Behavioral Health Policy in Illinois: Major Policy Initiatives in 2013 and Beyond

PRESENTATION TO THE MEDICAID ADVISORY COMMITTEE

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Behavioral Health Policy in Illinois

- Context
  - One in five Americans has a mental illness every year, including Illinois residents of all ages, races, and SE backgrounds
  - Prevalence estimates for persons with SMI are at 5.4% for adults meaning that more than 526K Illinois adults have a serious mental illness
  - Economic burden of disease is estimated to be 15% of total of economic burden for all diseases, yet as many 40% do not even seek treatment
  - In Illinois, of all Medicaid beneficiaries with 'disabilities', 60-65% have significant MI issues

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Context: Medicaid Data

- Approximately 328K received psychiatric pharmacy services through Medicaid (with 4.5M scripts)

- Approximately 18.4K adult recipients of Medicaid had a psychiatric hospitalization; 11.4K children were hospitalized in 2012

Cost to state Medicaid program:

$276M in 'psychiatric' pharmacy

$239M in inpatient care

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Drivers of Policy Change

- National Level
  - Passing of the Mental Health Parity and Addiction Equity Act (2008) requiring parity of mental health benefits with medical and surgical benefits with respect to lifetime and annual dollar limits.
  - Affordable Care Act– Behavioral Health as one of the ten essential services required by private insurance plans in the Marketplace.
  - Presidential "Dialogues" on Mental Health following the shootings at Sandy Hook and in other states focusing on reducing stigma, increasing awareness, supporting research

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Drivers of Policy Change

- Local Level
  - Five Year Mental Health Strategic Plan for Illinois- a blueprint for change
  - Consent Decrees and Class Action Suits
    - Williams Consent Decree
    - Colbert Consent Decree
  - ACA and Medicaid Expansion in Illinois for approx. 300K
  - Medicaid Reform- requiring 50% of recipients in "care coordination" by 2015
  - The Smart Act- reducing Medicaid spending by $1.68B through UM and service reduction

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- Local Drivers of Change- cont'd
  - Increased pressure for services for persons with MI and criminal justice involvement through various legal challenges
  - Significant workforce shortages and capacity issues

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- General Policy Direction
  - Increased focus on interagency collaboration on MH issues to eliminate "silo" approach to system planning and service delivery
  - DMH and DASA are on track to merge to become one Division in DHS
  - Exploring consolidation of licensure for DASA/DMH providers
  - Integrated service delivery approach (primary care and behavioral health) through "care coordination" models (MCO, MCCN, CCE)
  - Promotion of telepsychiatry, a Medicaid covered service since 2010, and use of other technology in service delivery

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Adults

- BH Policy impacting Adults
  - Rule Changes
    - Rule 132
      - Increase amount of comprehensive services
        - Definitions that allow flexibility & innovation
      - Update definition of medical necessity
      - Allow for earlier treatment interventions
      - Modernize payment methodology
        - Minimize use of 15 minute units
        - Develop base rates with incentive payments to achieve outcomes
    - Present draft to Stakeholders early 2014

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Adults

- Rule Changes Cont'd
  - Rule 140 Supervised Transitional Residential Services
    - Creates standards for supervised level of care
    - Separates medically necessary residential treatment from housing
    - Move from grant funded to fixed rate per diem
    - Encourages move toward housing
    - Finalize Stakeholder input
    - File with JCAR December 2013

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Adults

- Rules 2060/2090
  - Continue working with the Managed Care Organizations to ensure the delivery of substance abuse services as per Rule 2060 and 2090.
  - This includes use of the American Society of Addiction Medicine (ASAM) criteria. DASA will work with the voluntary MCOs in order to determine the payment of domiciliary services.
  - Pursue Utilization Management for substance abuse.
  - Review and update medication assisted treatment for addiction.
  - Develop rules for recovery support services
  - Modernize payment methodology for web based services.

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Adults

- Rule Changes
  - All rule changes will be considered in the context of the state's application for the 1115 waiver
  - 1115 Waiver to be submitted by February, 2014
  - Expectation is that waiver will provide for services not typically covered by Medicaid such as supportive housing

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Adults

- LTC "Rebalancing" Initiatives
  - Money Follows the Person (MFP)
    - Continued expansion under MFP in areas with large volume of transitions from long term care
  - Williams Consent Decree
    - Service expansion primarily in team services (ACT,CST)
      - Expansion is occurring through traditional MH provider network, ICP vendors
    - Network expansion following newly developed eligibility criteria for provider applicants: 13 new providers enrolled
    - New services/ delivery models developed:
      - In-Home Recovery Support
      - Enhanced Skills Training and Assistance
      - Dual diagnosis Residential Treatment
      - Bi-directional integrated health care
  - Colbert Consent Decree
    - Over 50% of persons choosing to transition have a SMI

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Adults

- LTC "Rebalancing" Initiatives
  - Balancing Incentive Program
    - Collaborating with other State Agencies on required structural changes:
      - No Wrong Door/Coordinated Entry Process:
        - Reduce silos & streamline intakes
      - Standardized Assessments:
        - Utilization of universal assessment tools to determine need (initial screening & full assessment)
        - Conflict-Free Case Management

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Adults

- LTC "Rebalancing" Initiatives
  - Specialized Mental Health Rehabilitation Facilities (SMHRFs)
    - Creates 4 new levels of care: Triage, Crisis Stabilization, Transitional Living, Recovery and Rehabilitative Supports
    - Rules to be filed the end of November
  - Subpart S Rules for Psychiatric Certification of Nursing Homes
    - Rules are currently under review
    - To be filed within 60 days

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Adults

- LTC "Rebalancing" Initiatives
  - Assessment/Authorization/Pre-admission Screening and Resident Review (PAS-MH-RR)

    Developing new standards that will:
    - More thoroughly define medical necessity for different levels of care within SMHRFs and Nursing Homes
    - Advance time-limited authorizations
    - Promote consumer choice in community alternatives to LTC
    - Require routine ongoing assessments with expectation to transition to least restrictive level of care
    - Minimize conflict of interest
    - In process of creating RFP with anticipated posting early 2014

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Adults

- LTC "Rebalancing" Initiatives
  - Pilot of Community-based Programs Comparable to Programs in former IMD's
    - Triage:
      - Crisis Assessment & Linkage to Services;
      - Transportation between levels of care
    - Crisis Stabilization:
      - Discharge Linkage & Coordination of Services
      - Outreach to Individuals to Engage in Services
      - Residential Crisis Beds
    - Transitional Living:
      - Transitional Living Centers;
      - Transitional Supervised Residential Setting

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Adults

- Care Coordination– a delivery system in which recipients receive care from providers who participate in integrated delivery systems responsible for providing primary care, behavioral health services and inpatient and outpatient hospital services; and are funded by a risk-based payment arrangement related to health outcomes.

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Adults

- Care Coordination Models
  - Managed Care Organizations (MCO)– traditional insurance companies accepting full risk capitated payments
  - Managed Care Community Networks (MCCN)- provider organized entities accepting full risk capitated payments
  - Care Coordination Entities (CCE)- Provider organized networks providing care coordination for risk and performance based fees, but with medical and other services paid on a fee for service basis
  - Accountable Care Entities (ACE)- Provider organized entities on a 3 year path to full risk capitated payments

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- Care Coordination models are being implemented in stages
- Strong support for bi-directional integration including models for “behavioral health” homes
- Strong need for increased review of all care coordination contracts for adequacy of behavioral health quality and outcome indicators

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Youth

- Residential Treatment for Youth
  - Growing pressure from litigation related to residential care for Medicaid youth with 12 in residential care in 7 states at a cost of $1.5M in 2012
  - A focus on enhancing community services, (e.g.. "System of care" services as the evidence based alternative to residential care) is required
  - HFS, DHS-DMH, DCFS will implement Choices Demonstration project seeking an experienced System of Care entity to establish an integrated care coordination model for youth as an alternative to institutional care (Champaign, Ford Iroquois and Vermillion counties)

- Rule 135 Changes – Individual Care Grants
  - Further defining levels of care
  - Review of eligibility requirements
  - Appeals process
  - Addressing community infrastructure for alternatives to "institutional" care
  - Reviewing outcome measurements

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Youth

- Continued evaluation and monitoring of effective programs to determine how programmatic successes and "learning" can be leveraged
  - SASS –lack of community service options has lead to increased utilization of SASS services and inpatient care
  - DocAssist– 4600 consultations to physicians by UIC Child Psychiatrists
- Increasing Medicaid claiming in foster care settings
  - Identifying existing home and community based mental health services that may be more appropriate and efficacious than traditional in office therapy approaches
  - Review of existing trauma services to determine if they can be billed to Medicaid
  - Assess impact of Medicaid expansion on the ability to bill Medicaid for mental health services for biological parents

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Youth

- Psychotropic Medication Quality Improvement Collaborative (PMQIC)
  - A 3 year learning collaborative between DCFS and UIC School of Psychiatry reviewing the psychotropic utilization of wards
  - Through data sharing agreements, DCFS has enhanced its capacity to monitor and manage drug consents and may result in edits in HFS systems to allow for prior approval for scripts
  - Results will be reviewed in light of all Medicaid youth receiving psychotropic medication

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Justice Involved SMI Population

- DOC initiative to enroll eligible offender population in Medicaid and routinely update that system
  - Will enhance treatment continuity upon re-entry and reduce recidivism
- Developing Community Programs to treat forensic individuals in the community when appropriate
  - Will reduce stress on inpatient waiting list
  - Programs to include:
    - Community based UST fitness restoration
    - NGRI transitional residential
    - Forensic ACT teams
    - Jail Data Link Coordinators (coordinate transition from Cook/Winnebago jails)

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"The decision is not whether we will ration care, the decision is whether we will ration with our eyes open."

Donald Berwick, M.D.

- Questions??