Health and Human Services Transformation

OASAC

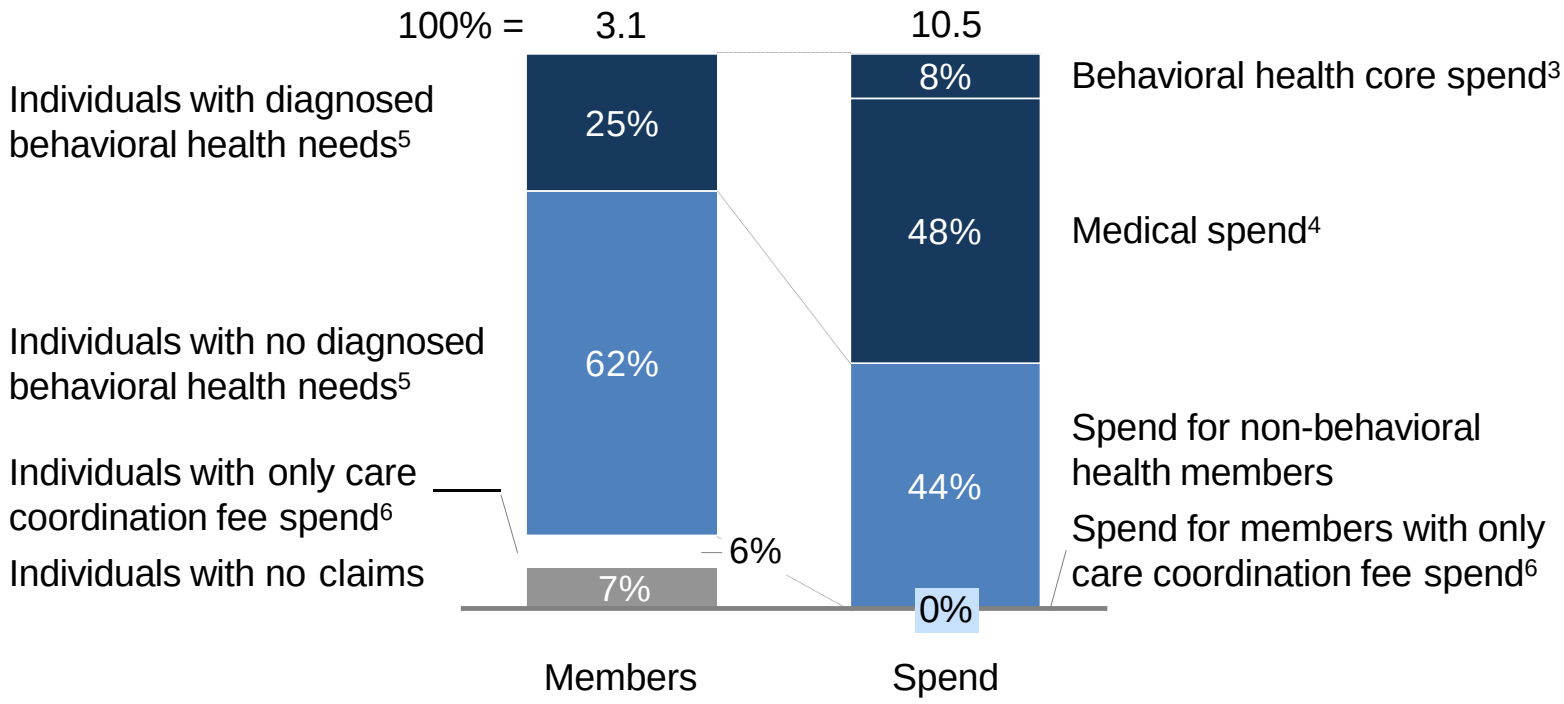
Behavioral Health Transformation

August 20, 2018

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

FY2015 members and spend[1,2]

Annualized members (millions), dollars (billions)

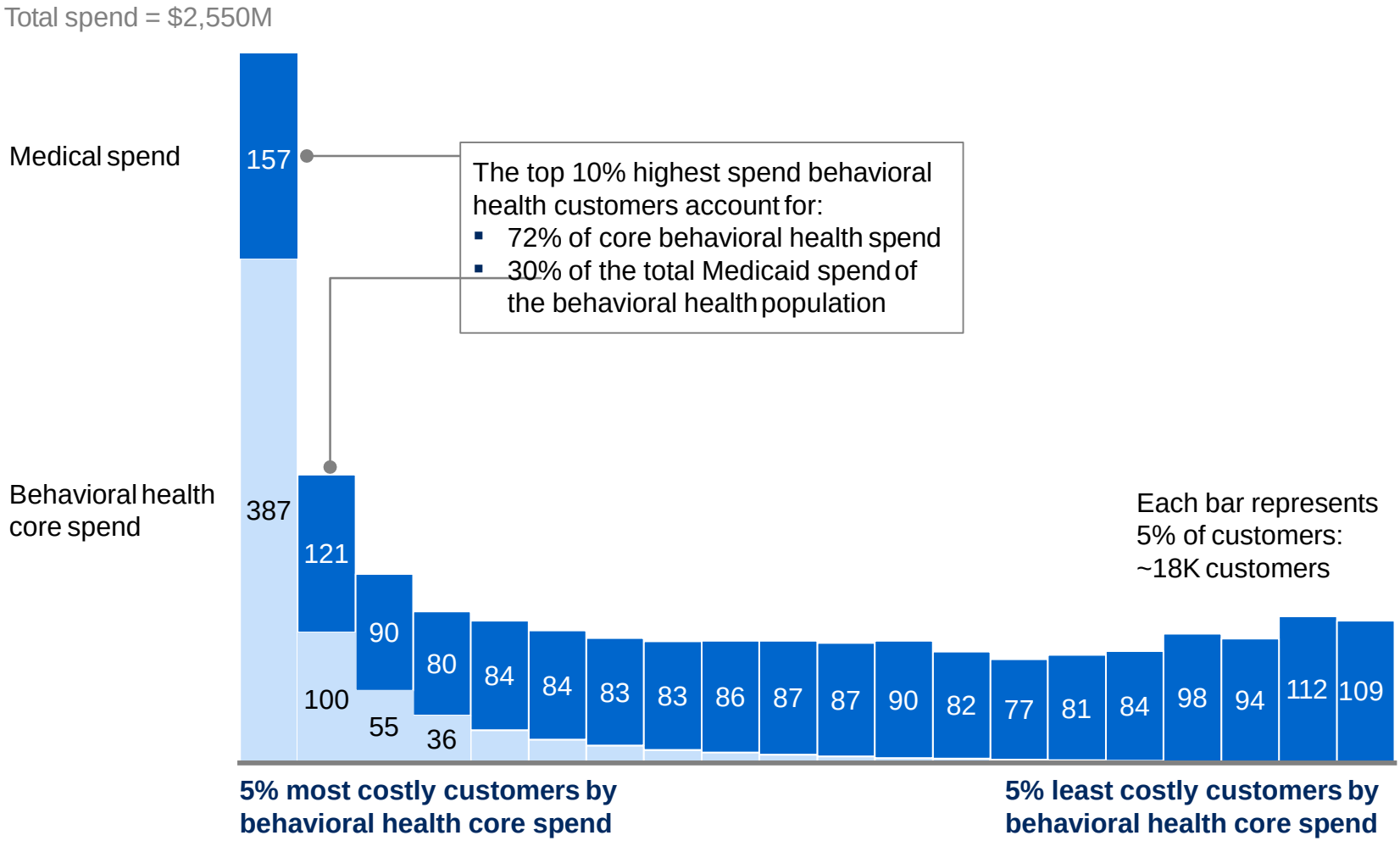


1 Annualized members (not unique members) shown here with no exclusions made on population or spend. Annualized member count = Sum of member months/12
2 Most inclusive definition of behavioral health population used here of members who are diagnosed and treated, diagnosed but not treated, and treated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

SOURCE: FY15 State of Illinois DHFS claims data

In Illinois, the costliest 10% of Medicaid members account for 72% of behavioral health spend

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



1 Distribution of unique members shown here

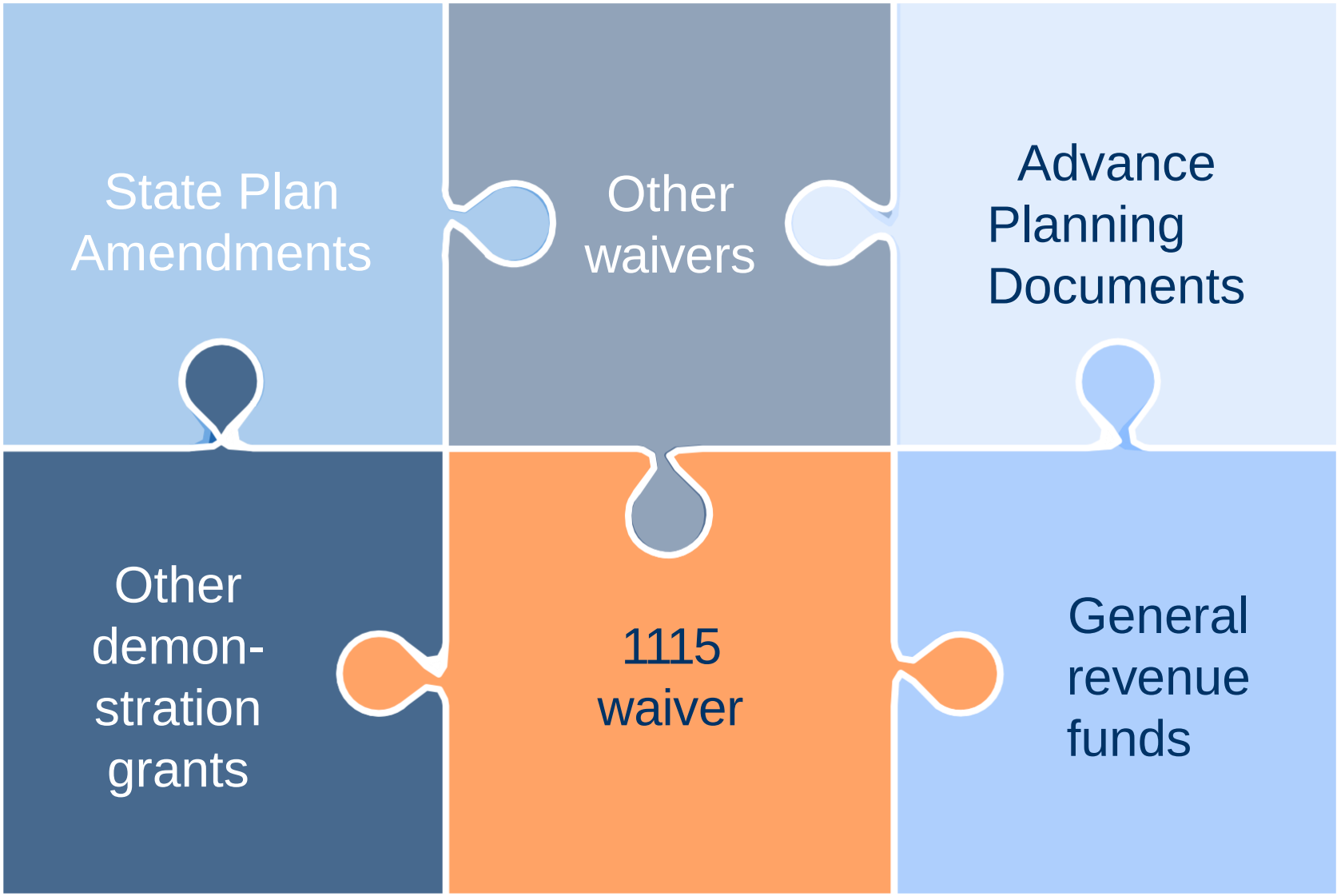
2 Primary population defined as Medicaid members with behavioral health needs minus those who have been treated but not diagnosed and those who have been diagnosed but not treated. It also excludes those with dual eligibility or non-continuous eligibility or third-party liability, It also excludes those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

SOURCE: FY15 State of Illinois DHFS claims data

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

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

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


State Plan Amendments
Other waivers
Advance Planning Documents
Other demon-stration grants
1115 waiver
General revenue funds

STATE PLAN AMENDMENTS

DESCRIPTION	PROPOSED EFFECTIVE DATE
Medication Assisted Treatment	January 2017
Mobile Crisis Response	Summer 2018
Crisis Stabilization	Summer 2018
Uniform Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA)	January 2019
Integrated Physical and Behavioral Health Homes	January 2019

WAIVER PILOTS APPROVED

Description	DY1	DY2	DY3	DY4	DY5	
SUD/IMD	X	X	X	X	X	
SUD Case Management	X	X	X	X	X	
Withdrawal Management	X	X	X	X	X	
Peer Recovery Support Services	X	X	X	X	X	
Crisis Intervention Services	X	X	X	X	X	
Evidence-based Home Visiting Services	X	X	X	X	X	
Assistance in Community Integration Services		X	X	X	X	
Supported Employment Services		X	X	X	X	
Intensive In-Home Services	X	X	X	X	X	
Respite			X	X	X	

WAIVER PILOTS

Description	Eligibility	
	Geographic	Recipient
SUD/IMD	X	
SUD Case Management	X	
Withdrawal Management	X	
Peer Recovery Support Services	X	
Crisis Intervention Services		X
Evidence-based Home Visiting Services		X
Assistance in Community Integration Services		X
Supported Employment Services		X
Intensive In-Home Services		X
Respite		X

What an Integrated Health Home is and is not

Integrated Health Homes in Illinois are:

Primary focus is on coordination of care…

- **Integrated, individualized care planning and coordination resources,** spanning physical, behavioral and social care needs
- An opportunity to **promote quality** in the core provision of physical and behavioral health care
- A way to **encourage team-based care** delivered in a member-centric way
- A way of **aligning financial incentives** around evidence-informed practices, wellness promotion, and health outcomes

For members with the highest needs:

- A means of facilitating **high intensity, wraparound care coordination**
- An opportunity to obtain **enhanced match for care coordination needs**
- **Identifying enhanced support** to help these members and their families manage complex needs (e.g., housing, justice system)

Integrated Health Homes in Illinois are NOT:

… and NOT on the **provision of all services**

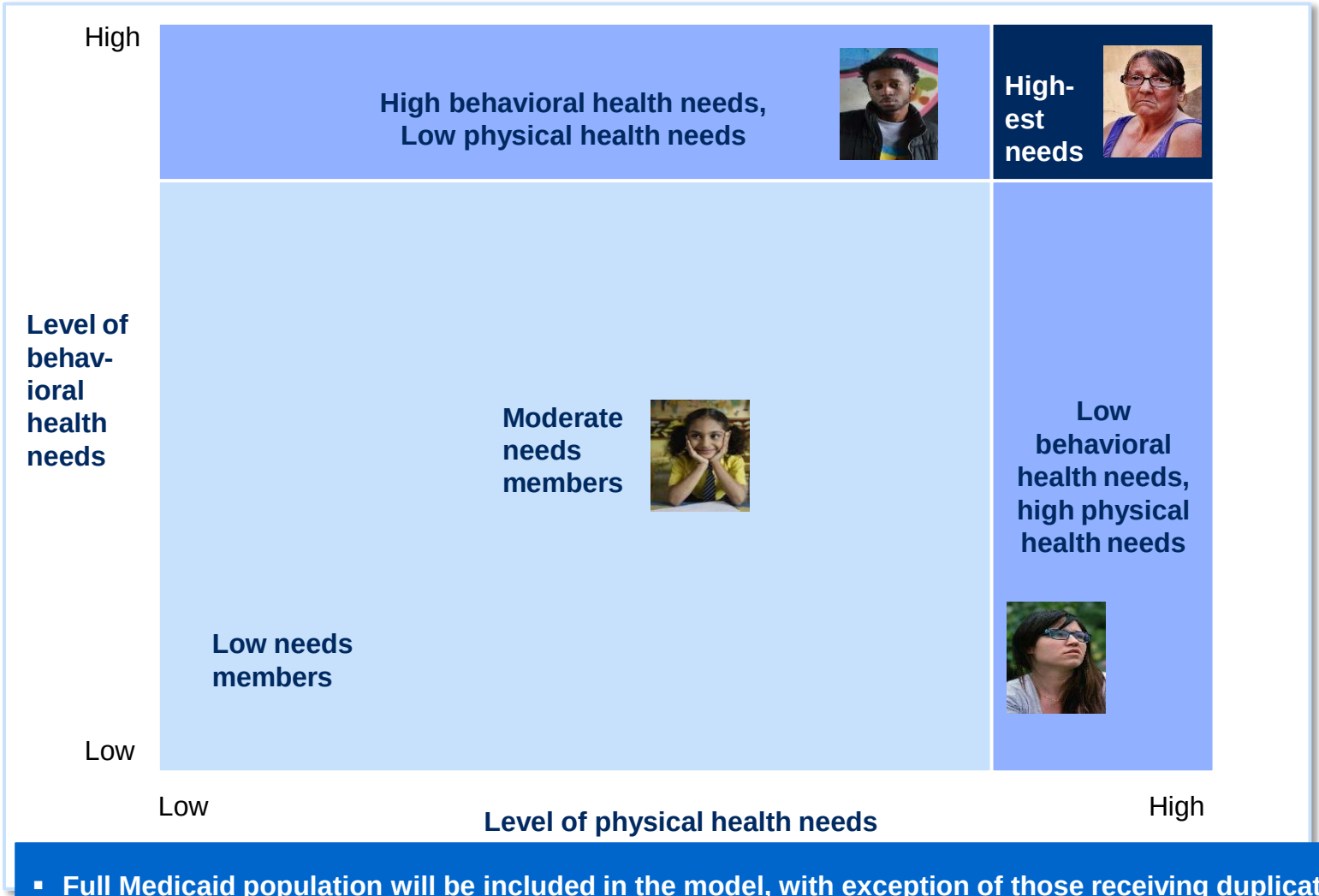
- **Provider of all services for members**
- **A gatekeeper** restricting a member's choice of providers
- **A physical place** where all Integrated Health Home activities occur
- **A care coordination approach that is the same for all members** regardless of individual needs

Principles for developing care delivery model

- Develop a **person- and family-centered care delivery model for the whole Medicaid population, regardless of match status,** that encourages member and family engagement
- Evolve toward **full clinical integration of behavioral, physical, and social healthcare**
- Craft a flexible care delivery approach that reflects **the diverse needs of members in Illinois** and recognizes that member needs change over time
- Acknowledge and accommodate **geographical variation in provider capabilities, readiness, and priorities**
- Strike an **appropriate balance between provider flexibility and accountability** to enable capabilities and readiness
- Prioritize **economic sustainability of care delivery model** at both the systemic and provider levels

A Overview of potential approach to IHH member stratification

ILLUSTRATIVE



- Full Medicaid population will be included in the model, with exception of those receiving duplicative care coordination, in LTC facilities after 90 days, or with MMAI dual, partial eligibile, or TPL status
- Approach to tiering adopted to ensure members with similar needs receive comparable care coordination support, and to focus resources on those members who need greatest support