroin are significantly higher than the nation as a whole. Nationally, heroin treatment admissions comprised 16.4% of total state-funded treatment in 2012, while Illinois heroin treatment admissions accounted for 25.3% of all IDHS/DASA-supported treatment admissions. In 2012, the percentage of treatment admissions for heroin in the Chicago metropolitan area was more than twice the national average (35.1% vs. 16.4%)
- Across the state, age-adjusted overdose death rates have increased significantly over the past decade ([Exhibit 21](#))

Exhibit 21: Age-adjusted death rates by overdose over the past ten years

**Estimated age-adjusted overdose death rate by county**



SOURCE: CDC: Drug Poisoning Mortality County Trends

According to the Centers for Disease Control and Prevention, over 8,200 people died nationally from heroin overdoses in 2013. In Illinois, 2,135 drug-related overdose deaths were reported from January 1, 2014 to October 31, 2015, according to the Illinois Department of Public Health. Heroin accounted for 59.3% (1,266) of these drug overdose deaths. Other opioids accounted for an additional 36.9% (788) of these fatalities.

To combat the opioid crisis, in 2016 Illinois enacted a groundbreaking piece of legislation entitled “Public Act 099-0480.” The act comprehensively addresses the opioid crisis by:

- Expanding the availability of opiate overdose reversal drugs, such as naloxone. The Act allows pharmacies to dispense them, school nurses to administer them, and requires all police and fire agencies and emergency medical technicians to carry the drugs and be trained on how to administer them
- Upgrading the prescription monitoring program and data reporting system. The Act improves the current EHR system interface with the prescription monitoring program and requires coroners, medical examiners, and other health care professionals to report all cases of drug overdose to the Department of Public Health
- Amending existing drug court programs to keep more users in treatment and less in jail

- Establishing a medication take-back program to collect and dispose of unused medications
- Establishing drug education programs in schools, mandating public awareness campaigns on the dangers of unused prescription medications

Finally, the Act mandates that all FDA-approved forms of medication-assisted treatment prescribed for the treatment of SUD be included under the medical assistance program. As a result, Medication Assisted Treatment using methadone (MAT) will qualify as a covered Medicaid service, effective January 1, 2017, and will substantially increase access to services for individuals on the road to recovery.

### *Section 3.1.5: Optimization of the mental health service continuum*

Through the creation of IHHs and an expanded community service package, Illinois intends to dramatically reduce the inappropriate utilization of inpatient, institutional, and residential mental health services. However, Illinois also recognizes that, when appropriate, these deep-end settings are a critical element of the full mental health service continuum.

To promote appropriate utilization of high-acuity services and ensure that all Medicaid members have access to a full range of behavioral health services, Illinois requests Medicaid coverage for three additional benefits:

- **Stays in IMDs of up to 30 days for members enrolled in fee-for-service** to enable Medicaid coverage for appropriate, short-term residential stays that focus on stabilization and transition to community care
- **Stays in IMDs of 15 to 30 days for members enrolled in managed care**
- **Crisis beds** to create a diversion service setting for individuals experiencing a crisis who cannot be maintained in the community but who also do not require inpatient mental health care

#### **Section 3.1.5.1: Stays in IMDs of up to 30 days for members enrolled in fee-for-service and 15 to 30 days for managed care**

The federal IMD exclusion represents a significant barrier to ensuring availability of a full spectrum of behavioral health services. In Illinois today the IMD exclusion undermines access to appropriate services for individuals in crisis and vulnerable populations with mental illness diagnoses.

While Medicaid beneficiaries can receive physical health services in a wide range of inpatient facilities, individuals with mental health conditions may encounter barriers to accessing inpatient mental health services, even when inpatient treatment is most appropriate. Therefore, the IMD exclusion unnecessarily restricts and complicates care for individuals with mental health needs. In addition, the IMD exclusion drives up otherwise avoidable system costs such as inappropriate use of expensive emergency room services. CMS' recent managed care



rule acknowledges this in part by allowing capitation payments to managed care organizations (MCOs) for enrollees who are patients in an IMD for 15 days or less, lending credence to the argument that IMD services can be paid in lieu of more costly hospital based services – a rationale Illinois supports.

Through the 1115 waiver, Illinois seeks to test provision of crisis intervention and acute stabilization services within IMD facilities for stays of up to 30 days for all Medicaid members including those deemed unfit to stand trial (UST) (four of Illinois' state psychiatric hospitals serve this UST population). Illinois intends to ensure that individuals who are admitted to IMDs for shorter stays are admitted as part of a seamless and appropriate continuum of care, fully coordinated with that individual's IHH.

Illinois believes that the addition of this IMD benefit, within the context of a transformation to a system of IHHs that take accountability for providing whole-person care and are complemented by new community-based behavioral health and supportive services, will increase rates of long-term recovery and maintenance of behavioral health members in the community while improving outcomes and lowering costs.

#### **Section 3.1.5.2: Crisis beds**

Under the 1115 waiver, Illinois seeks coverage under Medicaid for the treatment and room and board costs of short-stay residential care for both children and adults. These crisis beds will be used exclusively as diversion/step-up beds for individuals that meet medical necessity requirements and are in need of stabilization due to crisis but do not have needs acute or high enough to require an inpatient stay.

These beds will offer a stable environment, structure, and support to facilitate symptom stabilization and respite for family members. Providers offering crisis beds will participate as needed in crisis assessment, individual treatment planning, family needs assessment, development of safety plans and longer-term individual plans of care, and the coordination of linkages to appropriate community resources. These providers may also facilitate transportation between the stabilization site and other service sites and maintain continuous communication and coordination with the IHH's care coordinator and mobile crisis response service team.

Staffing for these beds will involve direct care by a MHP (mental health professional) or RSA (rehabilitative services associate) and supervision provided by a QMHP (qualified mental health professional) or LPHA (licensed practitioner of the healing arts). Members will have 24/7 access to psychiatric consultation and nursing/medical staff.

#### ***Section 3.1.6: Additional benefits for children and youth with behavioral health conditions and/or serious emotional disturbance***

Children with behavioral health conditions and SED, especially those who are transitioning back to their communities from out-of-home care, are often at risk of requiring intensive inpatient or

residential care. To prevent this disruption and maintain more children in their home and communities, the State proposes to offer at-risk children with serious behavioral health conditions and/or SED a set of additional benefits as described in the 2013 CMS guidance, “Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions.” The vast majority of the benefits in the CMS guidance that are not described in this waiver are being pursued through SPAs.

Under the 1115, Illinois proposes piloting two additional key benefits for children: intensive in-home services and respite care. These benefits have been tested in other major initiatives, including the SAMHSA Children’s Mental Health Initiative and the CMS Psychiatric Residential Treatment Facilities (PRTF) demonstration program, showing cost savings and significant improvements in quality of life for children and their families.

In addition, intensive in-home services and respite care will serve as critical services for IHHs to leverage when appropriate to maintain their members with high behavioral health needs and/or SED in the community and avert the need for higher-acuity care.

**Section 3.1.6.1: Intensive in-home care**

Intensive in-home services are interventions provided in the home to stabilize behaviors that may lead to crisis, prevent the need for inpatient hospitalization, and prevent the need to move from residences into out-of-home living arrangements. Services offered through the intensive in-home care pilot will include both home-based clinical and support services. Home-based clinical services are face-to-face, individual, strengths-based therapeutic interventions driven by a clinical intervention plan focused on symptom reduction. Home-based support services are intended to support both the child and his/her family in implementing therapeutic interventions, skill development, and behavioral techniques that focus on symptom reduction. Specifically, supports include teaching methods for social, emotional, and behavioral development, self-help, coping with stress, and parenting.

These intensive in-home services will be time-limited as families gradually learn to stabilize their learning environments. Further details of the proposed delivery system, services, and eligible members are outlined in [Exhibit 22](#).

*Exhibit 22: Intensive in-home services details*

| INTENSIVE IN-HOME SERVICES |  |
|----------------------------|--|
| <b>Service details</b>     | <p>Intensive in-home services are therapeutic interventions delivered to children and families in their homes and other community settings to improve youth and family functioning and to prevent out-of-home placement in inpatient or residential treatment settings. Service components include:</p> <ul style="list-style-type: none"> <li>• Individual and family therapy</li> <li>• Skills training</li> </ul> |

|                         |   |
|-------------------------|---|
|                         | <ul style="list-style-type: none"> <li>Behavioral interventions</li> </ul>  |
| <b>Service delivery</b> | <p>Services are expected to be delivered in the child’s home and offered at the time of day when they are most needed and when the family is most receptive to them.</p> <p>These services will be authorized for an initial 60-day period with potential for authorization for an additional two 30-day renewals. Both home-based clinical services and home-based support services must be provided for a minimum of one hour per week.</p> |
| <b>Eligible members</b> | Children (5 to 21 years old) with high behavioral health needs at risk of transition to a higher level of care on a pilot basis   |

**Section 3.1.6.2: Respite care**

Intensive in-home services alone may not provide a sufficient continuum of support to meet the needs of the child and family and keep the child in the least restrictive environment possible. For this reason, to adequately reduce caregiver stress, sometimes a short break from the home environment for the child or family may be needed. Respite services can help to relieve stress and ultimately maintain individuals in the community after a short time away. As described in the 2013 CMS guidance, respite services “provide safe and supportive environments on a short-term basis for children with mental health conditions when their families need relief.”

Currently, respite care is offered through select, population-based HCBS waivers across the State as well as through a State-funded demonstration. Through the 1115 waiver, Illinois seeks to pilot the respite program with a targeted group of children with high needs and families across the State.

Details on the proposed delivery system, services, and eligible members for respite care are outlined in [Exhibit 23](#).

*Exhibit 23: Respite care service details*

| RESPITE CARE           |   |
|------------------------|---|
| <b>Service details</b> | <p>Respite care is a set of individualized time-limited services that provide families scheduled relief to help prevent stressful situations, including avoiding a crisis or escalation within the home.</p> <ul style="list-style-type: none"> <li>Services can be delivered in or out of the home as long as they take place in community-based settings</li> <li>Services must be provided on a scheduled basis and planned as part of a child’s individualized care plan and therefore are not to be utilized as emergency child care</li> <li>Services will be culturally competent and aligned with the family’s beliefs and preferences</li> </ul> |

|                         |  |
|-------------------------|--|
|                         | <ul style="list-style-type: none"> <li>• Services shall not exceed seven hours per event, 21 hours per month, or 130 hours annually</li> <li>• Services are not standalone and must be offered in conjunction with other treatment services</li> </ul> |
| <b>Service delivery</b> | Medicaid funds under the 1115 waiver would be used by the State to contract with an entity approved by the Department of Healthcare and family Services who would administer Medicaid dollars for respite care   |
| <b>Eligible members</b> | High-needs children and youths (5 to 21 years old) who have a serious emotional disturbance and/or complex behavioral health conditions and are at risk of transition to a higher level of care on a pilot basis                                       |

**Section 3.2: Cost-sharing requirements**

There is no cost-sharing for any benefit provided under the waiver; copayments, coinsurance, and/or deductibles for any of the above benefits. State Plan benefits will continue to be applied in accordance with the State Plan.

## **Section 4: Other Waiver Initiatives**

Under the 1115 waiver, Illinois requests coverage of four initiatives to maximize the impact of the benefits enumerated in [Section 3](#) and create the systemic changes necessary to pave the way for integration and value-based payments.

First, the State recognizes the importance of aligning system transformation efforts with broader population and preventative health reform. Just as supportive housing, supported employment, respite care, and lower-acuity crisis alternatives are vital components of the behavioral health continuum of care, so are prevention services. To build this continuum of care, Illinois requests support through the 1115 waiver for select infant and early childhood mental health interventions.

Second, to prepare the State and providers to successfully implement IHHs, Illinois requests support through the 1115 waiver for Medicaid funding for select behavioral and physical health integration activities. This funding will provide payers and providers resources to develop the infrastructure, technology, and provider capabilities required to implement health homes.

Thirdly, to ensure the Illinois workforce is sufficiently sized and trained to provide the services requested in this waiver and prepared to function within a value-based payment system, Illinois requests through the 1115 waiver Medicaid funding a set of workforce-strengthening initiatives. These initiatives range from broad support for graduate medical education to funding for telemedicine infrastructure.

Lastly, to ensure first episodes of psychosis can be addressed and managed as early and effectively as possible, Illinois requests Medicaid funding to expand the reach of first episode psychosis programs by supporting the creation of teams to address this critical inflection point in members' lives.

### **Section 4.1: Behavioral and physical health integration activities**

In Illinois, as in other states, behavioral health is a key driver of healthcare utilization and Medicaid spending. As previously noted, although Illinois Medicaid members with behavioral health conditions make up 25% of the Medicaid population, they account for 56% of Medicaid spending when factoring in both behavioral and medical costs.

While individuals with behavioral health conditions have some of the greatest needs, the Illinois healthcare system is often too fragmented to serve them in an ideal fashion. For behavioral health members with high needs, the complexity of accessing physical and behavioral health services separately can be prohibitive. There are also many behavioral health conditions that can and should be addressed within primary care settings, but members often encounter primary care providers who lack experience in treating behavioral health conditions or engaging behavioral health members in their own care. Behavioral health members often have difficulty

adhering to medication regimens, managing appointments, or finding transportation to appointments or to pick up medications.

The integration of behavioral and physical health is essential to fully address the needs of these members. Furthermore, integrating care for these hard-to-serve members can also play a pivotal role in bending the Medicaid cost curve. This is illustrated by the cost differential between behavioral health and non-behavioral health members with similar conditions: Illinois Medicaid members with diagnosed and treated behavioral health conditions are approximately 3.5 times as likely (59%) as other members (17%) to have a chronic medical condition, and their annual treatment costs are nearly twice as high (not risk-adjusted) as those of non-behavioral health members with the same conditions ([Exhibit 24](#)).<sup>36</sup>

*Exhibit 24: Chronic conditions in Medicaid behavioral health members*

### Behavioral health Medicaid members are 3.5x as likely to have a chronic condition and almost 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 <sup>5</sup> |   |                                      |   |                                      |                            |
|---|---|--------------------------------------|---|--------------------------------------|----------------------------|
|   | Non-behavioral health population <sup>1</sup> | Average PMPM spend <sup>2</sup> , \$ | Behavioral health primary population <sup>1</sup> | Average PMPM spend <sup>3</sup> , \$ | Percent difference in PMPM |
| No chronic condition  | 83%   | 101                                  | 41%   | 186                                  | 84%                        |
| Asthma  | 7%  | 268                                  | 15%   | 732                                  | 173%                       |
| Hypertension  | 6%  | 408                                  | 23%   | 986                                  | 141%                       |
| Hyperlipidemia  | 4%  | 327                                  | 15%   | 926                                  | 183%                       |
| Diabetes  | 3%  | 470                                  | 10%   | 1,219                                | 160%                       |
| COPD  | 2%  | 331                                  | 10%   | 1,102                                | 233%                       |
| Arthritis   | 2%  | 418                                  | 11%   | 976                                  | 133%                       |
| Chronic Kidney Disease  | 1%  | 1,171                                | 4%  | 2,368                                | 102%                       |
| Ischemic Heart Disease  | 1%  | 639                                  | 4%  | 1,659                                | 160%                       |
| Heart Failure   | 0%  | 1,389                                | 2%  | 2,653                                | 91%                        |
| Cancer <sup>4</sup>   | 0%  | 879                                  | 1%  | 1,796                                | 104%                       |
| Stroke  | 0%  | 1,799                                | 2%  | 2,267                                | 26%                        |
| Osteoporosis  | 0%  | 915                                  | 1%  | 1,567                                | 71%                        |
| Atrial Fibrillation   | 0%  | 992                                  | 1%  | 2,563                                | 158%                       |
| Alzheimer's disease   | 0%  | 1,052                                | 1%  | 2,164                                | 106%                       |
| <b>Total population<sup>1</sup> = 1,642,415</b>   |   |                                      | <b>Total population<sup>1</sup> = 357,785</b>     |                                      |                            |

1 Valid population after non-Medicaid and business exclusions  
 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  
 4 Includes breast, colorectal, lung, and prostate cancers  
 5 Excludes members with no claims or only PMPM coordination payments  
 SOURCE: FY15 State of Illinois DHFS claims data

Illinois has made substantial progress toward integration by carving in behavioral health during the transition to managed care. In addition, the State is migrating children who receive services from the DCFS—a population that tends to have behavioral health needs—to a specialized

managed care product. While the State believes these to be important starting points, it believes more progress needs to be made in partnership with its MCOs, to more deeply integrate behavioral and physical health care.

As described in [Section 1.2.3](#), to achieve its vision for integration, Illinois intends to design and implement IHHs. Authorized through a SPA, these IHHs will align incentives and reward providers for furnishing high-value, high-quality care that is fully coordinated across behavioral and physical health settings. Illinois believes this delivery system is equally necessary in both mandatory and voluntary managed care counties.

In IHHs, providers will treat the whole member, not only the specific complaint. Providers will proactively identify and target high-needs members as well as screen and refer those at risk of developing SUD. Physical and behavioral health providers will collaborate closely; share information; deliver care in a multi-disciplinary, team-based model; and co-develop treatment plans. This integrated care team will jointly consider diagnosis and treatment with the member's socioeconomic, mental, and physical health needs; coordinate transitions in care (e.g., after incarceration, between residential and outpatient recovery treatment); and make referrals utilizing data on outcomes and cost.

Increased access will be critical to enable individuals to access care "where they are" (e.g., in schools). In addition, community and support service connectivity will extend beyond pamphlets in the office. Providers will actively connect members to appropriate social services and community-based prevention programs for which they are eligible.

To make these changes, provider operating models under the IHHs will shift from those that focus primarily on managing member flow and volume toward those that optimize staff mix, leverage technology, and enable all providers to practice at the tops of their licenses. In addition, providers and payers will consistently share and review performance data to leverage best practices, monitor quality improvements, and prioritize outreach efforts.

While Illinois firmly believes that this IHH model will transform the State's healthcare delivery system, it acknowledges that not all actors can make this transition alone. Indeed, this transition requires a fundamental shift in operating models from one that is siloed and throughput-based to one that is integrated and value-based. Support is needed to make this difficult shift. Therefore, through this 1115 waiver, Illinois seeks Medicaid funding to assist health system actors in their transition to integrated care. Support will come in two forms:

- Support for the State and MCOs to enable IHH design, development, and implementation
- Support for providers to offer resources that facilitate development of IHHs and enable success as health homes

Indexed heavily in the first three years of the waiver, this integration support enables the State and MCOs to invest in the people, facilities, processes, and technology needed to promote IHHs. For providers, it acts as both a catalyst to incentivize them to become health homes and a resource to provide support required to succeed in early life as a health home.

To be eligible for integration funds, providers may be required to submit a formal letter of intent to the State stating that they will become IHHs for their Medicaid members. Examples of initiatives that could be funded by support to payers and providers are outlined in [Exhibit 25](#). These will be refined in collaboration with stakeholders on approval of the waiver.

*Exhibit 25: Integration activities service details*

| SUPPORT FOR BEHAVIORAL AND PHYSICAL HEALTH INTEGRATION |   |
|--|---|
| Transition support for the State and MCOs              |   |
| <b>Prepare the workforce for integration</b>           | <p>Activities to be undertaken by the State in partnership with MCOs to help providers succeed as IHHs:</p> <ul style="list-style-type: none"> <li>• Design a curriculum that contributes to the healthcare workforce to promote knowledge of and capabilities for practicing integrated care from day one</li> <li>• Teach integration-specific skills and best practices</li> <li>• Build operational competence in offering integrated physical and behavioral health care</li> </ul> <p>Training and technical support will be targeted by provider type and topic areas, which may include:</p> <ul style="list-style-type: none"> <li>• For IHH leaders: workforce management and recruiting, patient access strategies (e.g., hours, scheduling), business support</li> <li>• For physical health providers: continuing education in managing basic behavioral health conditions (e.g. DATA 2000 waiver trainings) and developing processes to recognize and ensure members obtain appropriate support for more serious conditions</li> <li>• For behavioral health providers: continuing education in managing basic physical health conditions, as appropriate based on member circumstances, and developing processes to recognize and ensure members obtain appropriate support for more serious conditions</li> <li>• For clinical care coordinators: clinical workflows to manage members admitted to higher levels of care, methods to manage member engagement</li> <li>• For case managers: patient and family education and support, planning for community engagement and resource utilization, clinical workflow management</li> </ul> |



|   |   |
|---|---|
|   | <ul style="list-style-type: none"> <li>• For police officers: crisis intervention training</li> <li>• For volunteers and untrained individuals: mental health first aid training</li> </ul>   |
| <b>Assess provider readiness to become integrated health homes</b>              | <p>The State, in partnership with MCOs, will develop an IHH readiness assessment tool to evaluate processes that providers have in place and ability to perform integrated activities:</p> <ul style="list-style-type: none"> <li>• Providers must demonstrate sufficient competence in integrating physical and behavioral health to assure Illinois Medicaid that eligible members can be attributed to their IHHs</li> <li>• Comparisons across administrations of the readiness tool allow for evaluation of readiness improvement and progression as IHHs</li> <li>• Tool will be used to identify best practices to share, thus improving value over time</li> </ul>  |
| <b>Transition support for providers</b>   |   |
| <b>Accelerate partnerships between behavioral and physical health providers</b> | <ul style="list-style-type: none"> <li>• Support providers to build integrated care teams and become IHHs. For example to: <ul style="list-style-type: none"> <li>– Build care compacts or collaborative care agreements to formalize relationships with other providers to meet requirements of IHHs</li> <li>– Hold collaborative training sessions several times per year to provide ongoing education and idea exchanges on how to best integrate behavioral and physical health</li> <li>– Administer ongoing training modules</li> </ul> </li> <li>• Leverage learnings from the DocAssist program to ensure primary care providers receive the virtual psychiatric and clinical guidance they need when managing behavioral health conditions, particularly for those structurally incapable of cementing such relationships (e.g., due to distance from other providers)</li> <li>• Create care coordination links between outpatient clinics and office-based MAT services to establish a continuum of care so that members of different acuity/stability can be referred to appropriate levels of care</li> </ul> |
| <b>Launch disease-specific pilots</b>   | <ul style="list-style-type: none"> <li>• Disease-specific integration pilots to build a foundation for behavioral and physical health collaboration (and collaboration among relevant providers). Possible pilot collaborations include: <ul style="list-style-type: none"> <li>– Post-partum depression and physical health (obstetrician, mental health provider or mental health professional, and primary care physician)</li> <li>– Diabetes and depression (endocrinologist, MHP, PCP)</li> </ul> </li> </ul>   |

|  |  |
|--|--|
|  | <ul style="list-style-type: none"> <li>– Non-opioid collaborative therapy (physical therapy, CBT, weight-loss therapy for osteoarthritis, etc.) to manage chronic pain</li> </ul>  |
| <p><b>Create processes for tracking of data to inform quality improvement strategies</b></p> | <ul style="list-style-type: none"> <li>• Help providers develop and implement data collection and reporting mechanisms and standards to: <ul style="list-style-type: none"> <li>– Track utilization of integrated services</li> <li>– Track healthcare outcomes of individuals treated in integrated service settings</li> <li>– Help providers conduct quality improvement analyses to capture lessons learned, find opportunities to build scale, and identify challenges to broader expansion of integrated care</li> </ul> </li> </ul> |

## Section 4.2: Infant/early childhood mental health consultation

Social-emotional development during early childhood is the foundation for success in learning and in life, and it is correlated with improved long-term health and educational outcomes. Social-emotional development can be disrupted by a variety of health and environmental factors, including family or community violence, traumatic experiences, a child’s mental health issues, poverty, and mental health and substance abuse issues of caregivers. On the other hand, strong partnerships between families, providers, programs, and systems can promote and support healthy social-emotional development for infants and young children, helping them reach their full potential. According to the Centers for Disease Control and Prevention, “Assuring safe, stable, nurturing relationships and environments for children has a positive impact on a broad range of health problems and the development of skills that will help children meet their full potential.”<sup>37</sup>

To nurture healthy child-parent relationships, it is imperative to increase the capacity of the adults in children’s lives. Two tested ways to do this are through evidence-based home visiting (EBHV) programs and Infant/Early Childhood Mental Health Consultation (I/ECMHC).

Illinois has long believed home visiting and I/ECMHC to be effective and efficient strategies. Illinois has already invested heavily in EBHV, programs that pair families experiencing risk factors with trained professionals who provide information and support to improve the comprehensive health of children and their families by supporting parents’ ability to provide a safe, supportive, and healthy early learning environment. The programs improve the life trajectories of not only families and children at risk for poor health but also those at risk of poor educational, economic, and social outcomes.

Currently, EBHV services are offered through the federal Maternal, Infant, and Early Childhood Visiting (MIECHV) program, health Families Illinois, Parents Too Soon, Early Childhood Block

---

<sup>37</sup> *Children benefit when parents have safe, stable, nurturing relationships*, CDC National Center for Injury Prevention and Control: Division of Violence Prevention

Grant (ECBG) - Prevention Initiative, and Early Head Start. I/ECMHC services are offered as part of each EBHV program as well as through child care, Head Start, Preschool for All, Preschool Development/Expansion Grant, child welfare, and the Early Intervention program.

Illinois has yet to pursue I/ECMHC at scale. I/ECMHC teams multi-disciplinary early childhood mental health professionals with people who work with young children to build caregiver skills and capacity to effectively promote children’s social-emotional development, health, and well-being. Many studies have shown that access to EBHV programs and I/ECMHC can improve health outcomes as well as social outcomes. The programs improve child-parent relationships, decrease caregiver stress, facilitate the development of positive social skills, reduce preschool expulsions, and lead to better teacher-child interactions. Intervening early and engaging families may also be able to prevent severe disruptions later in a child’s life (e.g., suspension or expulsion from school, mental health issues, and involvement with the criminal justice system).<sup>38</sup>

Through the 1115 waiver, Illinois seeks to test models of early childhood mental health consultation that are integrated into the State’s comprehensive mental health delivery system. Through the 1115 waiver Illinois seeks to pilot this early childhood Medicaid model in select communities. Details of the proposed delivery system, services, provider qualifications, and eligible members are outlined in [Exhibit 26](#).

*Exhibit 26: Early childhood mental health intervention service details*

| INFANT/EARLY CHILDHOOD MENTAL HEALTH CONSULTATION |   |
|---|---|
| <b>Service details</b>                            | <p><b>Infant/Early Childhood Mental Health Consultation (I/ECMHC)</b> is a multi-level early intervention approach that teams early childhood mental health professionals with people who work with young children and their families. Its goal is to build their capacity and skills to promote social-emotional development, and behavioral health and well-being of children</p> <p>I/ECMHC services may be provided to child care, preschool, home visiting, child welfare, Early Intervention, and Head Start/Early Head Start programs</p> <p>I/ECMHC builds the capacity of teachers, home visitors, pediatricians, child welfare workers, and other adults who work with young children and families through a variety of services:</p> <ul style="list-style-type: none"> <li>• Case/program consultation</li> <li>• Reflective consultation with staff and supervisors</li> </ul> |

<sup>38</sup> Perry, D., Brennan, E., Bradley, J., & Allen, M. D. (2006, July). The evidence base on mental health consultation in early childhood settings: Child and family outcomes. Paper presented at Developing Local Systems of Care for Children and Adolescents with Emotional Disturbances and their Families, Orlando, FL.

|                         |  |
|-------------------------|--|
|                         | <ul style="list-style-type: none"> <li>• Support and consultation for program directors and administrators to implement effective strategies to support social--emotional development and enhance program quality</li> <li>• Identification of effective strategies and training for staff working with specific children as well as the classroom/program as a whole</li> <li>• Co-facilitation of parent or caregiver support groups</li> <li>• Identification of need for additional services (particularly health and mental health services) and referral</li> <li>• Design of training in response to observed need within a program or classroom</li> </ul> |
| <b>Service delivery</b> | <p>Medicaid funds under the 1115 waiver would be used by the State to contract with a set of providers to deliver I/ECMHC services. Pilot programs must target a significant fraction of effort at highest-need areas. Therefore, a majority of pilot sites will be required to be located in highest-need areas as defined by income, rate of violent crime, and a set of early childhood indicators to be determined. Geographic diversity of pilots will also be required to test efficacy in rural areas.</p>  |
| <b>Eligible members</b> | <p>Providers of services to children and families who work with:</p> <ul style="list-style-type: none"> <li>• Children who are: <ul style="list-style-type: none"> <li>– Medicaid-eligible</li> <li>– Less than five years old</li> <li>– At risk of needing future social, emotional, behavioral, or health intervention</li> </ul> </li> <li>• Pregnant women who are Medicaid-eligible</li> <li>• Parents of Medicaid-eligible children identified as eligible members</li> </ul>   |

**Section 4.3: Workforce-strengthening initiatives**

A state’s behavioral health outcomes are only as good as the workforce that provides it. Overall, the national healthcare workforce is aging and not adequately trained to meet growing demand for integrated physical and behavioral health care. Illinois has a shortage of physicians, which is particularly severe for certain population groups:

- 28.5% of Illinois residents live in areas that have been designated primary care Health Professional Shortage Areas (HPSAs); the national median is 18.6%<sup>39</sup>

---

<sup>39</sup> Illinois Health Care Workforce Report & Recommendations, from the Illinois Health Care Reform Implementation Council Workgroup on Workforce. January 2014

- Illinois meets the national average in number of active primary care physicians per 100,000 residents (approximately 104.8)<sup>40</sup>
- Only 73.2% of Illinois physicians reported that they were accepting new Medicaid patients in 2013<sup>41</sup>
- Illinois is projected to need more than 100,000 new healthcare workers by 2020<sup>42</sup>

This workforce shortage is felt acutely by the behavioral health system. Like other states, Illinois has a need for more specialists including child and adolescent psychiatrists, advanced practice nurses (APNs), physician assistants, occupational therapists, and other behavioral health care workers. As Illinois seeks to integrate behavioral and physical health, many members of the workforce will require additional training. Addressing these workforce needs will be critical to the success of the other initiatives in the waiver demonstration. A robust and highly skilled workforce is critical for delivering on the integrated behavioral and physical health vision Illinois has developed.

Under the 1115 waiver, Illinois requests Medicaid funding to enhance its existing behavioral health workforce while building the behavioral health workforce of the future. In the near-term, this will enable existing providers to better serve behavioral health members with a team-based, integrated approach. In the long term, it will enhance the behavioral health workforce supply, particularly in underserved areas, and ensure that all providers are proficient in the practice of integrated care.

The 1115 support for workforce initiatives will be split into two elements:

- **Support for workforce development:** to attract, train, and retain behavioral healthcare workers
- **Support for workforce optimization:** to train providers to be culturally and linguistically competent and to be equipped to address whole-person care for those in need

### **Support for workforce development**

Support for workforce development will initially be used to develop and refine the State's workforce development strategy focusing on:

- Conducting a comprehensive needs assessment
- Designing a strategy that builds capacity for current needs and anticipates future behavioral health workforce requirements
- Ensuring attractive incentives for the behavioral health workforce that keep pace with market conditions

---

<sup>40</sup> HPSA information from the Health Resources and Services Administration (HRSA); population data from ACS. Accessed through the Benchmark State Profile Report for Illinois provided by CMM

<sup>41</sup> Centers for Disease Control, 2015

<sup>42</sup> State of Illinois Industry Employment Projections

- Designing programs for loan repayment/forgiveness and graduate medical education investments for behavioral health workers

Later, support for workforce development will be directed toward funding execution of these programs.

**Support for workforce optimization**

Initially, support for workforce optimization will be used for:

- Designing a strategy to incent providers to serve Medicaid beneficiaries in underserved areas
- Conducting a telemedicine needs assessment across the State, funding and initiating rollout of telemedicine infrastructure, and training providers in use of telemedicine
- Developing a training curriculum for providers who require support to learn how to best partner with MCOs

Later, support for workforce optimization will be directed toward direct funding of this strategy as well as continued rollout, training, and maintenance of telemedicine infrastructure.

Details of the proposed workforce initiatives to be funded through these two streams are outlined in [Exhibit 27](#).

*Exhibit 27: Workforce initiative service details*

| SUPPORT FOR WORKFORCE INITIATIVES         |   |
|---|---|
| Workforce development                     |   |
| <b>Loan repayment/forgiveness program</b> | <p>Create a loan repayment assistance program to healthcare workers who commit to serving Medicaid populations in rural areas or other underserved places:</p> <ul style="list-style-type: none"> <li>• Loan repayment assistance could be provided for a wide range of professionals including social workers, occupational therapists, community health workers, and direct care workers</li> <li>• Bonus payment pools for critical-access and safety-net hospitals that establish tuition repayment programs to attract and retain behavioral health workers</li> <li>• Candidates for repayment would need to commit to a number of years of full-time employment following graduation</li> </ul> <p>This program could be administered by the Illinois Department of Public Health, which currently administers the Illinois National Health Service Corps State Loan Repayment Program</p> |
| <b>Graduate medical</b>                   | Provide payments directly to provider organizations that operate residency programs to increase residency slots or establish new  |

|   |  |
|---|--|
| <b>education investments</b>                      | residency programs. Payments may be tied to activity and performance metrics that ensure programs expand the capacity of the behavioral health system in underserved areas.  |
| Workforce optimization                            |  |
| <b>Telemedicine infrastructure</b>                | Payments to fund the infrastructure required for the provision of virtual care via telemedicine. Funding may be used to: <ul style="list-style-type: none"> <li>• Conduct a telemedicine needs assessment across the State</li> <li>• Purchase and install telemedicine infrastructure in areas of need</li> <li>• Train providers in use of telemedicine</li> </ul> |
| <b>Linking community services to managed care</b> | Funds used to develop training and learning collaboratives for smaller community providers in need of support to work effectively with MCOs.   |

#### **Section 4.4: First episode psychosis (FEP) programs**

Approximately 100,000 individuals across the United States experience their first episodes of psychosis each year.<sup>43</sup> Most of these individuals are between 15 and 25 years of age. Based on Illinois’ population, these statistics imply that more than 3,800 individuals in the State will experience a first episode of psychosis each year. These individuals are in critical need of intensive, specialized support. Historically, individuals diagnosed with Schizophrenia Spectrum Disorders experience significant impairment in most or all areas of functioning--social, academic, and vocational—and many wind up with permanent disabilities, resulting in tremendous personal, social, and fiscal costs.

First Episode Psychosis (FEP) programs are targeted at individuals in the initial onset of a Schizophrenia Spectrum Disorder. These programs have been shown to significantly improve chances of clinical and social recovery, thus stopping the usual trajectory into disability.

Illinois has not yet implemented any FEP program but is in the process of training providers and developing the necessary infrastructure to fund 13 teams statewide. These teams will include a clinical team lead, a psychiatrist or APN, two therapists, an IPS (supported employment/education) specialist, and a case manager. To be eligible for the FEP program, individuals will need to be between the ages of 14 and 40 years and experiencing an initial episode of psychosis resulting in a diagnosis of a Schizophrenia Spectrum Disorder. Qualified patients must enter the FEP program within 18 months of diagnosis.

---

43 McGrath J., Saha S., Chant D., & Welham J. (2008). Schizophrenia: a concise overview of incidence, prevalence, and mortality. *Epidemiologic Reviews*, 30, 67-76.

As part of this 1115 waiver, Illinois requests Medicaid coverage to expand the reach of the first episode psychosis initiative. This expansion will leverage the learnings from the FEP program discussed above and shift the provider payment structure to one that is outcomes-based.



## **Section 5: List of Proposed Waivers and Expenditure Authorities**

The State requests the following waivers:

### 1. Statewideness, § 1902(a)(1)

To the extent necessary to permit any limited service benefit (e.g., extended-release, injectable naltrexone MAT services for up to 200 individuals within 30 days pre-release, transitional services for justice-involved individuals at CCJ)

### 2. Comparability, § 1902(a)(10)(B)

To the extent necessary to limit the following benefits as set forth in the Demonstration Application

### 3. Freedom of Choice, § 1902(a)(23)(A)

To the extent necessary to enable the State to assign justice-involved individuals to a managed care plan so that services may begin promptly upon discharge

The State requests federal financial participation in the following costs not otherwise matchable (CNOMs):

#### 1. Supportive Housing Services

Expenditures for services to support an individual's ability to prepare for and transition to housing and maintain tenancy once housing is secured

#### 2. Supported Employment Services

Expenditures for services to support an individual who, because of serious mental illness, need ongoing support to obtain and maintain employment

#### 3. Transition Pre-Release Services

Expenditures for assessment, treatment, and coordination of focused services for justice-involved individuals 30 days prior to release to improve linkages with community behavioral health treatment

#### 4. Medicaid coverage for extended-release injectable naltrexone MAT services for targeted individuals within 30 days pre-release

Expenditures for extended-release, injectable naltrexone MAT services for justice-involved individuals appropriate for such services 30 days prior to release

#### 5. Short-Term Residential Treatment in a Substance Use Disorder IMD

Expenditures for services for individuals who, as part of a continuum of care, are receiving residential substance use disorder treatment in facilities that meet the definition of an Institution for Mental Disease for 30 days or less

#### 6. Substance Use Disorder Case Management

Expenditures to provide substance use disorder case management to individuals not otherwise receiving case management

#### 7. Withdrawal Management

Expenditures to provide substance use disorder withdrawal management

#### 8. Substance Use Disorder Recovery Coaching

Expenditures to provide recovery coaching services to individuals who have entered treatment for substance use disorder

#### 9. Short-Term Residential Treatment in a Mental Health IMD

Expenditures for services for individuals who, as part of a continuum of care, are receiving inpatient mental health treatment in facilities that meet the definition of an Institution for Mental Disease for 30 days or less

#### 10. Crisis Beds

Expenditures to provide subacute inpatient treatment

#### 11. Intensive In-Home Services

Expenditures to provide intensive in-home services to families and children with high behavioral health needs at risk of transition to a higher level of care

#### 12. Respite Care

Expenditures to provide respite care to children and caregivers of children with serious emotional disturbance and/or complex mental health issues

### 13. Behavioral Health and Physical Health Integration Activities

Expenditures to support the infrastructure and activities required (e.g., workforce preparation, provider readiness assessment, partnership development between providers, launch of disease specific pilots, etc.) to integrate behavioral and physical health, reduce fragmentation of service, reduce total cost of care, improve behavioral and physical health outcomes, and promote patient centered care

### 14. Infant/Early Childhood Mental Health Consultation

Expenditures to train and support members of the community in identifying and managing behavioral health issues in children

### 15. Workforce Development and Workforce Optimization

Expenditures to develop and implement development of a robust behavioral health workforce, including loan repayment/forgiveness and graduate medical education programs and expenditures to develop and implement behavioral health workforce optimization, including telemedicine infrastructure and improving linkages between community service providers and managed care organizations

### 16. First Episode Psychosis

Expenditures to expand the First Episode Psychosis program

### 17. Designated State Health Programs

Expenditures for costs of designated programs which are otherwise state-funded

## Section 6: Demonstration Financing and Budget Neutrality

Illinois understands that when submitting a Section 1115 demonstration waiver, states are required to include an initial view illustrating that they expect the demonstration to be budget neutral. The test for budget neutrality will be applied according to the terms and conditions for the demonstration that are agreed to by the State and CMS, will be measured periodically throughout the approval period, and evaluated at the conclusion of the demonstration based on per member per month (PMPM) costs.

Based on CMS guidance, a budget neutrality workbook will be provided to include historical enrollment, trends, and expenditures. Base year per-capita costs are total costs divided by total member months in order to calculate a yearly average PMPM cost for each of the five years captured in the historical data. Base year PMPM costs are derived by trending the last the historical PMPM forward.

To ensure budget neutrality, Illinois Medicaid will achieve cost savings from a range of sources including:

- Comprehensive management of members, particularly previously uninsured young adults, who experience SMI and SUD
- Deflecting members with behavioral health conditions away from high-cost institutional services when unnecessary, ensuring proper management under community-based services
- Stabilizing behavioral health conditions and co-morbid medical conditions to avoid long-term Medicaid eligibility for some individuals. For others, the outcome of the early intervention will result in conditions that are easier to manage and less costly than disability-related Medicaid
- Designing a value-based payment and delivery system that ensures provider responsibility for delivering the right care, in the right place, at the right time, at the right cost

Though not part of the budget neutrality model, the State also expects the demonstration to have a significant positive impact on the ability of enrolled individuals to become and remain employed (or continue their education) and avoid the correctional system, thereby reducing reliance on other publicly supported programs as well.

*Exhibit 28: Budget neutrality overview*

| Historical member months and expenditures |                  |                  |                  |                  |                  |                  |
|---|------------------|------------------|------------------|------------------|------------------|------------------|
|   | HY01             | HY02             | HY03             | HY04             | HY05             | Total            |
| Member months                             | 31,104,323       | 32,145,779       | 32,362,517       | 34,318,516       | 37,862,717       | 167,793,852      |
| Expenditures                              | \$12,540,460,017 | \$13,031,726,157 | \$14,207,325,984 | \$14,667,679,798 | \$16,757,846,285 | \$71,205,038,241 |

| Demonstration member months and expenditures |                  |                  |                  |                  |                  |                  |
|--|------------------|------------------|------------------|------------------|------------------|------------------|
|  | DY01             | DY02             | DY03             | DY04             | DY05             | Total            |
| <b>Member months</b>                         | 37,750,583       | 37,715,421       | 37,681,379       | 37,648,466       | 37,616,689       | 188,412,538      |
|  |                  |                  |                  |                  |                  |                  |
| <b>Expenditures</b>                          |                  |                  |                  |                  |                  |                  |
| Without waiver                               | \$18,576,508,609 | \$18,897,139,817 | \$19,239,445,018 | \$19,604,095,912 | \$19,984,282,470 | \$96,301,471,827 |
| With waiver                                  | \$18,452,538,364 | \$18,644,845,445 | \$18,849,218,411 | \$19,065,795,271 | \$19,290,173,701 | \$94,302,571,192 |
| <b>Variance</b>                              | \$ 123,970,245   | \$ 252,294,372   | \$ 390,226,607   | \$ 538,300,642   | \$ 694,108,769   | \$ 1,998,900,635 |
|  |                  |                  |                  |                  |                  |                  |
| Total CNOMs                                  | \$ 193,613,729   | \$ 252,714,824   | \$ 212,371,503   | \$ 171,374,210   | \$ 171,132,910   | \$ 1,001,207,177 |
| Total DSHPs                                  | \$ 199,039,900   | \$ 199,039,900   | \$ 199,039,900   | \$ 199,039,900   | \$ 199,039,900   | \$ 995,199,500   |
| <b>Net change</b>                            | \$ (268,683,384) | \$ (199,460,352) | \$ (21,184,797)  | \$ 167,886,532   | \$ 323,935,959   | \$ 2,493,958     |

Illinois requests to invest the federal share of this variance in the benefits and initiatives described above. To finance the non-federal share of the demonstration, Illinois intends to use the state share of savings to be realized through the demonstration as well as general fund dollars generated through approved designated state health programs (DSHP). DSHP protocol guidelines from CMS indicate 3 approval categories. Illinois is currently assessing options for programs that we anticipate will qualify as the primary source of non-federal funding.

## **Section 7: Stakeholder engagement and public notice**

As part of the stakeholder engagement process required within the development of this Section 1115 Demonstration Waiver, Illinois is seeking consultation with stakeholders including state, county, and local officials and health care providers, health care payers, patients, and their families. The State will gather this input during the required public comment period from August 26, 2016 until October 2, 2016 at 5 p.m. (Central). Comments received within this public comment period will be reviewed and revisions to the waiver application will be considered.

During this public comment period, the state will hold two public hearings and host a dedicated website. The public hearings on the waiver are intended to solicit input on the proposed waiver and the State will accept verbal and/or written comments. The dates for the public hearings are Thursday, September 8, 2016 and Friday, September 9, 2016. The website for public information on this Section 1115 Demonstration Waiver is <http://www.illinois.gov/hfs/>. The web page will include a copy of the waiver draft, materials from stakeholder meetings, logistics on public hearings, and instructions on how to submit comments on the waiver application draft.

During the approval process and upon approval from CMS, the State will continue to seek stakeholder input and will conduct a robust engagement process to spread awareness about these system improvements.

## Section 8: Demonstration administration

Please visit the HFS website at <http://www.illinois.gov/hfs/>

Please attend the public hearings:

Thursday, September 8, 2016

10:30 AM to 1:00 PM

Howlett Auditorium

Michael J. Howlett Building

501 South Second Street

Springfield, IL 62756

Friday, September 9, 2016

10:30 AM to 1:00 PM

Assembly Hall Auditorium

James R. Thompson Center

100 W. Randolph Street

Chicago, IL 60601

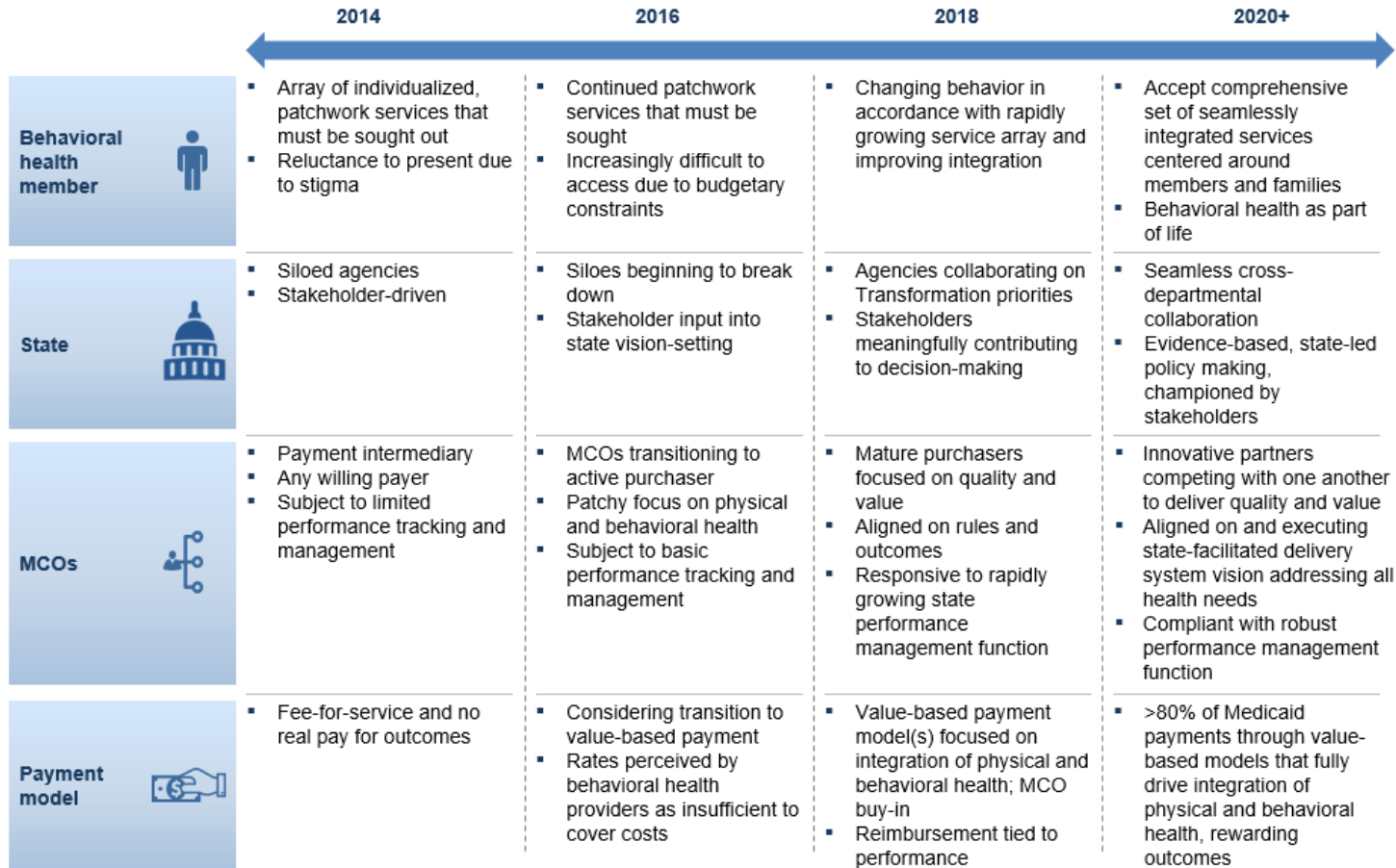
Please email [hfs.bpra@illinois.gov](mailto:hfs.bpra@illinois.gov) to submit questions and comments regarding the Illinois Section 1115 Demonstration Waiver

## Appendix

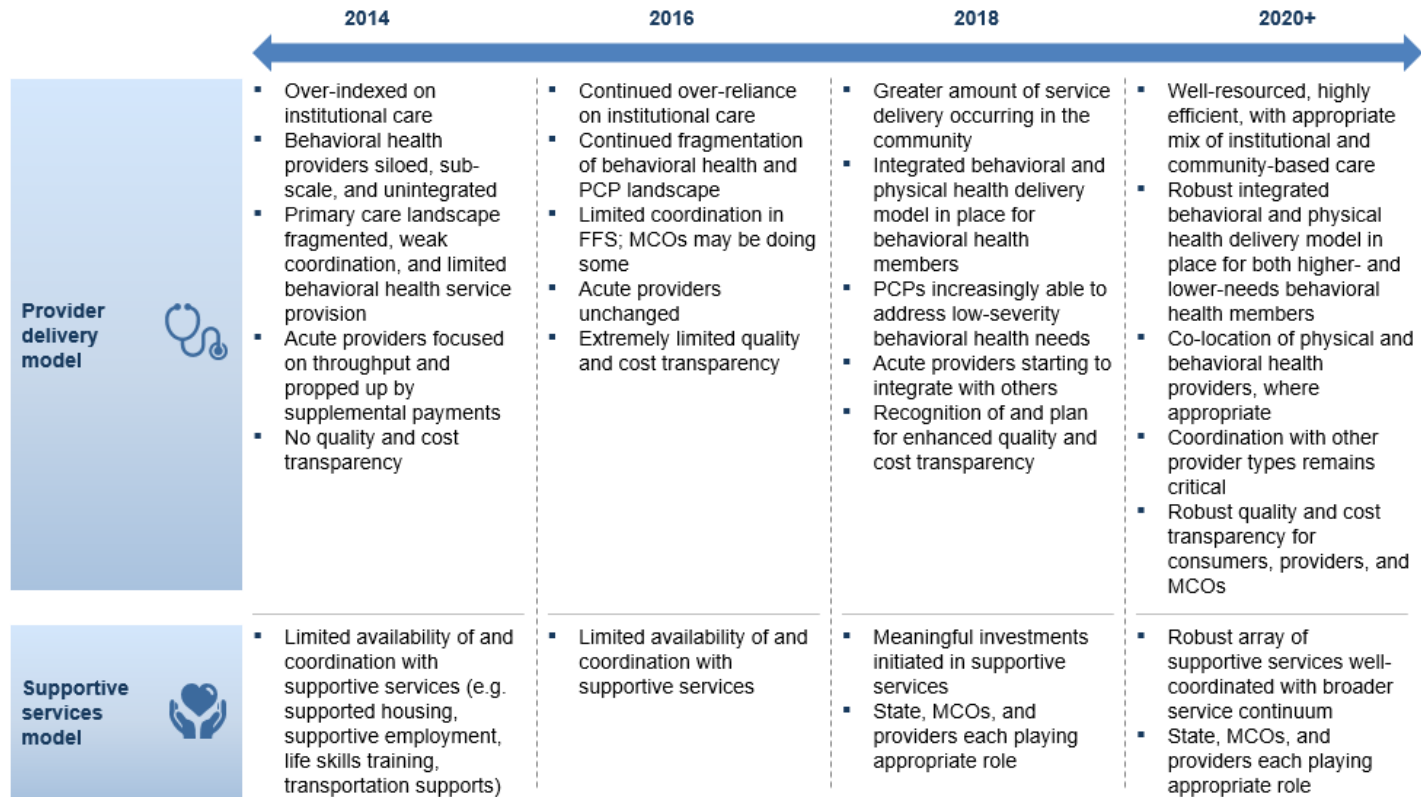


## Appendix A: Evolution of Illinois' behavioral health ecosystem

### Evolution of Illinois' behavioral health ecosystem (1/2)



## Evolution of Illinois' behavioral health ecosystem (2/2)



**Appendix B: Proposed Designated State Health Programs (DSHPs)**

| Agency                                     | Service  | Description   |
|--|--|---|
| Division of Alcoholism and Substance Abuse | Problem gambling services                      | Targeted outpatient group and individual services for adults experiencing compulsive gambling disorders   |
| Division of Developmental Disabilities     | Child Care Institution (CCI)                   | Structured environment for children and adolescents who cannot reside in their own home   |
| Division of Developmental Disabilities     | Family Assistance Program                      | Assistance to families to help provide care at home for children with serious mental disabilities including financial assistance to help meet the special service needs and unusual expenses connected with having a severely disabled child living in the home                                     |
| Division of Developmental Disabilities     | Respite Program- group                         | Respite services either in the form of intensive or non-intensive support services for individuals with developmental disabilities to maintain these individuals in their homes including supervision and care for children and adults in a group setting for a portion of the day                  |
| Division of Developmental Disabilities     | Respite Program- in-home / residential         | Intensive or non-intensive support services to help maintain individuals in their homes and provides short-term stays for individuals in a residential setting  |
| Division of Developmental Disabilities     | Case Management and Support Coordination       | Assistance to provide prior authorization for all individuals for whom there is a reasonable basis to suspect the presence of a developmental disability who request Medicaid-funded services or nursing facility services; includes assessments, education and referrals                           |
| Division of Developmental Disabilities     | Independent Service Coordination (ISC) Program | Education, referral, and linkage services for children and adults with developmental disabilities; general ISC functions include: intake, education, goal setting, referral and linkage to both generic and specialized services, and transportation to facilitate referrals, linkage, and planning |

|  |   |   |
|--|---|---|
| Division of Developmental Disabilities | BOGARD Service Coordination   | Provides a range of services including assessments and reassessments of needs and goals, coordination of the individual service plan, specialized service facilitation and brokering for persons in nursing facilities, development of natural support networks, and performance of activities to maintain or improve availability, accessibility, and quality of services. |
| Division of Developmental Disabilities | Other Support Services  | Ongoing and new special projects to address the varying needs of the participants served by the Division of DD  |
| Division of Developmental Disabilities | Bogard Specialized Services   | Aggressive, accountable, competent, and knowledgeable interactions that are habilitative in nature and directed toward meeting the individual's wants and needs   |
| Division of Developmental Disabilities | Day Services  | Structured individualized program of community habilitation activities for individuals for whom the more traditional day program is not appropriate   |
| Division of Developmental Disabilities | Regular work/sheltered employment   | Long-term employment in a sheltered environment for individuals whose functional levels require supervision but are not precluded from future movement into a Supported Employment position or a competitive employment position  |
| Department of Public health            | Expenses of Adverse Reporting, Patient Safety and the Adverse Pregnancy Outcome Reporting System (APORS) in Support of Infant Mortality Reduction | Collection system for information on infants born with birth defects or other abnormal conditions and conducts surveillance on birth defects to guide public health policy in the reduction of adverse pregnancy outcomes and identify and refer children who require special services to correct and prevent developmental problems and other disabling conditions         |
| Department of Public health            | Grants for Vision and Hearing Screening Programs  | Mandated screenings at specific age and grade levels done by technicians/nurses trained and certified by the Department; screenings result in approximately 1 million children screened annually for both vision and hearing  |

|                                 |  |  |
|---------------------------------|--|--|
| Department of Public health     | Expenses Incurred for the Rapid Investigation and Control of Disease or Injury   | Grants for the rapid investigation and control of disease or injury  |
| Department of Public health     | Expenses of Environmental Health Surveillance and Prevention Activities, Including Mercury Hazards and West Nile Virus | Grants for Environmental Health Surveillance and Prevention Activities, Including Mercury Hazards and West Nile Virus  |
| Department of Public health     | Expenses for Expanded Lab Capacity and Enhanced Statewide Communication Capabilities Associated with Homeland Security | Grants for Expanded Lab Capacity and Enhanced Statewide Communication Capabilities Associated with Homeland Security   |
| Department of Public health     | Grants for Immunizations and Outreach Activities   | Grants for Immunizations and Outreach Activities   |
| Department of Public health     | Operating Expenses to Provide Clinical and Environmental Public Health Laboratory Services                             | Grants for Clinical and Environmental Public Health Laboratory Services  |
| Department of Public health     | Expenses for Promotion of Women's Health   | Service to answer questions about health related issues free of charge; open for all women in Illinois and operates 8:00 am - 4:30 pm on workdays  |
| Department of Veterans' Affairs | Illinois Warriors Assistance Program   | Confidential assistance for returning Illinois veterans and their families to help with the emotional challenges of transitioning back into their daily lives                                    |
| Department of Veterans' Affairs | Veteran's Service Officers (VSOs)  | Assistance to veterans in navigating the complex web of services and benefits available  |
| Department of Veterans' Affairs | VetCare  | Comprehensive, affordable healthcare for Illinois' uninsured veterans  |
| Illinois Board of Education     | Adolescent health  | Financial support and resources through the Division of Adolescent and School Health (DASH) to improve adolescent health -- specifically, sexual health -- through education in Illinois schools |

|  |  |   |
|--|--|---|
| Illinois Board of Education              | Healthy Community Incentive Fund                                       | Enables school districts to take a lead role in cross-sector partnerships as centers of collective impact and develop partnerships with local governmental entities, education organizations, faith-based organizations, civic organizations, and philanthropic groups                  |
| Illinois Board of Education              | Substance Abuse and Mental Health Services                             | Builds and expands the capacity of state educational agencies to increase awareness of mental health issues among school-aged youth, train school personnel and other adults, and connect children, youth, and families who may have behavioral health issues with appropriate services |
| Illinois Board of Education              | Evidence-based Home Visiting (EBHV)                                    | Pairs families experiencing risk factors with trained professionals who provide information and support to improve the comprehensive health of children and their families by supporting parents' ability to provide a safe, supportive, and healthy early learning environment         |
| Department of Health and Family Services | Individual Care Grant program  | Services for children with a serious emotional disturbance under the age of 18 to assist in obtaining the appropriate level of treatment services required to improve their condition   |
| Department of Child and Family Services  | Department of Child and family Services institutional/group home care  | Costs associated with residential and group home programs for DCFS involved youth   |
| Department of Corrections                | Department of Corrections in facility mental health treatment          | Mental health services provided to justice-involved individuals including outpatient services, crisis intervention, and enhanced inpatient treatment  |
| Department of Corrections                | Department of Corrections in facility substance use disorder treatment | SUD treatment provided to justice-involved individuals including DASA licensed outpatient treatment, screening, and pre and post release case management  |
| Department of Juvenile Justice           | Department of Juvenile Justice in facility mental health treatment     | In-facility mental health treatment for juvenile justice populations that utilizes screening and assessment tools to identify needs and provide a continuum of care that includes individual therapy, group therapy, family therapy, and pet therapy                                    |

|                                |   |   |
|--------------------------------|---|---|
| Department of Juvenile Justice | Department of Juvenile Justice in facility substance use disorder treatment | In-facility substance use disorder treatment for juvenile justice populations provided by the "Wells Center." The staff utilizes a cognitive behavioral and strength based approach to extinguish behaviors that are toxic and ineffective and encourage behaviors that are effective and positive so that the individual can stay drug free on return to the community; Includes intake assessment |
|--------------------------------|---|---|

We welcome any comments, data, views or arguments concerning these proposed changes. All comments not provided at the hearing must be in writing and received by September 26, 2016, and addressed to:

**Illinois Department of Healthcare and Family Services**  
**Division of Medical Programs**  
**Bureau of Program and Policy Coordination**  
201 South Grand Avenue East  
Springfield, IL 62794  
Email address: [hfs.bpra@illinois.gov](mailto:hfs.bpra@illinois.gov)

