Health and Human Services Strategy

Strategy briefing

Discussion document

May 10, 2016

Objectives for today's discussion

- Share our vision for HHS transformation, with a focus on behavioral health
- Solicit your input
- Request your support in championing this effort

Objectives of the HHS transformation as outlined in the 2016 State of the State address

"Our transformation 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"

SOURCE: Governor's 2016 State of the State address

The HHS transformation is enabled by an historic level of collaboration

Twelve agencies / departments / offices are participating in HHS transformation…

1. Governor's Office
2. Department of Healthcare and Family Services (DHFS)
3. Department of Children and Family and Services (DCFS)
4. Department of Human Services (DHS)
5. Department of Juvenile Justice (DJJ)
6. Department of Corrections (DOC)
7. Department of Aging (DOA)
8. Department of Public Health (DPH)
9. Department of Veteran's Affairs (DVA)
10. Illinois Housing Development Authority (IHDA)
11. Department of Innovation and Technology (DoIT)
12. Illinois State Board of Education (ISBE)

…and focusing on four pillars

1. Prevention and Population Health
2. Pay for value, quality and outcomes
3. Moving from institutional to community care
4. Education and self sufficiency

We have already had a number of successes…

EXAMPLES ONLY – NOT EXHAUSTIVE

- Stepped down 330 youth from deep-end residential treatment since April 2015 when census was ~1,150, creating space for placements that enabled a 50% reduction in the number of youth in emergency shelter and detention
- Number of managed care contractors has been reduced from >30 to 13 with estimated savings of more than $60 million in the next year
- Illinois Warrior Assistance Program now provides mental healthcare counseling as well as financial and legal counseling to veterans and their family members 24/7
- Chicago Home project modification planned, looking at options for providing skilled nursing care for veterans with behavioral health issues
- Drop-in center (Day Reporting Center) made available for released juveniles that provides support on education, life skills, and employment; used existing state space and funding
- Support offered to ~2,800 people with physical disabilities to help them obtain employment
- 1,500 individuals with physical or developmental disabilities or mental illness were moved from institutions to live in community placements
- 11,500 DOC staff being trained this year (1,800 thus far) on a National Alliance on Mental Health (NAMI)-developed, 2-day training program

… and we see this as the first step in a multi-year journey

EXAMPLES ONLY – NOT EXHAUSTIVE

Near-term priorities
~6-12 months

Behavioral health and other key focus areas

- Design nation's leading behavioral health strategy
- Pursue funding opportunities to maximize impact for IL
- Engage key stakeholders

Mid-term Focus Areas
~1-2 years

Implement behavioral health strategy

- Roll-out behavioral health strategy (e.g. integration of physical and behavioral health)
- Continue stakeholder engagement and maximize funding opportunities

Expand focus to other parts of HHS transformation

- Select example areas could include:
  - Comprehensive strategy for LTSS and DD populations
  - Fraud, Waste and Abuse
  - Linking community services to Managed Care

Rationale for initial focus on behavioral health

- Drives significant costs ~$2-3Bn+ across the system annually, with substantial opportunity to derive better value
- Affects a growing share of the State's population as substance use and mental health challenges on the rise
- Reflects State priority given Consent decrees and other litigation across HFS, DHS, DCFS, DOC, and DJJ
- Affects multiple agencies, therefore a good starting point for collaboration
- Garners Federal interest – and potentially greater opportunities for funding – as currently Federal priority

Emerging pain points to be addressed in behavioral health strategy (1/6)

Pain Point	Description	Evidence
1 **Lack of coordination of behavioral health services around the customer**	▪ No designated point of accountability for whole customer needs including: – Both medical and behavioral health care – Focus on timely care with eye toward value at right time ▪ Transitions between care settings and major life changes a common failure point	*"Customers transitioning out of care settings are not given the necessary guidance to remain in the continuum of care."* *"Customers aging out often get lost"* ▪ Lack of information flow across the behavioral health ecosystem is a significant reason for care deficiencies and sub-optimal care setting allocation ▪ In 2014, national benchmarking suggests IL had ~50% lower utilization of community care settings yet ~40% greater utilization of state-operated psychiatric hospitals than the national average

SOURCE: Recent State experience

Emerging pain points to be addressed in behavioral health strategy (2/6)

Pain Point	Description	Evidence
2 System failures to identify and access those with the greatest needs	▪ Inability to identify customers with behavioral health needs due to: – Lack of evidence-based approach to identify need and target care accordingly – Limited funding and services for identification and prevention – Insufficient and unintegrated access points for those with greatest need (e.g., homeless, people recently released from prison) ▪ Reactive rather than proactive, preventative care	*"Without a well-functioning assessment, we cannot channel the behavioral health population into the right modes of treatment, resulting in overuse of deep-end care"* *"The way our department is organized, we effectively have only one arrow in our quiver and this one-size-fits-all approach does not work for everyone or even a majority of our customers"* *"We have an adverse selection problem– vendors select for lower-risk customers who are easier to treat (and often do not require care) and avoid high-risk populations"* *"We are truly failing folks early in life with enormous downstream ramifications"* ▪ 21% of adults and 45% of children needed but did not receive mental health services, ranking Illinois 26th and 41st in the nation, respectively

SOURCE: Recent State experience

Emerging pain points to be addressed in behavioral health strategy (3/6)

Pain Point	Description	Evidence
3 Lack of community capacity for behavioral health services	▪ Insufficient ability to provide behavioral health services in the most appropriate, lowest acuity-setting possible due to: – Lack of provider capacity / willingness (e.g. PCP, NP) – Infrastructure shortcomings (e.g. OP clinics, crisis services) ▪ Community capacity not purpose-built for current population due to major changes in coverage (e.g. ACA expansion, transition to managed care	*"The lack of community-based infrastructure and resources for behavioral health results in an over-indexing on deep-end care"* *"Too often are folks referred for things that should be done by PCPs"* ▪ IL community utilization per 1,000 population is less than half the national average (10.5 vs. 22.3 / 1,000) ▪ IL 45th/ 50 States in mental health care HPSA[1] designations ▪ IL 22nd/50 States in psychiatrists per 100,000 (8.2)[2] ▪ IL one of three states to address psychiatrist shortage by granting prescribing capabilities to qualified psychologists

1 Health Professional Shortage Areas

2 Behavioral Health: "The Silent Shortage" 2015

SOURCE: Recent State experience

Emerging pain points to be addressed in behavioral health strategy (4/6)

Pain Point	Description	Evidence
4 **Limited set of comple-mentary services**	▪ Insufficient "beyond-core/ medical" services (e.g. housing, transport, job training) to address whole-person ▪ Existing services not sufficiently coordinated	*"Folks need to understand that housing is healthcare"* *"We lack the full complement of wraparound services and those that do exist are not integrated well into the broader system"* ▪ The IL MH strategic plan cites "Limited community conditional release residential program capacity relative to need" for forensic and justice involved adults

SOURCE: Recent State experience

Emerging pain points to be addressed in behavioral health strategy (5/6)

Pain Point	Description	Evidence
5 Duplication and gaps in behavioral health services across agencies	▪ Redundancies, gaps in services, and lack of accountability across agencies resulting in inefficient delivery and missed handoffs ▪ System currently agency / program-centric rather than customer-centric ▪ Duplication of services resulting in value maximization opportunities across system	▪ Interviewees cited a “patchwork structure” for behavioral health with fragmentation across agencies and customers “falling through the cracks” – Programs/services/grants beyond purview of “natural owners” – Common vendors without shared procurement strategy – Lack of clear ownership for customers' needs as well as who should mobilize delivery system (e.g., which agency is responsible for a foster child on Medicaid)

SOURCE: Recent State experience

Emerging pain points to be addressed in behavioral health strategy (6/6)

Pain Point	Description	Evidence
6 **Data, analytics, and transparency limitations**	▪ Insufficient availability, usability, and integration of data, compromising insights ▪ No single source of truth ▪ No current predictive analytics capability to target efforts ▪ MCO encounter data currently incomplete	*"There is no way what we have available today prepares us for the challenge of building the nation's leading behavioral health system"* *"There is so much potential in using data to drive insights and we're behind the ball"*

SOURCE: Recent State experience

Other States have attempted solutions to address similar pain points (1/2)

Pain Point	Solutions pursued in other States	Example States
1 Lack of coordination of behavioral health services around the customer	▪ Provide intense care coordination for high needs behavioral health customers through health homes (payment and delivery)	▪ TN, MO, AR, IA
	▪ Integrate behavioral health into primary care through PCMH model	▪ PA, OR, AR
	▪ Create service navigators to guide customers through critical transition points (across agencies, life events, etc.)	▪ NY, DE
2 System failures to identify behavioral health needs	▪ Roll out universal assessment tool for screening and assessment to all populations	▪ IL in progress (children)
	▪ Scale up and train access points to care for behavioral health customers (e.g. in-home visiting, public safety, libraries, homeless shelters, etc.) including concept of “one-stop shops”	▪ CA
3 Lack of community capacity for behavioral health services	▪ Scale up community service infrastructure (primary care integration, outpatient mental health clinics, crisis clinics, mobile crisis teams)	▪ Multiple in various ways
	▪ Build technology-based solutions to enhance service provision (e.g. telemedicine, SMS-based counseling, virtual visits)	▪ SC, MN
	▪ Optimize workforce capacity through top-of-license practicing and role redefinition (e.g. psychologists able to prescribe)	▪ IL (as of July 1)

Other States have attempted solutions to address similar pain points (2/2)

Pain Point	Solutions pursued in other States	Example States
4 **Limited set of complementary services**	▪ Expand suite of services to include housing, employment, and transportation	
	– Supportive housing	▪ UT, LA
	– Employment services (job training, life skills training , etc.)	▪ CT, MT, WI
	– Non-emergency transportation beyond requirements (e.g. for meetings with care coordinators)	▪ WA
5 **Duplication and gaps in behavioral health services across agencies**	▪ Build centralized, cross-agency leadership capability dedicated to building a customer-centric behavioral health (and broader health) system	▪ OH
	▪ Resolve coverage gaps through system adjustments (e.g., Rule changes; suspension vs. termination of Medicaid coverage for DOC population) as well as eligibility changes	▪ Multiple: state-specific context
6 **Data, analytics, and transparency limitations**	▪ New measures and sources coupled with broader payment and delivery system reform strategy	▪ AR
	▪ System-wide transparency	▪ OH
	▪ Predictive analytics strategy	▪ *Still nascent*

Federal CMS provided written feedback on State's previous attempt at an 1115 Waiver that can inform other potential funding efforts for the Transformation

Feedback theme	Selected evidence
Clarity of vision, internal consistency, and detail	▪ "It was unclear what delivery system interventions the state was seeking to advance through this [Delivery System Reform Incentive Payments (DSRIP)] funding request and how those interventions help solve compelling delivery system challenges in Illinois. To move forward on our review of a DSRIP proposal, we would need details on the program structure."
Use of State Plan Authority	▪ "In general, if a state can do something under a Medicaid state plan authority, CMS would like to see the state pursue that authority." ▪ "The state acknowledged that several of its key programmatic requests could be achieved via state plan authority and, indeed, the state has already submitted several state plan amendments (SPAs)"
Longstanding rules for which CMS had not expressed flexibility	▪ "SMHRFs appear to be Institutions for Mental Diseases and are subject to the federal statutory payment exclusion. Therefore, we would not be able to provide expenditure authority for these SMHRFs." ▪ "We are not able to approve a financial arrangement that is dependent on tax revenues from a tax that is not permissible under 1903(w) of the Social Security Act and implementing regulations" [Home and Community Based Services (HCBS) Provider Assessment Fee]
Budget Neutrality	▪ "The state did not demonstrate that projected savings would offset the state's request for federal funding for the proposed DSHPs and DSRIPs."

SOURCE: CMS feedback from Eliot Fishman received on June 2, 2015

Questions for you

- What else would be useful to know about the HHS transformation?
- Who are some key stakeholders you want to ensure are engaged early in the process?
- How would you like to be engaged?
- Can we enlist your support to champion the effort?