

September 12, 2016

The State of Illinois recently released a draft Section 1115 Demonstration Waiver application, an overview, and Frequently Asked Questions (FAQs). It also posted a PowerPoint presentation for two public hearings held late last week in Springfield and Chicago. IHA presented brief testimony at the Sept. 9 hearing.

Before submitting the waiver proposal to the Centers for Medicare & Medicaid Services (CMS), the State will continue to accept public comments until October 2. Comments should be addressed to the Illinois Department of Healthcare and Family Services (HFS) and emailed to hfs.bpra@illinois.gov (see public notice).

The waiver is focused on addressing the numerous issues surrounding behavioral health in an effort to improve care coordination and increase access to community services for individuals with behavioral health needs, which include mental illness and substance abuse. The waiver intends to use federal funds to shift behavioral health patients from institutional care settings to community care settings, while at the same time enhancing community-based services and supporting care coordination.

Five-Year Demonstration Period

The 1115 waiver is one piece of the State's plan to receive \$2.7 billion in federal matching funds for Medicaid services over a five-year proposed waiver demonstration period. The waiver proposes a series of modifications to the Illinois Medicaid program to test a collection of behavioral health delivery models.

The State proposes that these new models of delivery and payment will help bend the cost curve of the Illinois Medicaid program by nearly 2% annually over the demonstration period, and that long term, the State will benefit from a less inflationary cost trend line while simultaneously improving the behavioral health delivery system.

The waiver proposes to save \$1.2 billion in federal Medicaid spending compared to the current model, over the five-year demonstration period, which the State is in turn requesting permission to re-invest into the Medicaid program, thereby permitting the State to finance services currently solely supported by General Revenue Funds (GRF).

Additionally, the State plans to file a series of Medicaid State Plan Amendments (SPAs) to secure an additional \$1.5 billion in federal Medicaid matching funds over the demonstration period.

An example of State Plan Amendments includes but is not limited to:

- Integrated physical and behavioral Health Homes (IHHs)
- Crisis stabilization and mobile crisis response
- Medication-Assisted Treatment (MAT)
- Uniform Child and Adolescent Needs and Strength (CANS) and Adult Needs and Strength Assessments (ANSA)

A waiver must be budget neutral to CMS, meaning that CMS will not spend more than it would have in the absence of the waiver. Therefore, in return for receiving federal funding up front during the five-year life of the waiver, these investments must lead to savings in the later years of the waiver.

Projected Savings Intended for Waiver Implementation

These projected savings would become the federal investment the State would receive to implement the waiver and transform the behavioral health system.

The State has identified the following as sources of the savings:

- Comprehensive management of members, particularly previously uninsured young adults, who experience serious mental illness (SMI) and substance use disorder (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; and
- 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.

Once the State submits the waiver application, CMS will begin its evaluation and engage the State in negotiations that may result in changes to the requested funding amounts and specific initiatives that have been proposed in the application.

Therefore, many of the implementation details will not be developed until the application is reviewed and refined by CMS. Overall, the State's draft application contains many of IHA's behavioral health transformation high-priority initiatives.

Background: Hospital Role in Transforming Healthcare

Under Section 1115 of the Social Security Act, the federal government has authority to waive certain Medicaid requirements, giving states flexibility in the operation of their Medicaid program and allowing states to obtain federal funding to assist in transforming the underfunded Medicaid system. As hospitals continue to broaden their service offerings and take on a central role as care coordinators, the waiver presents opportunities to support behavioral health care coordination activities.

Having served their communities in many cases for over 100 years, Illinois' hospitals and health systems know that it takes much more than "traditional" medical care to achieve healthy communities. The predominant model of healthcare delivery for IHA members has evolved to support enhanced quality of life for communities by identifying and addressing health and social needs.

Hospitals and health systems provide a broad range of services—not just "traditional" emergency, trauma, inpatient/acute and surgical care and not just within the walls of their buildings, but well beyond those walls, all across their communities.

Hospitals and health systems currently provide the following services:

- Extensive preventive and primary care services
- Post-acute services, including skilled nursing, rehabilitation, long-term care, home health, palliative and hospice care
- Mental health and substance abuse programs

Illinois' hospitals and health systems also provide free and subsidized health services, wellness programs, support groups, medical research and neighborhood revitalization projects, and are uniquely qualified to work with stakeholders to improve behavioral health outcomes.

In addition, our hospitals and health systems are training the next generation of physicians and other critically needed healthcare professionals to meet the workforce needs of the State's healthcare delivery system, often within training programs where the costs exceed the financial support for training.

Hospitals and health systems are truly the cornerstones of their communities and the State's healthcare delivery system and are the key mechanism to integrate various providers to form an integrated delivery system (IDS) and provide care across the continuum. Typically, it is the hospital that has the necessary infrastructure to bring together a wide range of providers to ensure patients receive the full range of care in the right setting at the right time.

Summary of Draft State Waiver Application

The State has identified the following overall goals of the waiver:

- Rebalance the behavioral health ecosystem, reducing overreliance on institutional care and shifting to community-based

care;

- Promote integrated delivery of behavioral and physical health care for behavioral health members with high needs;
- Promote integration of behavioral health and primary care for behavioral health members with lower needs;
- 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;
- Invest in support services to address the larger needs of persons with behavioral health conditions, such as housing and employment services; and
- Create an enabling environment to move behavioral health providers toward outcomes and value-based payments.

IHA Behavioral Health Priorities

IHA shares a number of these goals and we are encouraged that the State has proposed a framework recognizing that the community-based behavioral services are in need of substantial capacity enhancement, while at the same time putting forward proposals to increase care coordination.

In June, IHA submitted a [letter to HFS](#) with waiver recommendations developed by our Behavioral Health Advisory Forum. Most of IHA's recommendations have been included in the State's draft proposal. We are pleased that the following IHA behavioral health recommendations have been included in the proposal:

- Health Homes and integration of behavioral and physical health: Funding to support care coordination appears to be a top priority of the waiver and sufficient incentives need to be in place to incentivize the necessary investment to create a care coordination system.

This entails having individuals with behavioral health training working with patients, physical health clinicians, behavioral health clinicians, long-term care and social service providers, and ideally ultimately sharing data to provide effective care coordination.

The waiver appears to support such an initiative and it will be important that the program be implemented in a flexible manner so as not to discourage participation, while at the same time recognizing the central role hospitals play in coordinating care.

The role of Managed Care Organizations (MCOs) are emphasized in the waiver, and we would caution that some MCOs will need to shift their focus from acting as gatekeepers with an emphasis on managing costs, to that of care coordinators assisting patients in receiving appropriate care. Hospitals and their partners should play a more central role in implementing and providing the services described in the waiver.

- Crisis stabilization enhancements: The waiver makes a strong case for the benefits of crisis beds for individuals in need of stabilization due to a crisis, but may not need an inpatient stay.

While the waiver does not specify eligibility criteria, hospitals should be eligible for waiver funding to develop and expand models that are coordinated with emergency departments, which is where individuals frequently present for care.

- Workforce development and Telehealth expansion: The waiver offers a comprehensive workforce strategy and includes telehealth capacity expansion as a key element in the workforce strategy.

Funding for telehealth capacity expansion has the potential to not only increase access to healthcare but play an important role in facilitating the integration of physical and behavioral health.

Greater use of tele-psychiatry and specialty telemedicine holds particular promise in areas of the state where workforce shortages and transportation limitations serve as barriers to care.

The waiver proposes using funds to:

- Conduct a telemedicine needs assessment across the state
- Purchase and install telemedicine infrastructure in areas of need
- Train providers in use of telemedicine

While we are encouraged by the inclusion of telehealth in the waiver, one of the biggest impediments to greater adoption of this technology is the low reimbursement rates. Any needs assessment should examine the impact that current low rates have on telemedicine usage.

Also, current Medicaid regulations should be examined to determine if changes are needed to update rules pertaining to staff eligible for reimbursement. While providing training and infrastructure funding is helpful, adequate reimbursement rates are necessary to sustain telehealth services.

Many of the waiver proposals are predicated on having a sufficient workforce, and the waiver accurately recognizes that there is a workforce shortage affecting the behavioral health system. The waiver seeks to provide support for workforce development to attract and retain health care workers, and workforce optimization to train providers to be culturally and linguistically competent.

IHA supports an educational loan forgiveness program for behavioral health professionals who practice in mental health professional shortage areas and we are pleased to see such a program included as part of workforce initiatives. In addition, the waiver proposes increasing residency slots to expand the capacity of the behavioral health system.

Waiver Benefit Enhancements

The waiver proposes several benefit enhancements that are needed for successful physical and behavioral health integration:

- Supportive housing services: Individuals with serious mental illness (SMI) who are either at risk of institutionalization or homeless or currently reside in an institution or permanent supportive housing, in what appears to be all areas of the state
- Supported employment services: Individuals aged 14 years and up with serious and persistent mental illness (SPMI), substance use disorder (SUD), or serious emotional disturbance (SED) needing ongoing support to obtain and maintain a job
- Services to ensure successful transitions for Illinois Department of Corrections (IDOC) and Cook County Jail (CCJ) justice involved individuals: Medicaid-eligible IDOC-justice involved individuals within 30 days of release to the community; and Cook County detainees eligible for managed care not previously enrolled in CountyCare
 - Medicaid coverage for extended-release injectable naltrexone; medication assisted treatment (MAT) services for targeted individuals within 30 days pre-release; Medicaid-eligible individuals incarcerated at the IDOC appropriate for MAT therapy within 30 days of release to the community
- 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 for 30 days or less. Additional clarification is needed to determine eligibility of hospital inpatient care
 - Substance use disorder case management: Individuals with SUD receiving any ASAM (American Society of Addiction Medicine) treatment level of care but not receiving case management from other sources (e.g., Integrated Health Homes (IHH))
 - 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
- Short-term residential treatment in an Institution for Mental Diseases: 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
- Intensive in-home services: Families and children with high behavioral health needs and/or SED at risk of transition to higher level of care; 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; limited to children 5-21 years of age.

Other Waiver Initiatives

In addition to the benefit changes listed above the waiver will include the following four initiatives that will be tested.

- 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 the physical and behavioral health, etc.);

- Infant/Early childhood mental health interventions. Consultations to teach professionals who have frequent contact with young children (e.g., teachers, care providers) ways to improve the socio-emotional and behavioral health and development of at-risk children;
- Workforce-strengthening initiatives. Investment funds for the State and providers to support behavioral health workforce-strengthening initiatives (e.g., creation of a loan repayment program, continuing education and telemedicine infrastructure); and
- First episode psychosis (FEP) programs. Programs that address individuals in the initial onset of a psychotic episode, stopping the usual trajectory into disability.

Future Considerations

While the waiver application is consistent with IHA priorities such as health homes, integration of behavioral health and physical health, crisis stabilization services, expanding community- based behavioral health services, expanding telehealth capacity, and addressing critical behavioral health workforce shortages, the ultimate funding levels available for IHA priorities will depend on achieving CMS and Office of Management and Budget (OMB) approval of the State's budget analysis, which has yet to be released.

The State will have to demonstrate to CMS and OMB that although the State will receive increased federal funding, overall federal funding for the State's Medicaid program will not be more with the waiver than it would be without the waiver. IHA will be closely following the waiver application process and will be providing members with updates, as well as periodic issue briefs on particular waiver topics that are of interest to members.

There are a number of implementation questions that we will be exploring further with the State, but a key issue is given the track record of many of the Medicaid MCOs to date, it raises concerns as to whether the MCOs are capable of working cooperatively with IHA members to transform the delivery system, assist in coordinating care and ensure that waiver funding to providers is received accurately and timely.

For the waiver to succeed, the MCOs must be willing to share risk while being held accountable and liable for outcomes and develop value-based reimbursement models that fairly align incentives with providers rather than imposing one-sided provisions.

Additionally, the release of the application has given rise to a number of questions such as:

- How will the State's share of the program be financed, and are the assumptions realistic, sound and acceptable? Overall behavioral health funding must be increased rather than redirecting funding among providers or programs.
- What role does the State envision for hospitals in terms of coordinating care?
- What is the role of MCOs, and what level of state oversight and accountability will be implemented, including oversight on the submission of accurate encounter data?
- What input will hospitals have on any value-based reimbursement methodology? What are the savings assumptions attributed to value-based reimbursement?
- How will stakeholders provide input and oversight during waiver implementation?



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