Illinois Department of Healthcare and Family Services
Integrated Health Homes (IHH) Frequently Asked Questions
Updated September 21, 2018

Overview – Added August 23, 2018 – IHH Webpage

1. **Question: What is an Integrated Health Home?**
   Answer: An Integrated Health Home is a new, fully-integrated form of care coordination for all members of Illinois Medicaid. The Integrated Health Home will coordinate physical, behavioral, and social healthcare for its members, either as a single entity or through collaborative agreements with multiple entities. An Integrated Health Home is responsible for care coordination for members but would not be responsible for provision of all services and treatment to members. An Integrated Health Home is not a gatekeeper for services and will still be required to seek prior approval for services when necessary.

2. **Question: What populations can an Integrated Health Home serve?**
   Answer: Integrated Health Homes (IHH) are designed for all Medicaid members in Illinois except for select technical exclusions (i.e., members with partial benefits, MMAI duals, and members with high third-party liabilities). Additionally, members enrolled in long-term care for more than 90 days will have their Integrated Health Home care coordination suspended. IHH enrollment for members in Tiers A, B andC is targeted to begin January 1, 2019. Members in Tier D will be enrolled at a later date.

3. **Question: Will the IHH model include both children and adults?**
   Answer: Yes, Illinois' Integrated Health Home (IHH) model includes both populations. Federal CMS felt strongly that an IHH must be able to serve a family, without family members being required to enroll with different IHH providers. However, IHH's may decide to employ different strategies for different populations in their design.

Additional FAQs – Added August 31, 2018

4. **Question: Can an IHH be specialized for a particular type of population? For example, can DD providers create an IHH for DD members only and their families with partnerships with other providers?**
   Answer: Illinois' Integrated Health Home (IHH) model must include capacity for all eligible populations. However, IHH's may decide to employ different strategies for different populations in their design. HFS encourages providers to partner with specialized entities and build on their strengths.

5. **Question: Where do we find the A, B, C, and D requirements?**
   Answer: All of the requirements for Integrated Health Homes including the tier requirements can be found at:
   https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/IntegratedHealthHomes.aspx

6. **Question: Will each IHH have a dedicated phone number that can be placed on the ID card?**
   Answer: The Department is not going to dictate this level of information for the MCO ID cards.

7. **Question: Will there be any financial support for startup related expenses (hiring on doctors /nurse / etc.)?**
   Answer: There is no funding for start-up costs.

8. **Question: Will there be a published list of IHH's in geographic area?**
   Answer: Yes

9. **Question: With all due respect, this seems to be a costly endeavor, particularly to non-profits. Where do suggest a non-profit seek funding for this project?**
   Answer: There is no funding for start-up costs.

10. **Question: Who will be the administrators of the IHH?**
    Answer: Each IHH will be organized individually and must make their own determinations regarding internal administration structures.

Additional FAQs – Added September 20, 2018

11. **Question: Can IHHs limit the number of enrollees as long as they accept at least 500 members?**
    Answer: Yes. While an IHH must have at least 500 continuous members for 6 months in order to qualify for bonus payments, an IHH must only take as many members as according to their enrollment in IMPACT for staffing levels as well as who choose (or are assigned) to the IHH.

12. **Question: Does the staff meeting the ratio have to be located at the same site?**
    Answer: No. The required professional staff must be linked by contractual agreements but are not required to be co-located.

13. **Question: In regard to submitting the care coordination codes can the Department speak to the following language from the SPA: as appropriate (and subject to final guidelines issued by the State) completed activities may merit a claim not only via direct in-person provision to the member, but also if appropriate, telephonically (or through other means of electronic communication) or if appropriate, to the member's immediate collaterals and caregivers?**
    Answer: Telehealth services provided in accordance with 89 Illinois Administrative Code Section 140.403 may qualify as a face-to-face visit.

14. **Question: Are all ICFs and SMRHFs considered long term care facilities?**
    Answer: Members with extended stays (more than 90 days) in either of these facilities will not be included in the IHH program.

15. **Question: Can an IHH close to new assignments once they have reached capacity?**

Answer: Yes, an IHH may limit enrollment. However, minimum panel sizes are required to qualify for the annual bonus payments. Please refer to the Staffing Ratios that are posted on IHH webpage for specific staffing requirements.

16. **Question: Can one IHH partner/contract with another IHH to manage individuals they may have more experience with?**
Answer: Yes, or these entities may wish to consider becoming an IHH together.

17. **Question: Do you specify which members of the care coordination team, if any, must be full time dedicated members of the care coordination team?**
Answer: An IHH must employ or contract with appropriate core team to meet the required ratios for their client mix. Please refer to the Staffing Ratios that are posted on IHH webpage for specific staffing requirements.

18. **Question: Is there a cap on enrollment after panel size is achieved?**
Answer: No, unless an IHH does not staff appropriately for the increased panel size. Please refer to the Staffing Ratios that are posted on IHH webpage for specific staffing requirements.

19. **Question: The communication that will be going out to the clients, outlining IHH, will it be in languages other than English?**
Answer: Communications are available in English and Spanish. If member has designated Spanish as their preferred language, then Spanish materials are sent. Additionally, a language block will be included with the most frequently spoken languages, which includes how to contact translation services for those languages.

20. **Question: Will IHHs be able to limit their geography or panel size? What will happen if there is part of the state that does not have an IHH signed up?**
Answer: An IHH chooses the geography where the entity is available to service clients and staffs to the appropriate panel size. Size is a factor of staffing.

Provider Requirements, Expectations and Staffing Ratios – Added August 23, 2018 – Webinar Posting

21. **Question: Are any providers excluded from enrolling as an IHH?**
Answer: Any provider or practice enrolled in the Medical Assistance Program is eligible to be an Integrated Health Home as long as they meet all of the requirements of an IHH (such as required staff) and sign a supplemental provider agreement.

22. **Question: Must an IHH serving Tier A members, also serve Tiers B, C and D?**
Answer: Yes, IHHs serving Tier A members must also serve Tiers B, C, and D. IHHs serving Tiers B members must serve Tier D as well. IHHs serving Tier C members, must serve Tier D as well. Specifics on Tier D IHHs will be provided later after approval of a separate State Plan Amendment. The Department encourages partnering with other providers / entities to cover required populations outside your area of specialty.

23. **Question: Some organizations may already have agreements and linkages with multiple service providers. Is this allowable?**
Answer: To be enrolled as an IHH, the IHH must have all required staff secured either through contracts or through collaborative agreements. The IHH must enroll as a new Provider Type with a new NPI. Agreements and linkages with other providers may be advantageous for an IHH but is not required.

24. **Question: If an IHH has a memorandum of understanding or agreement with an underperforming provider, how can they address this problem?**
Answer: The IHH (with assistance from the MCO) should work with that provider to try to improve his or her performance. If that does not work, the IHH may choose to work with the MCO to encourage referrals to another provider. The IHH must notify HFS of any changes in provider associations on IMPACT.

25. **Question: What if the member continues to choose the underperforming provider?**
Answer: As the care coordinator, the IHH has the responsibility to work with an underperforming provider to improve their services, as well as with the member to help him or her understand the potential consequences of their choice.

26. **Question: What is impact on smaller providers that might not have infrastructure?**
Answer: The expectation is that smaller providers who are offering quality services to members will continue to do so. Smaller providers may want to join with other entities to create IHHs that can offer care coordination to members. However, this project is designed to drive relationship development between care coordination and providers, not to force all providers to become IHHs. We will need IHHs and we will need quality providers offering direct services to members. MCOs, IHHs and providers are all necessary as we work toward the same goal for better outcomes for members.

27. **Question: What if required staff are affiliated with a different IHH?**
Answer: That is OK. This is a collaboration model. Required staff can be affiliated with multiple IHHs. The IHH's main concern is that they have agreements that cover all required staff members. If required staff have the capability, they may be involved in multiple IHHs.

28. **Question: Will there be requirements for IHHs established by MCOs separate from HFS?**
Answer: HFS is establishing the baseline requirements for IHHs. MCOs may develop enhanced contracting requirements with each IHH that are over and above the HFS requirements. However, HFS will only reimburse IHHs at the established PMPM for each of the tiers. If MCOs establish additional contracting requirements, reimbursement or other accommodations over and above the established PMPM will have to be agreed upon between the MCO and the IHH.

29. **Question: Does an MCO have to contract/enroll all IHHs in their network?**
Answer: No. MCOs must demonstrate network adequacy but are not required to contract with all IHHs. Members have ability to change MCO based on IHH selection during annual choice process.

30. **Question: Can IHH choose geographic region?**
Answer: Yes

31. **Question: What is contractual relationship between PCP and MCO if PCP is not enrolled in client's IHH?**
Answer: PCPs will continue to contract with MCO(s) and will be able to offer primary care services to clients regardless with which IHH the client is enrolled. The IHH will want to establish a relationship with the PCP to ensure that the IHH is able to effectively communicate with the PCP for the purposes of care coordination. However, a PCP is encouraged to also contract with and/or collaborate with one or more IHHs to assist in meeting the needs of their members.

32. **Question: Are there staffing requirements?**
Answer: Information regarding the staffing requirements may be found in the IHH Town Hall Presentation located on the IHH Web site

33. **Question: Is there an expectation that IHHs will monitor provider performance?**
Answer: It is in the best interest of the IHH to engage with collaborating providers to achieve desired outcomes. Provider performance will affect the outcomes and value-based payments to any IHH, as well as to any MCO. The approach to monitoring any individual provider should be worked out between the MCO in its role as the care monitor and the IHH in its role as the care coordinator.

34. **Question: Can the IHH subcontract care coordination activities if the subcontractor can do it better?**
Answer: Yes. It is important to ensure that members' needs and those of their family are met, so if a subcontractor is better suited to perform this task, that contractual relationship should be established by the IHH.

35. **Question: Will/could physician groups lose their panel of patients to IHHs?**
Answer: No. IHHs will only be providing care coordination, not direct services. Physician groups member panels should not be impacted.

36. **Question: How is high fidelity wraparound handled in the IHH model?**
Answer: It is not specifically required in the model. However, IHH may certainly use that model for appropriate populations, but it will not be dictated by HFS.

37. **Question: Some providers already do care coordination. Must they still have collaborative agreements?**
Answer: To be enrolled as an IHH, the IHH must have all required staff secured either through contracts or through collaborative agreements. The IHH must enroll as a new Provider Type with a new NPI.

Additional FAQs – Added August 31, 2018

38. **Question: Can an MCO be an IHH?**
Answer: No. However, an MCO can certainly support any contracted IHHs through sharing of systems, data, best practices and other support and expertise. Remember, the MCO and IHH are strategic partners joining together to serve the beneficiary.

39. **Question: If we are strictly a Behavioral Health provider (Mental Health and Substance Abuse) how do we become part of the IHH/ensure that we are on the list of "preferred" behavioral health providers? Do we need to go out and contract with an IHH?**
Answer: The IHH initiative does not impact a provider's ability to provide services. Providers are encouraged to develop strategic alliances with as many IHHs and MCOs as your capacity allows.

40. **Question: If we were to contract for the medical staff with a local hospital, it sounds like they will be doing duties outside of their regular billable opportunities, in which case I would assume we would need to financially compensate them?**
Answer: The financial relationship in and among the IHH core professionals will not be prescribed by HFS, but the core professionals must be contracted in some way if not employed by the IHH lead provider.

41. **Question: If one of the required professionals leaves the IHH, what is the required time frame that the IHH would have to replace that professional?**
Answer: The IHH must notify the Department of any change of partner entities within three (3) business days of the change and submit a copy of any contractual or collaborative agreement with a new partner entity within ten (10) business days of the change. This requirement will be detailed in the IHH Provider Agreement.

42. **Question: Do individual providers need to have agreements with every MCO?**
Answer: Nothing about the IHH initiative affects provider relationships with or requirements by MCOs.

43. **Question: How many IHH will be selected at the state or regional level?**
Answer: HFS will not place a cap on the number of IHHs that are allowed to enroll. MCO contracting is a second component of the equation and MCOs must maintain an adequate network.

44. **Question: All providers in an IHH must be contracted with the MCO?**
Answer: The IHH itself is the entity that must have the contract with an MCO. Core professionals within that IHH must have collaborative agreements with each other / the IHH and be attributed to the IHH in the HFS IMPACT enrollment process as well as have Medicaid provider identification numbers.

45. **Question: So we could make a collaborative agreement with a provider that gives primary care and signs up to be an IHH but we (the Behavioral health specialists) would still be eligible to be in the IHH?**
Answer: A provider may be a core professional in more than one IHH. An individual professional's time may not exceed one (1) FTE across all IHHs. For example, if a professional's time is required at 20% (0.2 FTE) for each IHH of 500 clients, that professional may not be the required professional in more than 5 IHHs.

46. Question: What if the IHH providers with whom they have agreement are NOT contracted with the MCO?

Answer: Core professionals within the IHH do not have to have individual contracts with a given MCO; however, the IHH entity must contract with an MCO to be chosen or assigned clients from that MCO.

47. Question: When do the IHH start and what's the evaluation period i.e. annually or quarterly reports back to the IHH?

Answer: IHH begins for Tiers A, B, and C on January 1, 2019. Quarterly reports will show most recent activity to give IHH updates on their performance with clients. Six months after the end of each calendar year to allow for claim run out, an (annual) evaluation will be completed and appropriate incentive/bonus payments will be made.

48. Question: Will IHH be able to issue referrals to specialists? Even if they are CMHCs?

Answer: The IHH does NOT authorize services. They should have relationships with MCO contracted providers in order to meet the required appointment standards. If a service requires prior authorization, that will continue to be secured from an MCO or HFS, as appropriate. IHHs can and should advocate on behalf of their members to ensure that needed services are available and accessed.

49. Question: Will sub-contracted providers be required to obtain authorization for services from the IHH prior to service delivery?

Answer: No.

50. Question: Would the client require a new consent form under IHH?

Answer: The consent form will be needed to allow the exchange of information for the purpose of care coordination. HFS is preparing a consent form template for use by the IHH. The template will be posted to the IHH web site in the near future.

51. Question: If a provider needs a minimum of 500 participants, how can we insure that we have that number that will be assigned to us, or exist in our area?

Answer: IHHs will need a minimum of 500 participants to qualify for incentive / bonus payments. However, HFS may approve a smaller panel based on limited availability of members in a geographical area.

52. Question: The IHH provider will receive the PMPM along with the incentive payment, please confirm it is their responsibility to distribute the payment to the other providers making up the IHH. Will HFS require the IHH to distribute the funding in a specific manner?

Answer: The financial relationship in and among the IHH core professionals will not be prescribed by HFS, but the core professionals must be contracted in some way if not employed

by the IHH lead provider (and these contracts / collaborative agreements must be shared as part of the enrollment process).

53. **Question: What is minimum number of individuals in an IHH?**
Answer: An IHH must build capacity for at least 500 individuals across all tiers.

54. **Question: Can a care coordinator work for more than one IHH?**
Answer: Yes. An individual professional's time may not exceed one (1) FTE across all IHHs. For example, if a professional's time is required at 20% (0.2 FTE) for each IHH of 500 clients, that professional may not be the required professional in more than 5 IHHs.

55. **Question: Can primary care providers be in more than one IHH?**
Answer: Yes. Primary care providers can participate in more than one IHH. An individual professional's time may not exceed one (1) FTE across all IHHs. For example, if a professional's time is required at 20% (0.2 FTE) for each IHH of 500 clients, that professional may not be the required professional in more than 5 IHHs.

56. **Question: How will patient information be shared between the interdisplinary team in the IHH in the context of regulations around medical records privacy and confidentiality?**
Answer: The consent form will be needed to allow the exchange of information for the purpose of care coordination. HFS is preparing a consent form template for use by the IHH. The template will be posted to the IHH web site in the near future.

57. **Question: How will IHH work in rural areas? Can you also elaborate on the 500 panel capacity requirements and how accessibility and availability of services in rural areas may impact IHH?**
Answer: IHH requirements for staffing ratios and care coordination capabilities will be consistent statewide. IHHs will need a minimum of 500 participants to qualify for incentive / bonus payments. However, HFS may approve a smaller panel based on limited availability of members in a geographical area.

58. **Question: For patients that have not received behavioral services before, who will determine which behavioral health provider they go to?**
Answer: IHHs are responsible for understanding individual's needs as they arise and ensuring that they are connected to providers who are capable of meeting their needs.

59. **Question: Can a hospital become an IHH, by itself? As a part of a group?**
Answer: Any provider may be the lead in an IHH; however, the appropriate core professionals must be contracted by the IHH in some way if not employed by the IHH lead provider (and these contracts / collaborative agreements must be shared as part of the enrollment process).

Additional FAQs – Added September 12, 2018

60. **Question: Can you please clarify the clinical care coordinator requirements? It states the coordinator must have a minimum of a bachelor's degree and license and certifications. What license and certifications are you referring to?**
Answer: The clinical care coordinator must possess a minimum of a bachelor's degree and demonstrate previous case management experience. However, if a licensed staff is fulfilling the role of the clinical care coordinator, then there must be evidence that their license is active and in good standing with the licensing body.

61. **Question: Can you please clarify the role of the provider rendering the services (i.e. physical or BH) in the interdisciplinary team? How will they work with the core team?**
Answer: The IHH core team must collaborate with the provider of services to coordinate the integrated care of the member. All other services will be billed by the provider of the services as it is done today, not the IHH.

62. **Question: Clinical care coord; that bachelor's degree may eliminate LPNs from serving in this role**
Answer: Clinical care coordinator requires a minimum of a bachelor's degree.

63. **Question: Does the provider have to meet the staffing requirements at the time of the start of the contract?**
Answer: At the time of application, the IHH must show that they have met all the core professionals requirements that are appropriate for the tier and panel size the IHH will serve. As the make-up of the panel size becomes finalized, appropriate adjustments should be made to ensure staffing ratio requirements are met at the time of program launch. HFS will need to be informed of any changes in the required IHH core team professionals through the enrollment and certification process (IMPACT). Please refer to the Staffing Ratios that are posted on IHH webpage for specific staffing requirements.

64. **Question: Is it required that a live care coordinator is available 24/7? What is the expectation for the 24/7 requirement?**
Answer: An IHH must provide direct access to members for coverage 24 hours a day, seven days a week, at the very least through an answering service/direct notification mechanism or other approved arrangement , e.g., secure electronic messaging system and/or video conferencing system to offer interactive clinical advice to members. In addition, providers must develop emergency contact protocols for members to establish contact with clinical personnel directly during crisis situations, and protocols for timely sharing of information with other providers relevant to members' care.

65. **Question: What level does an APN fall under?**
Answer: An APN can be the nurse care manager.

66. **Question: Is there a prescribed frequency for the interdisciplinary meetings?**

Answer: No, the interdisciplinary meetings shall be held as often as necessary for the care coordination of the member. The IHH must submit the appropriate care coordination service for the interdisciplinary meetings.

67. **Question: Does the required staff need to be on staff with the participating agency (in our case a health system) or can we contract for some of the services. We have all staff employed by our entity except for a substance abuse specialist.**
Answer: The appropriate core professionals must be contracted by the IHH in some way if not employed by the IHH lead provider (and these contracts/collaborative agreements must be shared as part of the enrollment process).

68. **Question: Can the collaborating network contain providers not participating in a specific MCO?**
Answer: The IHH itself is the entity that must have the contract with an MCO. Core professionals within that IHH must have contractual agreements with each other. However, those core professionals must have a Medicaid provider ID number and must associate with the IHH in IMPACT.

69. **Question: Are there a minimum number of collaborative agreements that must be in place if we have all the necessary elements within our health home?**
Answer: No. There is not a minimum number of collaborative agreements for the core professionals of the IHH in order to provide the care coordination services. However, the expectation is that the IHH will work with as many of providers and professionals in the lives of the beneficiary to provide the care they need.

70. **Question: Who qualifies as a Mental Health Specialist? APN with psychiatric specialty?**
Answer: Psychiatrist, psychologist or other behavioral health specialist possessing appropriate clinical licenses and/or professional certifications qualifies as a Mental Health Specialist. An APN with a psychiatric specialty would meet the qualifications of a mental health specialist.

71. **Question: Are the professionals listed in the slide required to be on staff? Or can their services be enlisted via a networking/partnering agreement?**
Answer: Any provider may be the lead in an IHH; however, the appropriate core professionals must be contracted by the IHH in some way if not employed by the IHH lead provider (and these contracts/collaborative agreements must be shared as part of the enrollment process).

Additional FAQs – Added September 21, 2018

72. **Question: Can HFS please clarify exactly what credentials are necessary for the SUD Specialist in the IHH required professionals? Does this person need certification specifically in SUD treatment? Would a licensed clinician with experience in SUD treatment qualify?**
Answer: The SUD Specialist must hold a clinical certification as a Certified Alcohol and Drug Counselor from the Illinois Alcoholism and Other Drug Abuse Professional Certification

Association (IAODAPCA), OR hold assessor certification as a Certified Assessment and Referral Specialist (CARS) from IAODAPCA.

73. **Question: Please clarify the role of the required staff: are they intended to be provider relationships that ensure the ability to meet timely appointment standards? Or are they intended to provide program supervision only? The latter significantly adds to the cost of coordination service, particularly as the coordinators will also be working with the relevant specialists specifically assigned to each member.**
Answer: Please refer to the Town Hall and Provider Requirements webinars posted on IHH webpage for further information regarding the role of the Required Staff.

74. **Question: If an entity does not have a MD/RN on staff, is it able to meet that staff requirement via MOU with a medical provider.**
Answer: Yes

75. **Question: Are we required to have multiple behavioral health type staff, i.e., licensed clinical social worker AND psychologist AND psychiatrist? Is one type sufficient?**
Answer: Please refer to the Staffing Ratios that are posted on IHH webpage for specific staffing requirements.

76. **Question: What are the requirements (certification/etc.) for the recovery support specialist?**
Answer: The SUD Specialist must hold a clinical certification as a Certified Alcohol and Drug Counselor from the Illinois Alcoholism and Other Drug Abuse Professional Certification Association (IAODAPCA), OR hold assessor certification as a Certified Assessment and Referral Specialist (CARS) from IAODAPCA.

77. **Question: Can a mid-level (APN) be used for the physician time?**
Answer: No.

Enrollment in the IMPACT System – Added August 23, 2018 – Webinar Posting

78. **Question: What will the IHH contract with the State look like?**
Answer: Providers seeking to become IHHs will be credentialed through the IMPACT system and will have to sign a specific provider agreement with the State (see slides on IMPACT enrollment link), not a contract. Organizations will need a new NPI and will only bill for care coordination services that qualify for reimbursement under one of five care coordination codes under the new NPI. IHHs will need to bring associated entities together through contracts or collaborative agreements outlining which entity handles which aspect of the IHH requirements and how funding is distributed amongst the IHH entities. A contract will also need to be signed between the MCO and the IHH to serve participants in MCOs.

79. **Question: IHHs serving individuals in Tiers A, B and C must have a new NPI, provider agreement and enroll in IMPACT?**

Answer: Yes, IHHs serving individuals in Tiers A, B and C must secure a new NPI, provider agreement and enroll in IMPACT. In addition, they must also contract with one or more Managed Care Organizations (MCOs). An IHH will only need one contract per MCO, meaning they do not have to have a separate contract for each tier that they are prepared to serve.

80. **Question: How is agency with multiple locations registered in IMPACT?**
Answer: An IHH can add service locations in IMPACT. Please refer to the IHH Enrollment in IMPACT presentation for additional information.

81. **Question: Will IHHs have to provide associated relationships?**
Answer: For purposes of IMPACT enrollment and billing/payment, HFS will need to be informed of any changes in the required IHH core team professionals through the enrollment and certification process (IMPACT).

82. **Question: If organizations are not ready by January 1, 2019, can IHH enroll later?**
Answer: Like any Medicaid provider, the IHH may enroll at any time. It would be to the advantage of the IHH to participate during the initial rollout as members are participating in the HealthChoice Illinois open enrollment period. This may give the IHH maximum opportunity to enroll members.

Additional FAQs – Added August 31, 2018

83. **Question: Do we have to have all of our contracts with MCOs, partner organizations, etc. in place before we apply to become in IHH? If so, it may be hard to get MCOs, etc. to sign contract with us before we become an IHH. Can we have a grace period after we apply to get the necessary contracts in place?**
Answer: As soon as an IHH has amassed the required professionals and other requirements, the IHH may begin registration with HFS in IMPACT (see webinar). Contracting with the MCOs can occur on a parallel track but the IHH must have a Medicaid provider number to sign a contract with the MCO. As soon as the IHH is enrolled in IMPACT (and after Jan 1 2019), an IHH may serve FFS clients.

84. **Question: IHH needs a unique NPI? What taxonomy code does HFS want used for IHH?**
Answer: Yes, each IHH will need a unique NPI. The taxonomy code which should be used is 171M00000X.

Additional FAQs – Added September 12, 2018

85. **Question: Do all providers use the same NPI that is designated for the Health Home?**
Answer: The IHH as an entity will have an NPI for billing the five care coordination codes. These are the only codes that can be billed with the IHH NPI. The core professional staff required in the staffing ratios will use their unique NPI as the rendering provider. All other services will be billed by the provider of the services as it is done today, not the IHH.

86. **Question: Are you having a single NPI for the health home or does each provider have to have a new NPI for the health home?**

Answer: Only the IHH needs to acquire a new NPI for billing the five care coordination codes.

87. **Question: Does a provider need an NPI for each site of the IHH or one for the whole IHH?**
Answer: The IHH only requires one NPI to bill the five care coordination codes. Additional sites may be added as other servicing locations in IMPACT.

88. **Question: Each IHH needs to have its own unique tax ID number. Will both employed and contracted professionals be required to bill under this tax ID number?**
Answer: Only the five care coordination codes will be billed by the IHH under their new unique NPI and current tax ID. Please refer to the Provider Enrollment presentation for additional information.

89. **Question: Will all providers, employed and contracted, need to bill under the IHH tax ID number?**
Answer: See response to question 71.

90. **Question: Someone mentioned a separate Tax-id. Please confirm that only a separate NPI is needed and not a separate tax entity.**
Answer: A unique NPI is needed and a separate unique tax ID is not necessary.

91. **Question: Where should a new organization that is interested in Health Home go to register? Is it to DASA/SURP?**
Answer: Please refer to the IHH Enrollment in IMPACT presentation for additional information.

92. **Question: It was mentioned that an IHH will have to submit an attestation or provide copies of contracts when enrolling in IMPACT. How will IMPACT determine if the prospective IHH has an adequate network?**
Answer: The IHH must meet staffing ratios as required in the IHH provider agreement. The IHH will be monitored closely through the quality measures and by care monitoring by the MCO's and HFS for FFS.

93. **Question: Please provide examples of atypical providers.**
Answer: Atypical providers do not have NPI's because the services they provide are not typical medical services. Examples of an atypical provider are personal assistant, service coordinator, nutritionist, case manager. Atypical providers will need to be enrolled as a Medicaid provider and be attributed to the IHH in the HFS IMPACT enrollment process.

Additional FAQs – Added September 21, 2018

94. **Question: Prior to provider enrollments through IMPACT to become an IHH, how will be known which tiers we should be enrolling for? When will we know when the tiers are issued to our current clients?**

Answer: The IHH should enroll for the appropriate tier based on the staffing and clinical expertise that they are able to support. Please refer to the Staffing Ratios that are posted on IHH webpage for specific staffing requirements.

95. **Question: What specialty do we select when applying for the NPI?**
Answer: For individuals - Case Manager/Care Coordinator - **171M00000X**
For agencies - Case Management - **251B00000X**

96. **Question: What is the deadline to apply and be approved in order to be available for selection by members, or auto assignment of members?**
Answer: Tiering of members for tiers A, B and C will begin in mid-October and will be on going. There is no specific deadline for enrollment of the IHH. Enrollment of IHH providers will occur on an ongoing basis.

97. **Question: With having a separate NPI and the billing limitations does it make a difference if the agency is a CMHC or a BHC?**
Answer: No. A CMHC or BHC may enroll as an IHH with a separate NPI and appropriate staffing for the tier they wish to serve.

98. **Question: If we have FAO locations enrolled with IMPACT where do we add the IHH under the specialties?**
Answer: A new FAO enrollment must be submitted for the IHH using the IHH owner's tax ID and new NPI (IHH NPI). On step 3 of the enrollment, the IHH will choose provider type "Integrated Health Home," Specialty "Integrated Health Home," and the Subspecialty will be the tier that the IHH wishes to serve. Please refer to the IHH Enrollment in IMPACT presentation for additional information.

99. **Question: Will the IHH have its own Provider Information Sheet?**
Answer: Yes.

100. **Question: On one slide, it states that IHH (providers) will begin enrolling in IMPACT in mid-September. When will HFS notify those agencies that fit the criteria as IHHs? Also can you explain that process?**
Answer: After submission of the IMPACT enrollment, HFS will send an e-mail to the contact e-mail address on the enrollment requesting the additional documentation needed for the IHH enrollment. Once all documentation is received and reviewed, HFS will approve the IMPACT enrollment. An approval e-mail will be sent by IMPACT to the contact e-mail address and to the e-mail address of the person who submitted the enrollment. A provider information sheet will be generated by the HFS Legacy MMIS and will be mailed to the payee address.

101. **Question: Since IMPACT is an enrollment system, is it possible that a Provider would NOT be approved for the TIER election and therefore be reassigned a different TIER level? The**

question pertains to what the ACTAUL TIER value would be for a provider from a Provider Roster value perspective

Answer: HFS will not reassign an IHH to a different tier level. If the IHH does not meet the requirements for a tier, HFS would contact the IHH to review and revise the IMPACT enrollment. HFS will not make changes to an IMPACT enrollment.

102. **Question: So does each provider need to associate with the IHH through the IMPACT system?**
Answer: The only providers that need to be associated to the IHH are the core professionals that will be providing the care coordination services.

103. **Question: What is the deadline for signing up to be an IHH for the rollout of this program?**
Answer: There is no specific deadline for the rollout. The IHH will need to have an approved enrollment and the appropriate capacity and associations with all required professionals to begin serving members. Enrollment of IHH providers will occur on an ongoing basis.

Attribution, Tiering and Assignment – Added August 23, 2018 – Webinar Posting

104. **Question: How will HFS tier children?**
Answer: The Department has developed a model grouping individuals by their level of need across two domains: physical health and behavioral health. Members with high levels of need across both domains will receive the highest levels of support. Member tier assignment will be determined based on behavioral health and physical health needs. Behavioral health needs definitions will be determined based on Illinois-specific data analysis. Physical health needs will be defined using commercially-available risk-adjustment software (e.g., 3M CRG™).

105. **Question: Can we get the geographic location of Illinois Medicaid members currently attributed to Tier A?**
Answer: HFS is sharing aggregate regional data of individuals stratified by tier, effective August 2018. While this will change somewhat prior to October, it should be a fair proxy for the types of clients in each county/geographic area. Once assigned to an MCO, that MCO will know the client's tier and should share with the IHH. Please refer to the Attribution, Tiering and Assignment presentation for additional information.

106. **Question: How often will members be re-evaluated or re-tiered?**
Answer: Retiering will occur on a quarterly basis using claims data received during the previous quarter. Additionally the IHH or MCO could request that a member be retiered outside of the regular schedule if a "triggering event," such as a hospitalization or other significant change in the member's condition, occurred.

107. **Question: How will providers know what tier a member is in?**
Answer: An IHH indicator will replace the PCP indicator on the HealthChoice Illinois Plan card. MEDI will allow for viewing of tiers.

108. **Question: Children identified with complex medical needs by the Department may not match the MCO's tiering. Can children be retiered?**
Answer: The Department will be retiering on a quarterly basis. MCOs who feel a member is not in the appropriate tier may submit an appeal to the Department.

109. **Question: Are there other factors such as social determinants of health and justice involvement as part of tiering?**
Answer: Social determinants are not factored in tiering at this time but could be considered at a later date. Certainly, we hope the IHH will focus on these issues for their membership.

110. **Question: Who is deciding on the IHH for complex patients - the state or the MCO?**
Answer: HFS will complete the tier assignments for individuals. Individuals will have an opportunity to choose an IHH. If they do not select an IHH, then they will be auto-assigned to an IHH.

Additional FAQs – Added September 12, 2018

111. **Question: Will we know the client tiers prior to enrollment?**
Answer: HFS is sharing aggregate regional data of individuals stratified by tier, effective August 2018. While this will change somewhat prior to October, it should be a fair proxy for the types of clients in each county/geographic area. Once assigned to an MCO, that MCO will know the client's tier and should share with the IHH. Please refer to the Attribution, Tiering and Assignment presentation for additional information.

112. **Question: When will we see the heat map to see the number of qualified members in our area?**
Answer: The webinar on Attribution, Tiering and Assignment contains a statewide map with the aggregate regional data of individuals stratified by tier, effective August 2018. Tiering depicted in the map is preliminary and will be updated prior to final assignment.

113. **Question: Will auto assignment be performed by the state or the MCO and if performed by the state, will the MCO have any involvement in the assignment?**
Answer: Auto assignment will be performed by the state.

114. **Question: Is there a timeline for when Tier D participants will be enrolled into IHH's?**
Answer: Stay tuned for further information in calendar year 2019.

Additional FAQs – Added September 21, 2018

115. **Question: The state does the attribution based on the MCO that the patient is in?**
Answer: No, the attribution is based on a history of services and diagnoses or qualifying event regardless of which plan they are in or FFS.

116. **Question: I know 18 months of utilization data was used, but what 18 month period? What year did the 18 months start?**
Answer: We use the most recent enrollment and then 18 months of claims data back from that date and it will be updated on a quarterly basis.

117. **Question: So if client has diagnosis in category 3 with no self-harm they are considered to have low BH needs?**
Answer: If a person in category 3 has had one of the diagnosis in one of the facilities listed in the past 12 months then they are considered high behavioral health.

118. **Question: So if there is an individual with a Substance Use Disorder and no other qualifying medical conditions would they be put into Tier A or Tier B Hypothetically?**
Answer: Tier B – if they have had a diagnosis in one of the facilities listed in the past 12 months. Tier A is high behavioral health, high physical health needs

119. **Question: So the client or the organization working with the client has to get a hold of the MCO to let them know? This sound like clients won't be tiered correctly or enrolled in an IHH until well after the 2 week high risk period for hospitalizations and overdose.**
Answer: The IHH will need to work with the MCO to communicate this information to the Department. If the Department agrees the client needs to be placed in a different tier, then this will happen the first day of the following month of the Department's decision. Retiering will not be retroactive.

120. **Question: So to clarify, if a member has not had an inpatient visit in the last 12 months, OR a diagnosis of schizophrenia or bipolar OR history of self-harm... then they would be at most Tier C?**
Answer: It would need to be an inpatient visit with one of the diagnosis in box 3 to one of the facilities listed. Unless the person falls into levels 6-9 of the CRGs then the person would fall into Tier D.

121. **Question: Was it mentioned that mental illness since childhood was considered in tiering?**
Answer: The client will either have to have one of the diagnosis in the claims data that determines them to be high behavioral health or a triggering event (upon Department review and agreement) to be considered high behavioral health.

122. **Question: What about people being released from prison or jail. They wouldn't have had any claims in the past 18 months. According to what you said it sounds like they'd be tiered wrong. The majority of them will be a high risk population.**
Answer: Clients will default to tier D without claims data unless there is a triggering event. If a triggering event occurs and the MCO sends us the information and the Department agrees that the client needs to be retiered we will reassign the client. Reassignments will not be done retroactively.

123. **Question: Will patients be knowledgeable about the tier that they are in? Will they know they are Tier A or Tier B for example?**
Answer: The clients will not know the tier they are assigned, but will know what IHH they are assigned.

124. **Question: Would substance abuse clients without a mental illness diagnosis qualify for IHH?**
Answer: If they have had a SUD diagnosis and an inpatient stay in one of the facilities listed on slide 8 of the Attribution, Tiering and Assignment presentation in the past 12 months, then they would be considered high behavioral health.

125. **Question: Can you give link to the detail 3M CRG and SA?**

Answer: This information is provided in the Attribution, Tiering and Assignment presentation.

Billing, Claiming and Payment – August 23, 2018 – Webinar Posting

126. **Question: There are five care coordination procedure codes that an IHH may bill. How does the "face to face" requirement work within that billing structure?**
Answer: The IHH allowable codes are as follows:
G9004 – Comprehensive Care Management
G9005 – Care Coordination and Health Promotion
G9007 – Transitional Care
G9010 – Patient and Family Support
G9011 – Referral to Social Services
In order to qualify for the per member per month payment there must be a minimum of 1 face to face activity per month.

127. **Question: If my organization is a Federally Qualified Health Center (FQHC), can I bill for both services and care coordination?**
Answer: In order to receive reimbursement for care coordination, FQHCs must be enrolled as an IHH with a new Provider Type, a new NPI and all required staff. The IHH would be reimbursed for coordinating the care of the enrollees. The FQHC would be reimbursed separately for any physical or behavioral health services provided to enrollees.

128. **Question: What if the IHH did not see the member on a face to face basis during the month?**
Answer: The IHH would not qualify to receive the PMPM payment that month, as a minimum of one contact must be face to face.

129. **Question: What are the codes and rates for the IHH care coordination services?**
Answer: IHHs must submit a claim for the appropriate care coordination G-code. The care coordination G-code will be viewed in the HFS billing system as an encounter, and will be paid at $0. The encounter will set a trigger for the appropriate PMPM payment for the IHH based on the members tier. The PMPM will be paid to the IHH (fee-for-service) or passed through the MCO to the IHH as a "directed payment."
The IHH allowable codes are as follows:
G9004 – Comprehensive Care Management

G9005 – Care Coordination and Health Promotion
G9007 – Transitional Care
G9010 – Patient and Family Support
G9011 – Referral to Social Services

130. **Question: Will the care coordination rates be the same for IHHs for enrollees in MCOs and individuals in Fee-For-Service?**
Answer: Yes. The IHH rates established by the Department are the same for enrollees in MCOs and individuals in FFS.

131. **Question: Will HFS accept collaborative care codes?**
Answer: The IHH allowable codes are as follows:
G9004 – Comprehensive Care Management
G9005 – Care Coordination and Health Promotion
G9007 – Transitional Care
G9010 – Patient and Family Support
G9011 – Referral to Social Services

132. **Question: Can care coordination codes be billed by any required professionals who are part of the core team of the IHH?**
Answer: The care coordination codes must be billed under the IHH's NPI. Care coordination services may be rendered by any professional who is part of the IHH core team of required staff (as registered in IMPACT) and listed as the rendering provider on the claim.

133. **Question: Why is PMPM so much higher for complex children than adults?**
Answer: If children have complex needs, the expectation is that family is involved and should be served as well. Also, service costs for these children on average are higher than adults – more moving parts/services to coordinate.

Additional FAQs – Added September 12, 2018

134. **Question: Are the five IHH codes both encounter and billing codes? I know one has to be face-to-face to get the PMPM but can you also bill for the codes?**
Answer: The IHH care coordination codes are encounter codes. HFS requires the IHH to submit a claim each time a care coordination service is provided, but these are not payable as separate services. At the end of each month, assuming an appropriate face to face encounter with the U6 modifier has been billed, the PMPM will be paid for each client. The codes are applicable to be billed to both HFS directly and to the MCO's. Only the IHH can submit the care coordination codes.

135. **Question: As an IHH, in addition to providing the first face-to-face engagement that triggers the activities. May we bill additional HCPCS codes for the services we provide? Care Coordination and Transitional Care along with Case Management CCC or Case Management MH**.

Answer: IHH are required to bill every care coordination activity performed for the client with the appropriate G9004, G9005, G9007, G9010, and G9011 respectively. No other codes are billable by the IHH.

136. **Question: Can any provider treating the patient use the G codes if applicable or only the IHH NPI?**
Answer: Only the IHH can submit the G codes.

137. **Question: Will the encounters reporting the 5 CC codes go to the member's MCO or directly to HFS?**
Answer: If the client is enrolled in a managed care plan, the claim is to be submitted to the MCO. If the client is strictly FFS then the claim is to be billed to HFS directly.

138. **Question: Will there be new provider codes if an organization to provide transportation, for example, but is not leading the IHH so they can bill for their services?**
Answer: A provider must be enrolled as a transportation provider to bill for transportation. The IHH can only submit the five care coordination codes.

139. **Question: The 5 HCPC codes only to be billed by the care coordinator?**
Answer: IHH is the only provider that can bill the G codes.

140. **Question: During the face to face meeting, more than one code may be submitted?**
Answer: Yes, the IHH may submit more than one of the care coordination procedure codes for the face to face visit. Each procedure code must be billed with the U6 Modifier to indicate it was part of the face to face visit.

141. **Question: Must the member be present for all activities? Or can a G9004 can be submitted for a meeting of providers to collaborate, even if the member is not present. I understand there must also be a face to face with the member that month for reimbursement.**
Answer: The member does not have to present for every care coordination activity. However, to qualify for the per member per month payment there must be a minimum of 1 face to face activity per month.

142. **Question: Will providers working with an IHH have to bill through the IHH for their normal services (CMHC, etc.), or do they continue to bill directly to the MCO?**
Answer: If the client is enrolled in a managed care plan, the claim is to be submitted to the MCO. If the client is strictly FFS then the claim is to be billed to HFS directly. The IHH can only submit the five care coordination codes. All other services will be billed by the provider of the services as it is done today.

Quality Indicators, Incentive Payments and Reporting – Added August 23, 2018 – Webinar Posting

143. **Question: Will "shared savings" be triggered by the MCO and IHH?**
Answer: The potential for shared savings will not go into effect until Year Three of the program, and will result from evaluations by both the State and the MCOs.

144. **Question: What is incentive for billing additional codes after PMPM is met?**
Answer: Billing additional codes will likely improve IHH outcomes on metrics for value based payment, as well as determine which providers and provider types are producing results for their members. It may help both the state and the IHH to measure cost-effectiveness of the model over time.

145. **Question: Why is there a lag in metric reporting?**
Answer: Providers have 180 days to bill. While most bill within a few months, processing of lagged billing will continue to impact the metrics. HFS will be generating reports, as will the MCOs.

146. **Question: How are bonuses calculated? What are bonuses calculated upon**
Answer: Please refer to the Quality Indicators, Incentive Payments and Reporting presentation for more information.

147. **Question: Are value-based metrics excluded where there is not a valid pool (e.g. 30 members for 6 months)?**
Answer: Yes

Member Engagement/Freedom of Choice – Added August 23, 2018

148. **Question: Members are mobile. Can a member change their IHH selection if they move? How often can a member request to switch their IHH?**
Answer: Yes. Members may choose a different IHH if they relocate. Regardless of the situation, members may change IHHs as frequently as once per month. Members are also free to opt of the IHH program at any time.

149. **Question: Will a member be assigned to an IHH and a PCP?**
Answer: In fee-for-service, Tier A, B and C members will no longer have a PCP assigned by the Department. Instead, members will choose an IHH or be auto-assigned if no IHH is selected. The member will continue to receive care from their physician of choice as long as the physician is an enrolled provider and, if enrolled in an MCO, the provider is part of the network. MCOs may choose to also retain PCP relationships as well as IHH.

150. **Question: Will DCFS clients be enrolled in HealthChoice Illinois as of October 1, 2018?**
Answer: No. The official date for DCFS enrollment in HealthChoice Illinois has not been determined but it will not be October 1, 2018.

151. **Question: Can individuals have choice of their providers once enrolled in IHH?**
Answer: Yes. Members are not limited to IHH collaborating providers. However, different MCOs may encourage this to varying degrees.

152. **Question: Will there be a list of IHH providers?**
Answer: Yes. The Department will publish a listing of IHHs. MCOs will be responsible for communicating to their members the IHHs available for selection based on their tier assignment. The client enrollment broker will also be involved in choice of MCO / IHH.

153. **Question: If individual is receiving case management billed through Medicaid, are they excluded from IHH?**
Answer: Yes. A member who is already receiving case management through Medicaid and does not want to switch to care coordination through an IHH is not eligible. When an individual is included in IHH, a provider cannot bill additional case management services beyond the IHH care management PMPM.

154. **Question: How do we get members to engage? Some might be homeless or not engaged.**
Answer: While outreach efforts to this population may be difficult, IHHs should make every attempt to find and engage members. This is why the face to face contact is so important each month.

155. **Question: How do members know that there is IHH available?**
Answer: Members will receive letter in the mail informing them of their ability to select IHH - just like PCP today. Members will be informed of all eligible IHHs in their MCO network as well as how to choose.

156. **Question: How might family members be impacted by IHH assignment?**
Answer: IHHs will be able to serve all members of a family regardless of the family member's tiers. This arrangement will allow families to all be enrolled in the same IHH, if they choose to be. However, if one family member wants to choose another IHH, that is also acceptable.

Additional Questions - Added September 21, 2018

157. **Question: Are IHH assigned members geographically? How will providers know which IHH are serving their area?**
Answer: The MCO and the Department will make available a list of IHHs that serve the various geographical locations.

158. **Question: Can members elect to NOT participate in care coordination? i.e., are there any contractual requirements of the member to participate with the team?**
Answer: A member may opt out of utilizing IHH services at any time.

159. **Question: Could a member be in an IHH that their MCO is not contracted with or would they need to switch MCO's?**
Answer: An IHH is like any other provider of services. The member must choose an IHH that is contracted with the member's MCO.

160. **Question: How to handle members switching on and off between IHH program in the reporting?**
Answer: Please refer to the IHH Attribution, Tiering and Assignment webinar and slide presentation on the IHH webpage.

161. **Question: How would a member be assigned to an Integrated Health Home?**
Answer: Please refer to the IHH Attribution, Tiering and Assignment webinar and slide presentation on the IHH webpage.

162. **Question: What if there is no IHH in a member's county or geographical region?**
Answer: The department's goal is to have at least one IHH in every geographic region by January 1, 2019. IHHs will enroll on an ongoing basis and HFS and the MCOs will make this information available to its members.

163. **Question: Will members receive information on how to choose an IHH?**
Answer: Individuals will receive letters advising them of their need to choose an IHH and will also receive a list of IHHs with contact information. The process will be similar to the current PCP selection process, once a plan is chosen.

EHR/ADT – Added August 23, 2018

164. **Question: Many vendors have EHR and ADT systems. Is the state setting up an HIE platform for exchanging data?**
Answer: The Department's immediate goal is to implement a state-wide Admission, Discharge and Transfer (ADT) alerting notification system to advance our care coordination objectives. The Department is currently in the procurement process for an ADT system.

Additional Questions - Added September 21, 2018

165. **Question: Does the lack of a single EMR for all providers disqualify an application? If not, what are suitable alternative to the single EMR.**
Answer: No. Providers may already possess an EHR at the time of application OR commit to adopt, or make measurable progress towards adopting, an EHR.

166. **Question: There is a requirement to have capability to receive electronic notifications from other entities. Would you clarify what this means i.e. EMRs need to be interfaced? Able to accept a fax?**
Answer: Providers must be capable of engaging in multimodal communication with members and appropriate service providers (secure electronic communication, wireless patient technology) and ability to receive notification on members' status from rendering providers (ADT feed working towards EHR).

167. **Question: Does the organization required to have a certified EHR to meet the Meaningful Use requirements or just have an EHR?**
Answer: No. The organization is not required to have a certified EHR that meets meaningful use requirements.

Primary Care Provider FAQs – Added August 31, 2018

168. **Question: MCOs reimburse PCPs on a PMPM basis for their attributed patient population. If patients are being attributed to IHHs instead of PCPs, how will the PCPs get reimbursed their PMPMs from the MCOs? Will patients be selecting an IHH AND a PCP during enrollment or only an IHH?**
Answer: This contractual arrangement will need to be addressed between the PCPs and the MCOs.

169. **Question: Is the PCP or the IHH is responsible for submitting referral authorizations to the MCO?**
Answer: The IHH is not a gatekeeper for the MCO. However, the IHH can certainly advocate on the client's behalf for referrals, as needed.

170. **Question: If the IHH fits the first model - i.e. one fully integrated provider - will it also be assigned IHH members who's PCP or behavioral health provider is NOT at the integrated provider?**
Answer: Yes, IHHs will have to be capable of providing care coordination for all of their members even if those members are not receiving other direct services from that provider.

171. **Question: What is the difference between a PCP and an IHH?**
Answer: The IHH only offers care coordination services (see five allowable IHH care coordination billing codes). PCPs will continue to provide medical services as they do today.

172. **Question: Will all Tier A, B and C members in an IHH still have an assigned "PCP" through their MCO?**
Answer: The decision to assign a PCP will be made by the MCO.

173. **Question: Will PCP get paid for care provided to patients that are not assigned by the MCO to the PCP?**
Answer: Payment arrangements between the PCP and the MCO will need to be negotiated between those two parities.

174. **Question: It is a little unclear what the role of the PCP will be in this model. How does the PCP fit? Will they be on the client's Medicaid card or the IHH?**

Answer: PCPs will still provide medical services to members as they do today. The IHH will be responsible for coordination of care, not for delivering direct medical services. The information included on the ID card will be determined by the MCO.

175. **Question: Do you need agreements with all PCP's that seems like an attainable task?**
Answer: IHHs should have relationships with all of the PCPs that are serving their members for purposes of coordinating care and ensuring that required appointment times are met.

More FAQs will be posted in the near future.