



100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

SB2951

Introduced 2/14/2018, by Sen. Melinda Bush

SYNOPSIS AS INTRODUCED:

New Act

Creates the Early Mental Health and Addictions Treatment Act. Requires the Department of Healthcare and Family Services, and other specified agencies and entities, to develop a pilot program under which a qualifying adolescent or young adult may receive community-based mental health treatment from a youth-focused community support team for early treatment that is specifically tailored to the needs of youth and young adults in the early stages of a serious emotional disturbance or serious mental illness. Requires the Department to apply, no later than September 30, 2019, for any necessary federal waiver or State Plan amendment to implement the pilot program. Requires the Department to implement the pilot program no later than December 31, 2019 if federal approval is not necessary. Contains provisions concerning the creation of a community-based treatment model under the pilot program; the development of a pay-for-performance payment model; Department rules to implement the pilot program; and analytics and outcomes report. Requires the Department to develop an Assertive Engagement and Community-Based Clinical Treatment Pilot Program for individuals with opioid and other drug addictions. Contains provisions on in-office, in-home, and in-community services provided under the pilot program; application for a federal waiver or State Plan amendment to implement the pilot program; development of a pay-for-performance payment model; Department rules to implement the pilot program; and analytics and outcomes report. Effective immediately.

LRB100 18740 KTG 33974 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 1. Short title. This Act may be cited as the Early
5 Mental Health and Addictions Treatment Act.

6 Section 5. Medicaid Pilot Program; early treatment for
7 youth and young adults.

8 (a) The General Assembly finds as follows:

9 (1) Most mental health conditions begin in adolescence
10 and young adulthood, yet it can take an average of 10 years
11 before the right diagnosis and treatment are received.

12 (2) Over 850,000 Illinois youth under age 25 will
13 experience a mental health condition.

14 (3) Early treatment of significant mental health
15 conditions can enable wellness and recovery and prevent a
16 life of disability or early death from suicide.

17 (4) Early treatment leads to higher rates of school
18 completion and employment.

19 (5) Illinois' mental health system is aimed at adults
20 with advanced mental illnesses who have become disabled,
21 rather than focusing on youth in the early stages of a
22 mental health condition to prevent progression.

23 (6) Many states are implementing programs and services

1 for the early treatment of significant mental health
2 conditions in youth.

3 (7) The cost of early community-based treatment is a
4 fraction of the cost of a life of multiple
5 hospitalizations, disability, criminal justice
6 involvement, and homelessness, the common trajectory for
7 someone with a serious mental health condition.

8 (8) Early treatment for adolescents and young adults
9 with mental health conditions will save lives and State
10 dollars.

11 (b) As the sole Medicaid State agency, the Department of
12 Healthcare and Family Services, in partnership with the
13 Department of Human Services' Division of Mental Health and
14 with meaningful input from stakeholders, shall develop a pilot
15 program under which a qualifying adolescent or young adult, as
16 defined in subsection (d), may receive community-based mental
17 health treatment from a youth-focused community support team
18 for early treatment, as provided in subsection (e), that is
19 specifically tailored to the needs of youth and young adults in
20 the early stages of a serious emotional disturbance or serious
21 mental illness for purposes of stabilizing the youth's
22 condition and symptoms and preventing the worsening of the
23 illness and debilitating or disabling symptoms.

24 (c) Federal waiver or State Plan amendment; implementation
25 timeline.

26 (1) Federal approval. The Department of Healthcare and

1 Family Services shall submit any necessary application to
2 the federal Centers for Medicare and Medicaid Services for
3 a waiver or State Plan amendment to implement the pilot
4 program described in this Section no later than September
5 30, 2019. If the Department determines the pilot program
6 can be implemented without federal approval, the
7 Department shall implement the program no later than
8 December 31, 2019. The Department shall not draft any rules
9 in contravention of this timetable for pilot program
10 development and implementation. This pilot program shall
11 be implemented only to the extent that federal financial
12 participation is available.

13 (2) Implementation. After federal approval is secured,
14 if federal approval is required, the Department of
15 Healthcare and Family Services shall implement the pilot
16 program within 6 months after the date of federal approval.

17 (d) Qualifying adolescent or young adult. As used in this
18 Section, "qualifying adolescent or young adult" means a person
19 age 16 through 26 who is enrolled in the Medical Assistance
20 Program under Article V of the Illinois Public Aid Code and has
21 a diagnosis of a serious emotional disturbance as interpreted
22 by the federal Substance Abuse and Mental Health Services
23 Administration or a serious mental illness listed in the most
24 recent edition of the Diagnostic and Statistical Manual of
25 Mental Disorders. Because the purpose of the pilot program is
26 treatment in the early stages of a significant mental health

1 condition or emotional disturbance for purposes of preventing
2 progression of the illness, debilitating symptoms and
3 disability, a qualifying adolescent or young adult shall not be
4 required to demonstrate disability due to the mental health
5 condition, show a reduction in functioning as a result of the
6 condition, or have a reality impairment (psychosis) to be
7 eligible for services through the pilot program. A qualifying
8 adolescent or young adult who is determined to be eligible for
9 pilot program services before the age of 21 shall continue to
10 be eligible for such services without interruption through age
11 26 as long as he or she remains enrolled in the Medical
12 Assistance Program.

13 (e) Community-based treatment model. The pilot program
14 shall create youth-focused community support teams for early
15 treatment. The community-based treatment model shall be a
16 multidisciplinary, team-based model specifically tailored for
17 adolescents and young adults and their needs for wellness,
18 symptom management, and recovery. All services shall be
19 evidence-based or evidence-informed as applicable, and the
20 services shall be flexibly provided in-office, in-home, and
21 in-community with an emphasis on in-home and in-community
22 services. The model shall allow for and include each of the
23 following:

24 (1) Community-based, outreach treatment, and
25 wrap-around services that begin in the early stages of a
26 serious mental illness or serious emotional disturbance

1 (functional impairment shall not be required for service
2 eligibility under the pilot program).

3 (2) Youth specific engagement strategies to encourage
4 participation and retention in services.

5 (3) Same-age or similar-age peer services to foster
6 resiliency.

7 (4) Family psycho-education and family involvement.

8 (5) Expertise or knowledge in school and university
9 systems, special education and work, volunteer and social
10 life for youth.

11 (6) Evidence-informed and young person-specific
12 psychotherapies.

13 (7) Care coordination for primary care.

14 (8) Medication management.

15 (9) Case management for problem solving to address
16 practicable problems, including criminal justice
17 involvement and housing challenges; and assisting the
18 young person or family in organizing all treatment and
19 goals.

20 (10) Supported education and employment to keep the
21 young person engaged in school and work to attain
22 self-sufficiency.

23 (11) Trauma-informed expertise for youth.

24 (12) Substance use treatment expertise.

25 (f) Pay-for-performance payment model. The Department of
26 Healthcare and Family Services, with meaningful input from

1 stakeholders, shall develop a pay-for-performance payment
2 model aimed at achieving high-quality mental health and overall
3 health and quality of life outcomes for the youth, rather than
4 a fee-for-service payment model. The payment model shall allow
5 for service flexibility to achieve such outcomes and shall
6 cover actual provider costs of delivering the pilot program
7 services to enable sustainability. The Department shall ensure
8 that the payment model works as intended by this Section within
9 managed care.

10 (g) Rulemaking. The Department of Healthcare and Family
11 Services, in partnership with the Department of Human Services'
12 Division of Mental Health and with meaningful input from
13 stakeholders, shall develop rules for purposes of
14 implementation of the pilot program contemplated in this
15 Section within 6 months of federal approval of the pilot
16 program. If the Department determines federal approval is not
17 required for implementation, the Department shall develop
18 rules with meaningful stakeholder input no later than December
19 31, 2019.

20 (h) Pilot program analytics and outcomes report. The
21 Department of Healthcare and Family Services shall engage a
22 third party partner with expertise in program evaluation,
23 analysis, and research at the end of 5 years of implementation
24 to review the outcomes of the pilot program in stabilizing
25 youth with significant mental health conditions early on in
26 their condition to prevent debilitating symptoms and

1 disability and enable youth to reach their full potential. For
2 purposes of evaluating the outcomes of the pilot program, the
3 Department shall require providers of the pilot program
4 services to track the following annual data:

5 (1) days of inpatient hospital stays of service
6 recipients;

7 (2) periods of homelessness of service recipients and
8 periods of housing stability;

9 (3) periods of criminal justice involvement of service
10 recipients;

11 (4) avoidance of disability and the need for
12 Supplemental Security Income;

13 (5) rates of high school, college, or vocational school
14 engagement and graduation for service recipients;

15 (6) rates of employment annually of service
16 recipients;

17 (7) average length of stay in pilot program services;

18 (8) symptom management over time; and

19 (9) youth satisfaction with their quality of life,
20 pre-pilot and post-pilot program services.

21 (i) The Department of Healthcare and Family Services shall
22 deliver a final report to the General Assembly on the outcomes
23 of the pilot program within one year after 5 years of full
24 implementation compared to typical treatment available to
25 other youth with significant mental health conditions, as well
26 as the cost savings associated with the pilot program taking

1 into account all public systems used when an individual with a
2 significant mental health condition does not have access to the
3 right treatment and supports in the early stages of his or her
4 illness.

5 Section 10. Medicaid pilot program for opioid and other
6 drug addictions.

7 (a) Legislative findings. The General Assembly finds as
8 follows:

9 (1) Illinois' continues to face a serious and ongoing
10 opioid epidemic.

11 (2) Opioid-related overdose deaths rose 76% between
12 2013 and 2016.

13 (3) Opioid and other drug addictions are life-long
14 diseases that require a disease management approach and not
15 just episodic treatment.

16 (4) There is an urgent need to create a treatment
17 approach that proactively engages and encourages
18 individuals with opioid and other drug addictions into
19 treatment to help prevent chronic use and a worsening
20 addiction and to significantly curb the rate of overdose
21 deaths.

22 (b) With the goal of early initial engagement of
23 individuals who have an opioid or other drug addiction in
24 addiction treatment and for keeping individuals engaged in
25 treatment following detoxification, a residential treatment

1 stay, or hospitalization to prevent chronic recurrent drug use,
2 the Department of Healthcare and Family Services, in
3 partnership with the Department of Human Services' Division of
4 Alcoholism and Substance Abuse and with meaningful input from
5 stakeholders, shall develop an Assertive Engagement and
6 Community-Based Clinical Treatment Pilot Program for early
7 treatment of an opioid or other drug addiction.

8 (c) Assertive engagement and community-based clinical
9 treatment services. All services included in the pilot program
10 established under this Section shall be evidence-based or
11 evidence-informed as applicable and the services shall be
12 flexibly provided in-office, in-home, and in-community with an
13 emphasis on in-home and in-community services. The model shall,
14 at a minimum, allow for and include each of the following:

15 (1) Assertive community outreach, engagement, and
16 continuing care strategies to encourage participation and
17 retention in addiction treatment services for both initial
18 engagement into addiction treatment services, and for
19 post-hospitalization, post-detoxification, and
20 post-residential treatment.

21 (2) Case management for purposes of linking
22 individuals to treatment, ongoing monitoring, problem
23 solving, and assisting individuals in organizing their
24 treatment and goals. Case management shall be covered for
25 individuals not yet engaged in treatment for purposes of
26 reaching such individuals early on in their addiction and

1 for individuals in treatment.

2 (3) Clinical treatment that is delivered in an
3 individual's natural environment, including, in-home or
4 in-community treatment, to better equip the individual
5 with coping mechanisms that may trigger re-use.

6 (4) Coverage of provider transportation costs in
7 delivering in-home and in-community services in both rural
8 and urban settings. For rural communities the model shall
9 take into account the wider geographic areas providers are
10 required to travel for in-home and in-community pilot
11 services for purposes of reimbursement.

12 (5) Recovery support services.

13 (6) For individuals who receive services through the
14 pilot program but disengage for a short duration (a period
15 of no longer than 9 months), allow seamless treatment
16 re-engagement in the pilot program.

17 (7) Supported education and employment.

18 (8) Working with the individual's family, school, and
19 other community support systems.

20 (9) Service flexibility to enable recovery and
21 positive health outcomes.

22 (d) Federal waiver or State Plan amendment; implementation
23 timeline. The Department shall follow the timeline for
24 application for federal approval and implementation outlined
25 in subsection (c) of Section 5. The pilot program contemplated
26 in this Section shall be implemented only to the extent that

1 federal financial participation is available.

2 (e) Pay-for-performance payment model. The Department of
3 Healthcare and Family Services, in partnership with the
4 Department of Human Services' Division of Alcoholism and
5 Substance Abuse and with meaningful input from stakeholders,
6 shall develop a pay-for-performance payment model aimed at
7 achieving high quality treatment and overall health and quality
8 of life outcomes, rather than a fee-for-service payment model.
9 The payment model shall allow for service flexibility to
10 achieve such outcomes and shall cover actual provider costs of
11 delivering the pilot program services to enable
12 sustainability. The Department shall ensure that the payment
13 model works as intended by this Section within managed care.

14 (f) Rulemaking. The Department of Healthcare and Family
15 Services, in partnership with Department of Human Services'
16 Division of Alcoholism and Substance Abuse and with meaningful
17 input from stakeholders, shall develop rules for purposes of
18 implementation of the pilot program within 6 months after
19 federal approval of the pilot program. If the Department
20 determines federal approval is not required for
21 implementation, the Department shall develop rules with
22 meaningful stakeholder input no later than December 31, 2019.

23 (g) Pilot program analytics and outcomes report. The
24 Department of Healthcare and Family Services shall engage a
25 third party partner with expertise in program evaluation,
26 analysis, and research at the end of 5 years of implementation

1 to review the outcomes of the pilot program in treating
2 addiction and preventing periods of symptom exacerbation and
3 recurrence. For purposes of evaluating the outcomes of the
4 pilot program, the Department shall require providers of the
5 pilot program services to track all of the following annual
6 data:

7 (1) Length of engagement and retention in pilot program
8 services.

9 (2) Recurrence of drug use.

10 (3) Symptom management (the ability or inability to
11 control drug use).

12 (4) Days of hospitalizations related to substance use
13 or residential treatment stays.

14 (5) Periods of homelessness and periods of housing
15 stability.

16 (6) Periods of criminal justice involvement.

17 (7) Educational and employment attainment during
18 following pilot program services.

19 (8) Enrollee satisfaction with his or her quality of
20 life and level of social connectedness, pre-pilot and
21 post-pilot services.

22 (h) The Department of Healthcare and Family Services shall
23 deliver a final report to the General Assembly on the outcomes
24 of the pilot program within one year after 5 years of full
25 implementation. The analysis shall include the cost of the
26 pilot program compared to the cost of treatment as usual,

1 including the use of all other public systems when access to
2 addiction treatment is not available.

3 Section 99. Effective date. This Act takes effect upon
4 becoming law.