2017

STRATEGIC PLAN:
Medicaid
Behavioral Health
Delivery & Payment
System Reform
CURRENT SITUATION

Medicaid is the single largest payer for behavioral health services in the United States, and spending for individuals with a behavioral health diagnosis can be 2.5 to 3.5 times higher than for beneficiaries without a behavioral health diagnosis.\(^1\) Throughout Illinois, 74 counties lack inpatient mental health beds within their hospitals, necessitating strong collaboration and communication to ensure patients receive care at the right time and in the right setting.\(^2\)

Moreover, community-based crisis care and outpatient services are chronically underfunded, exacerbating behavioral health conditions and resulting in overuse or improper use of hospital emergency departments (EDs) to treat these patients.

As Illinois has shifted greater than 60% of Medicaid enrollees from fee-for-service to managed care since 2011, a commensurate shift to successfully integrate behavioral healthcare management and streamline care coordination has not occurred. Health systems and community-based behavioral health providers have voiced frustration over excessive delays in claims processing, lengthy and time-consuming authorizations, unreasonable or unexplained denials, a lack of responsiveness from managed care organizations (MCOs), difficulty in credentialing staff, and payment delays.

Furthermore, greater than one-third of our state remains in non-mandatory managed care areas that continue to depend on a disjointed system that has not received a rate increase in several years. These stressors on our behavioral healthcare safety net led the Illinois Health and Hospital Association (IHA) to develop overarching guidance to transform the Medicaid behavioral healthcare delivery and payment system for our membership, legislators, insurers, consumers and other healthcare stakeholders.

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\(^1\) Economic Impact of Integrated Medical-Behavioral Healthcare. Milliman, Inc. April 2014

\(^2\) IHA COMPdata, November 2015
ACTION PLAN

IHA and its over 200 member hospitals and nearly 50 health systems across the state would like to offer guidance and recommendations on targeted reforms necessary to improve the delivery and payment of behavioral healthcare, recognizing the limited workforce and other resources currently available. This strategic plan has been executed with leadership from the diverse statewide IHA Behavioral Health Advisory Forum, a group of expert administrative and clinical professionals from hospitals and health systems across the state that report to the IHA Board of Trustees.

IHA’s Safety Net Hospital Constituency Section has also provided input. This group represents disproportionate-share hospitals that serve a large proportion of the poor and uninsured population located in urban neighborhoods and rural communities where few healthcare professionals practice.

Overall, 93 IHA institutional members offer behavioral health services through hospital-based inpatient and outpatient services, nine of which are freestanding psychiatric hospitals. This strategic plan outlines specific recommendations targeting innovating federal funding streams in several areas, as described below.

ENHANCE CRISIS STABILIZATION SERVICES

Background

Crisis stabilization is “a direct service that assists with de-escalating 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”.

Mental health-related ED visits can cost up to 50% more than other ED visits. Individuals experiencing a behavioral health emergency need access to emergency and community-based crisis stabilization services, whether they are units within a hospital or facilities co-located with EDs. Enhancing services like mobile crisis units, crisis stabilization facilities and detoxification services will reduce boarding in the ED, while improving clinical transitions and health outcomes.

Example

Since the July 2015 opening of Chicago-based 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

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3 Behavioral Health Service Definitions- A Supplement to Substance Abuse and Mental Health Services Administration (SAMHSA) Description of a Modern Addictions and Mental Health Service System Brief, SAMHSA, 2012.
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, an expansion of outpatient mental health services in partnership with Catholic Charities and much-needed inpatient services have been established as a result.

Reimbursement

Providing start-up funding for services not typically covered by Medicaid and incentivized participation in crisis stabilization services would enhance hospital and community-based collaboration, while improving the overall quality and decreasing the cost of care. Regions would be targeted with high inpatient and ED utilization for behavioral health diagnoses. Reimbursement would be provided for establishing crisis stabilization units, then current rates for hospital-based and Rule 132 crisis assessment and crisis stabilization services would be enhanced to ensure long-term sustainability. Illinois hospitals have developed a variety of crisis stabilization programs but their ongoing viability is threatened due to lack of funding.

Quality Measures

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. Also, performance metrics would be based on the percentage admitted to inpatient psychiatric units after evaluation and treatment in the crisis service and overall cost savings for the Medicaid program.

SUPPORT COLLABORATIVE CARE MODELS, INCLUDING BEHAVIORAL HEALTH HOMES

Background

Behavioral health homes offer a team-based, integrated clinical approach to coordinated care to individuals with multiple chronic conditions, including physical health, mental health and substance use disorders. Provider developed- and operated-homes build linkages to community supports and resources, as well as enhance coordination and integration of primary and behavioral healthcare. Integrated clinical teams have direct contact with patients to address chronic and complex conditions, rather than remotely operating out of a centralized call center. This creates high-intensity assessment, care planning and coordination that are patient-centered.

Example

Missouri health homes have saved an estimated $23.1 million over an 18-month period through care coordination, saving taxpayer dollars and proving to be the most effective approach to
caring for individuals with complex physical health and behavioral health needs. In the first year of implementation, the behavioral health homes specifically reduced hospitalizations by 9.1%.

Ohio health homes have demonstrated the ability to improve supportive relationships with Medicaid beneficiaries in comparison to traditional fee-for-service beneficiaries. A survey administered to health home beneficiaries 13 months after implementation showed higher positive scores in all measured domains compared to a statewide sample, including overall General Satisfaction, Quality/Appropriateness of Care, Participation in Treatment, Access, Outcomes and Functioning. General Satisfaction scores alone improved over traditional fee-for-service by 8% over this initial implementation period.  

**Reimbursement**

Funding would include a service fee that would support both the planning and implementation of behavioral health homes within targeted high-need regions of the state, through a 90% Federal Medical Assistance Percentage from Section 2703 of the Affordable Care Act. In mandatory-managed care areas, health homes would be designated providers or a team of healthcare professionals would contract directly with the State or a managed care plan a payment would pass through the State or plan.

Funding through an additional 1115 Waiver or grant program would 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. 1115 Waiver or grant 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 ensure that the work is effective at the individual and population level. As Medicaid MCOs can provide incentives to improve care and have the flexibility to do so in innovative ways, MCOs could also support collaborative care pilots to demonstrate their efforts to improve care coordination.

**Quality Measures**

Core measures would include those recommended by the Centers for Medicare & Medicaid Services (CMS) for the health homes, such as follow-up after hospitalization for mental illness, screening for clinical depression and follow-up plan, and initiation and engagement of alcohol and other drug dependence treatment.

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EXPAND TELEHEALTH CAPACITY

Background

Funding for telehealth capacity expansion, including telepsychiatry consultations in the ED, will increase and strengthen access to provider networks, while facilitating behavioral health integration into hospital and primary care settings. Currently, hospital EDs are not eligible to receive reimbursement as Originating Sites via telehealth under Illinois Medicaid, creating an unnecessary access barrier for this coordinated service and preventing more widespread implementation in mental health professional shortage areas. Also, 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.

Example

The UnityPoint Health – Robert Young Center has successfully used past grant funding for their behavioral health practitioners to provide mental health assessments for five unaffiliated hospitals in the Quad Cities region, providing expedited transfers for patients from the ED 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 who 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 five additional hospital EDs in Iowa for a total of seven in the Eastern Iowa Mental Health Region.

Reimbursement

Eligibility for participating in a telehealth 1115 waiver fund would be contingent upon demonstrating behavioral healthcare gaps or access barriers in the hospital’s service community, which can be obtained from Community Health Needs Assessments or a review of provider network adequacy. Statewide requirements would be waived to target regions that have high inpatient and ED utilization for behavioral health diagnoses. 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 collecting specific performance metrics. Financial incentives would be included for hospitals, CMHCs and FQHCs that ensure electronic health record (EHR) interoperability with telehealth providers for accessible data sharing.

Quality Measures

Performance metrics would track hospital readmissions for behavioral health-related diagnoses and overall cost savings for the Medicaid program. For telepsychiatry consultations in the ED,
performance metrics would be based on the percentage admitted to inpatient psychiatric units after evaluation and treatment in the ED and overall cost savings for the Medicaid program.

**ADDRESS THE SHORTAGE OF BEHAVIORAL HEALTH PROFESSIONALS**

**Background**

Increasing workforce capacity through state-based educational loan forgiveness programs and graduate medical education pilot programs would help ensure the needs of patients are met and will act as a tool to help recruit behavioral healthcare professionals, many of whom 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.

Targeting the Illinois workforce, the state has 126 federally designated mental health care professional shortage areas, according to the U.S. Health Resources and Services Administration (HRSA). Less than 70 percent of the state’s needed level of mental health professionals was being met, according to HRSA, before budget cuts of $98.5 million to the Department of Human Services’ Division of Mental Health and $27.6 million to the Division of Alcoholism & Substance Abuse for FY 16. This exemplifies the access barriers faced within the state, where an adequate workforce could be achieved by a combination of loan forgiveness programs, innovative programs targeting behavioral health professionals and enhanced provider rates.

**Example**

In 2016, the IHA championed Senate Bill 3062, legislation that would have integrated behavioral healthcare professional loan forgiveness incentives with primary care provider incentives that already exist, which could better address the needs of patients with mental health and substance use disorders. The bill would have authorized the Illinois Department of Public Health to include behavioral health professionals who practice in mental health professional service areas within Illinois in educational loan forgiveness programs.

**Reimbursement**

AN 1115 waiver could also be used to provide innovative funding mechanisms for workforce development through targeted educational loan forgiveness programs and graduate medical education pilot programs for behavioral health professionals who practice in designated health professional shortage areas within Illinois.
INTEGRATE DELIVERY & PAYMENT SYSTEMS FOR PHYSICAL AND BEHAVIORAL HEALTHCARE

Background

Cost savings and better health outcomes could be achieved through training, incentives and billing alternatives for behavioral health screening and intervention services within acute and primary care. Mental health and medical conditions are risk factors for each other and the presence of one can complicate the treatment of the other. Patients with comorbid mental health and medical conditions experience higher healthcare costs, with much of the difference attributable to higher medical, not mental health, expenditures.

Example

Memorial Health System—Memorial Behavioral Health has embedded behavioral health consultants within FQHCs, rural health centers and other primary care settings in its service area in Springfield and surrounding communities. Memorial is currently engaged in a Six Sigma project to ensure all adults with certain targeted issues are screened for depression. Within the clinics, physicians provide a warm hand-off of those patients who screen positive or express behavioral health concerns to embedded behavioral health consultants for greater continuity of care.

While clinicians and social workers reported difficulties with client engagement in treatment, an analysis comparing children who enter behavioral healthcare through Memorial’s integrated care program and those who enter care in other ways has found better treatment engagement outcomes that were statistically significant for children receiving integrated care. Although better treatment engagement is not tantamount to better outcomes in child well-being, it suggests that children entering the care system through the integrated care program can achieve greater access to the right care in the right setting. Through the course of Memorial’s integrated care program, patient screening scores for both depression and anxiety have improved.

Reimbursement

Value-based or fee-for-service reimbursement needs to be strongly encouraged for public and commercial insurances to support behavioral health screening and integration efforts in settings across the care continuum. Funding through an 1115 Waiver would support integration start-up costs, as well as establish and support training hubs for education and support throughout implementation.
Quality Measures

Performance metrics would track the total number of behavioral health screenings, positive screens and referrals to behavioral health consultants. Performance metrics would also track health outcomes for targeted comorbid chronic diseases.

DEVELOP A COMPREHENSIVE OVERSIGHT SYSTEM METHODOLOGY FOR MEDICAID MCOs

Background

Most Medicaid MCOs subcontract with Behavioral Health Organizations (BHOs), carving-out the management of specialty behavioral health services and creating an additional layer of administrative complexity. Medicaid MCOs have presented hospitals with significant operational challenges, including lack of timely payment and administrative burdens:

- 71.2% of Illinois hospitals say the amount of time it takes to get paid by a Medicaid MCO has worsened in the last year; and
- More than one-third of Illinois hospitals (36.4%) have had to add staff to deal with the administrative burdens associated with Medicaid MCO contracts.5

Example

Develop a comprehensive oversight system methodology for Medicaid MCOs to better track and respond to all concerns made by beneficiaries, providers or other stakeholders. Building off of new mandates set forth by Public Act (PA) 99-0751, establish greater transparency, accountability and analytical expertise to improve data sharing from MCOs and various state agencies coordinating care, for more comprehensive care management, better state-health plan collaboration and to generate greater value from MCOs. PA 99-0751 was born of a need for beneficiaries, providers and the State to have publicly available data regarding the performance of the MCOs to assess not only individual MCO performance but also to evaluate the Medicaid Managed Care model.

The new law requires the Department of Healthcare and Family Services to develop and implement a Performance Metrics Report that publicly reports MCO performance in areas such as beneficiary complaints and rate of payment denials. Also, MCOs will be required to implement a process to improve accuracy of their provider directories to ensure that Medicaid beneficiaries and network providers have timely access to accurate network provider information.

5 IHA Medicaid Managed Care Impact Survey, February 2016
Reimbursement

New reimbursement models must be designed in a manner that encourages participation and be mutually agreed upon by providers and MCOs, with incentives aligned around realistic savings expectations. Building upon the current oversight system to ensure a comprehensive methodology would require minimal financial investment; however, stakeholder input would be critical. Stakeholder recommendations could also be used to target innovative federal funding streams that would transform the managed care model, like an 1115 waiver investment that would fund state-mandated coverage of mental health or substance use disorder benefits that are usually limited to crisis stabilization and ED telepsychiatry consultations, or enhance reimbursement for critical preventative and chronic care services.

SUPPORT PAYMENT REFORM FOR BEHAVIORAL HEALTH SERVICES

Background

Medicaid reimbursement continues to lag behind the rising costs of healthcare. As hospitals continue to care for uninsured or underinsured patients with complex needs, they face increasing difficulties cross-subsidizing from other departments to support inpatient and outpatient behavioral health services. Despite the flexibility to reimburse new behavioral health service options available under Medicaid managed care models, new administrative burdens, added payment barriers and payment delays are particularly challenging to under-resourced safety net hospitals that are dependent on Medicaid funding. Underfunded Medicaid rates for behavioral health must be evaluated and improved across the care continuum, while supporting opportunities to achieve greater value to payment systems as a whole.

Example

Two good first steps would be to improve parity between behavioral health benefits and medical and surgical benefits covered by Medicaid health plans, using parity provisions outlined in the Heroin Crisis Act (Public Act 99-0480), and for the state to convene stakeholders to obtain additional feedback. Establish funding for innovative programming for first episode psychosis identification, Mental Health First Aid, Zero Suicide and other evidence-based practices targeting prevention or early intervention, with the goal of increasing community social and emotional intelligence and response. This could include value-based incentive payments for hospital and community partnerships that target community benefit initiatives.

Reimbursement

Target provider and service rate enhancements for critically underfunded inpatient, outpatient and community-based behavioral health services like optional Medicaid mental health benefits (Rule 132) and substance use disorder treatment and intervention services (Rule 2090) to ensure care access and smooth transitions from our hospitals and health systems to post-acute care. Savings can be achieved by converting services traditionally reimbursed outside the
Medicaid State Plan by state General Revenue Funds, by adding to the Medicaid State Plan for federal reimbursement. AN 1115 Waiver or State Plan Amendment could be pursued for additional, regionally-targeted demonstration pilots.

**CONSIDER REGIONAL NETWORKS WITH DEDICATED EMERGENCY PSYCHIATRIC FACILITIES**

**Background**

Voluntary regional networks would establish a dedicated psychiatric hospital with an accompanying crisis stabilization unit. The regionalization of psychiatric care demonstrated in Alameda County, California, allows expedited transfers from local EDs to the designated psychiatric hospital. In 2012, the Joint Commission noted that boarding times in the ED can range from two hours or less to 24 hours or more, with behavioral health patients experiencing longer boarding times than medical or surgical patients.

**Example**

The Alameda model establishes a regionally dedicated psychiatric hospital with an accompanying crisis stabilization unit, which allows expedited transfers from local EDs for patients on involuntary mental health holds. This model reduced the length of boarding times in the ED 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.

**Reimbursement**

Funding for targeted, 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 the model implemented in Alameda County. Funding would include enhanced hourly crisis stabilization and care coordination services through an 1115 waiver for the targeted region’s qualifying patients.

**Quality Measures**

Performance metrics would track all ED 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 ED 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.
2017 Behavioral Health Advisory Forum Roster

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