Illinois Health and Hospital Association

June 10, 2016

Felicia Norwood
Director, Department of Healthcare and Family Services
Prescott Bloom Building
201 South Grand Avenue
Springfield, IL 62763

Dear Director Norwood:

Thank you again for your participation at the IHA Board of Trustees meeting last month. Your comments and the discussion were very informative and productive. I wanted to follow up regarding your efforts to develop a strategic plan for behavioral health and possibly developing an 1115 waiver as part of the plan. Given the prevalence of behavioral health-related diagnoses within the Medicaid population, we have concluded that a Medicaid 1115 waiver has the potential to improve access to integrated behavioral health services and achieve significant improvements for the beneficiaries and cost savings within the timeframe of a waiver. Our Behavioral Health Advisory Forum has identified some preliminary priority areas and will be examining these proposals as well as other potential solutions during an upcoming meeting on June 21. The meeting will be held in our Naperville office and I would invite you to identify your key behavioral health staff to participate in this portion of the meeting.

You mentioned at the Board meeting that you would like our thoughts on priority behavioral health issues that could inform your strategic plan. The IHA Behavioral Health Forum has identified the following five areas: (1) Enhancing emergency and community-based crisis stabilization services; (2) supporting behavioral health homes; (3) establishing voluntary regional networks that have dedicated emergency psychiatric facilities; (4) expanding telehealth capacity; and (5) establishing state-based loan forgiveness programs for behavioral health providers. In addition, the Forum will be discussing other issues such as the role that ED notifications can play in identifying high utilizers, the impact of homelessness, as well as strengthening the oversight of Medicaid MCOs to ensure adequate networks of behavioral health providers, and the impact MCOs have on access to behavioral health services.

The following is a brief overview of those priority areas that would be well suited for a focused 1115 waiver.

1. Funding for enhanced emergency and community crisis stabilization services will reduce boarding in the emergency department, while improving clinical

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transitions and health outcomes. Crisis stabilization is defined as "a direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services" (SAMHSA, 2012). Mental health-related emergency department visits can cost up to 50% more than other emergency department visits.

Providing start-up funding for services not typically covered by Medicaid, incentivized participation in crisis stabilization services would enhance hospital and community-based collaboration, while improving the overall quality and decreasing the cost of care. Statewide requirements could be waived to target regions with high inpatient and emergency department utilization for behavioral health diagnoses. Reimbursement would be provided for establishing crisis stabilization units, community crisis assessment and crisis stabilization services. Performance metrics would track hospital 30-day readmission rates for mental health and substance abuse primary diagnoses and overall cost savings for the Medicaid program.

For example, since the July 2015 opening of Holy Cross Hospital's on-site crisis stabilization unit, over 700 patients have been treated and average time spent in the ED has decreased by more than half. Based on current need, cost savings and the patient quality improvements demonstrated, Holy Cross Hospital plans to expand and co-locate the unit next to the ED with a public entrance for walk-in patients and police drop offs. Additionally, plans for a nearby community mental health center in partnership with Catholic Charities have been established as a result.

2. Funding to support establishing and expanding capacity for behavioral health homes will increase the efficiency and quality of care by transforming service delivery networks across Illinois. Funding would include a care coordination fee that would support both the planning and implementation of behavioral health homes from Section 2703 of the Affordable Care Act within targeted regions of the state. Funding would also create incentive payments to enhance partnerships, create shared data systems and develop the processes for care coordination across physical health, behavioral health, long-term care and other social service supports. Funding could be included for infrastructure development to create the capacity to co-locate physical and behavioral healthcare services, certify that health information technology is used to facilitate the health home's work, and establish quality improvement efforts to assure that the work is effective at the individual and population level.

3. Funding for voluntary regional networks with dedicated emergency psychiatric facilities to screen and treat acute psychiatric patients would increase the efficiency and quality

of care by using a model implemented in Alameda County, California. In 2012, the Joint Commission noted that boarding times in the emergency department can range from 2 hours or less to 24 hours or more, with behavioral health patients experiencing longer boarding times than medical/surgical patients. The Alameda Model establishes a regionally-dedicated psychiatric hospital with an accompanying crisis stabilization unit, which allows expedited transfers from local emergency departments for patients on involuntary mental health holds. This model reduced the length of boarding times in the emergency department for patients awaiting psychiatric care by over 80% compared to state averages. Moreover, the psychiatric emergency service provides assessment and treatment that may stabilize over 75% of the crisis mental health population, reducing the overall cost by reducing inpatient psychiatric care.

Funding to participate in a voluntary program would include hourly crisis stabilization services. Performance metrics would track all emergency department patients on involuntary mental health holds to determine boarding time, defined as the difference between when they were deemed stable for psychiatric disposition and the time they were discharged from the emergency department for transfer to the regional psychiatric emergency service hospital. Also, performance metrics would be based on the percentage admitted to inpatient psychiatric units after evaluation and treatment in the psychiatric emergency service and overall cost savings for the Medicaid program.

4. Funding for telehealth capacity expansion will increase and strengthen access to provider networks, while facilitating behavioral health integration into hospital and primary care settings. Telehealth has the potential to improve access to care in the 126 federally designated mental healthcare professional shortage areas in Illinois. Current Medicaid reimbursement rates for Telepsychiatry services are substantially below the costs of providing care leading to a dearth of psychiatrists who will provide these valuable services. Eligibility for participating in a telehealth waiver fund would be contingent upon demonstrating behavioral healthcare gaps or access barriers in the hospital's service community. Statewide requirements would be waived to target regions that have high inpatient and emergency department utilization for behavioral health diagnoses. Performance metrics would track hospital readmissions for behavioral health-related diagnoses and overall cost savings for the Medicaid program. Incentives would be provided for hospitals, community mental health clinics (CMHCs) and federally qualified health centers (FQHCs) to install appropriate technology (e.g., telehealth access to psychiatric care) in exchange for participating in specified performance metric collection. Financial incentives would be included for hospitals, CMHCs and FQHCs that ensure EHR interoperability with telehealth providers.

   Telehealth holds great promise as demonstrated by UnityPoint Health's Robert Young Center's use of grant funding to have their behavioral health practitioners provide mental health assessments for five unaffiliated hospitals in the Quad Cities region,

providing expedited transfers for patients from the emergency department and ensuring transitions are made to the most appropriate level and setting of care in the community. In 2015, over 70% of approximately 1,000 patients that used the telehealth-based mental health assessment service at the unaffiliated hospitals were able to transition to a lower level of community-based treatment, decreasing unnecessary hospitalizations and associated transfers by ambulance or police departments. The health system is now expanding the patient-centered service to 5 additional hospital EDs in Iowa for a total of 7 in the Eastern Iowa Mental Health Region.

5. A waiver could also be used to provide funding for workforce development, in authorizing an educational loan forgiveness program for behavioral health professionals who practice in mental health professional shortage areas within Illinois. Increasing workforce capacity would help ensure the needs of patients are met and will act as a tool to help recruit behavioral healthcare professionals, many of which are trained in Illinois. This incentive would increase access to professionals needed across the care continuum – psychiatrists, clinical psychologists, clinical professional counselors, clinical social workers, psychiatric nurses and marriage and family therapists.

If you have any questions or comments, please contact me or Patrick Gallagher, Group Vice President, Health Policy and Finance, at pgallagher@team-iha.org or 630-276-5496.

Also, please let me know if someone working on the behavioral health strategic plan would be able to attend the upcoming meeting of the Behavioral Health Advisory Forum, Tuesday, June 21, 2016 at 1:00 p.m. in our IHA Naperville and Springfield offices, and a future meeting where we could learn more about plans for an 1115 waiver.

Sincerely,

AJ Wilhelmi
President & CEO
Illinois Health and Hospital Association

CC: Patrick Gallagher, IHA