



# Integrated Health Homes

TOWN HALL MEETINGS

August 8, 9, 10<sup>th</sup>, 2018

# Overview

❖ **The Promise of Integrated Health Homes**

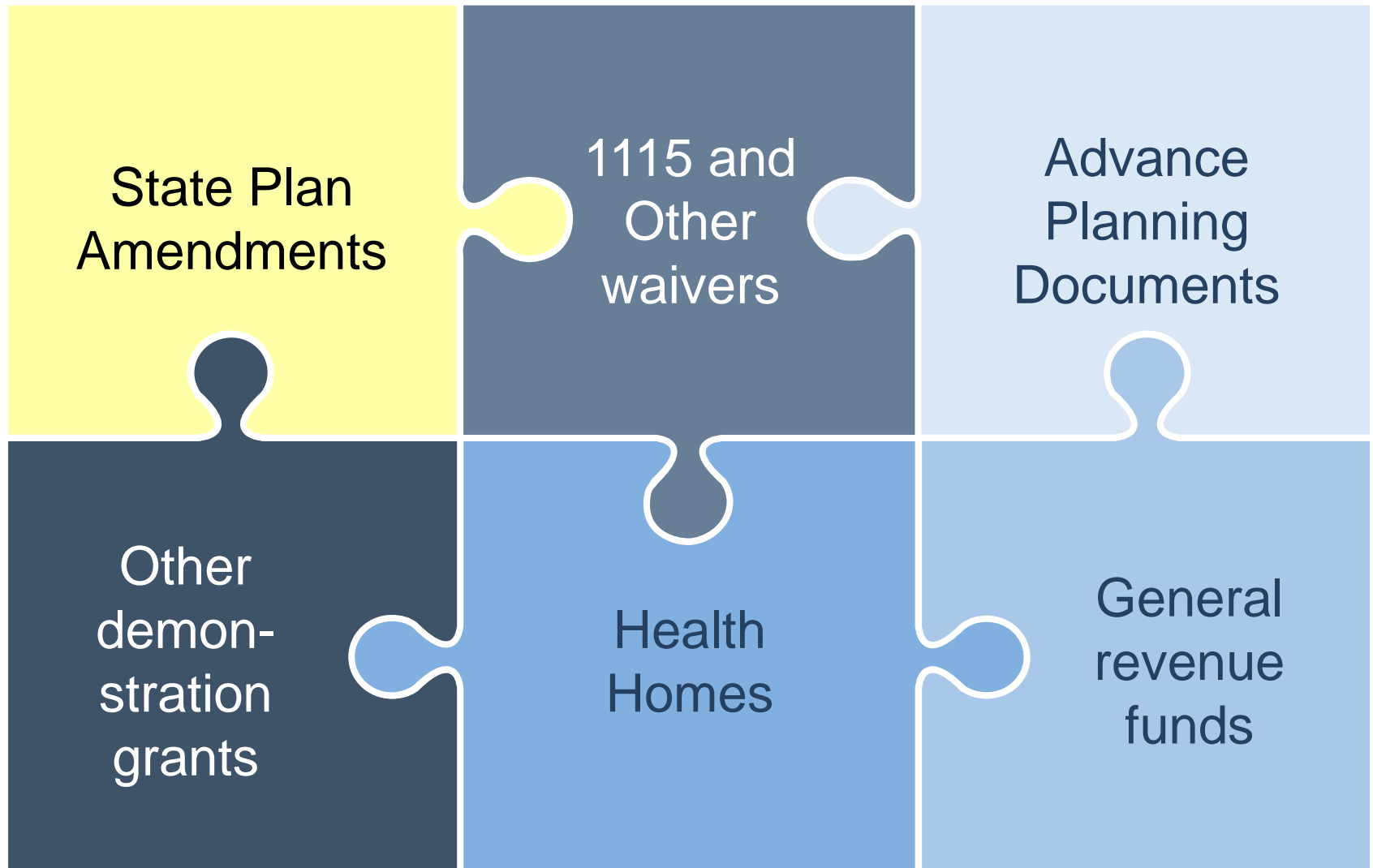
❖ **Enrollment Requirements**

❖ **Payment Levels**

❖ **Outcomes and Reporting**

❖ **MCO Partnership**

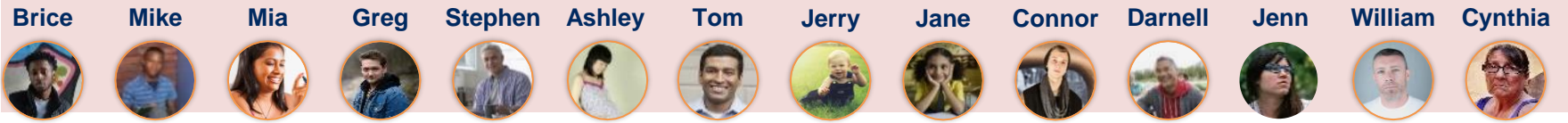
**The Integrated Health Homes (IHH) is one component of a range of initiatives to be employed by the HHS Transformation**



# Principles for developing care delivery model

- ✓ Develop a **person- and family-centered coordinated care delivery model for the whole Medicaid population, regardless of match status**, that encourages member and family engagement
- ✓ Evolve toward **full clinical integration of behavioral, physical, and social healthcare**
- ✓ Craft a flexible care delivery approach that reflects **the diverse needs of members in Illinois** and recognizes that member needs change over time
- ✓ Acknowledge and accommodate **geographical variation in provider capabilities, readiness, and priorities**
- ✓ Strike an **appropriate balance between provider flexibility and accountability** to enable capabilities and readiness
- ✓ Prioritize **economic sustainability of care delivery model** at both the systemic and provider levels

# Integrated Health Homes will deliver improvements in care delivery across a range of areas



## Managed Care Organizations

Enhanced access, screening, and assessment

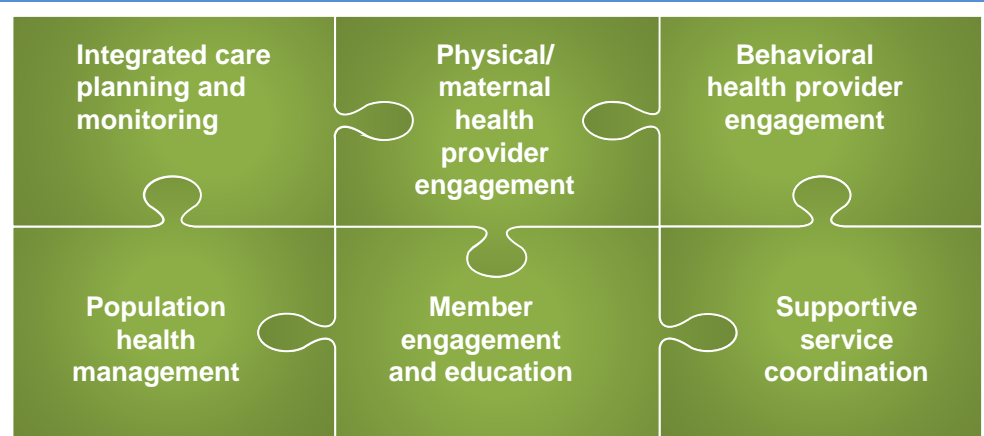
Higher-needs population<sup>1</sup>

Lower-needs population<sup>1</sup>

## Integrated Health Homes

Higher-intensity Integrated Health Homes

Lower intensity Integrated Health Homes



Reporting of quality and efficiency of care (i.e., member outcomes)

Payment streams, in response to Integrated Health Homes meeting requirements and improving outcomes

<sup>1</sup> Actual tiering of intensity of care coordination may not be binary

# Integrated Health Home Vision

- Fully-integrated coordinated care including **physical, behavioral** and **social** for members of Illinois Medicaid
- **Intensive set of services** for a small subset of members who require coordination at the highest levels
- **Comprehensive system of care coordination** for Illinois Medicaid individuals with chronic conditions
- Will have collaborative agreements with multiple entities / service providers to ensure service coordination
- **Coordinate with** and paid through **MCOs**
- Rewarded for outcomes

# What is an Integrated Health Home?

## Integrated Health Homes in Illinois are:

### Primary focus is on coordination of care...

- **Integrated, individualized care planning and coordination resources**, spanning physical, behavioral and social care needs
- An opportunity to **promote quality** in the core provision of physical and behavioral health care
- A way to **encourage team-based care** delivered in a member-centric way
- A way of **aligning financial incentives** around evidence-informed practices, wellness promotion, and health outcomes

### For members with the highest needs:

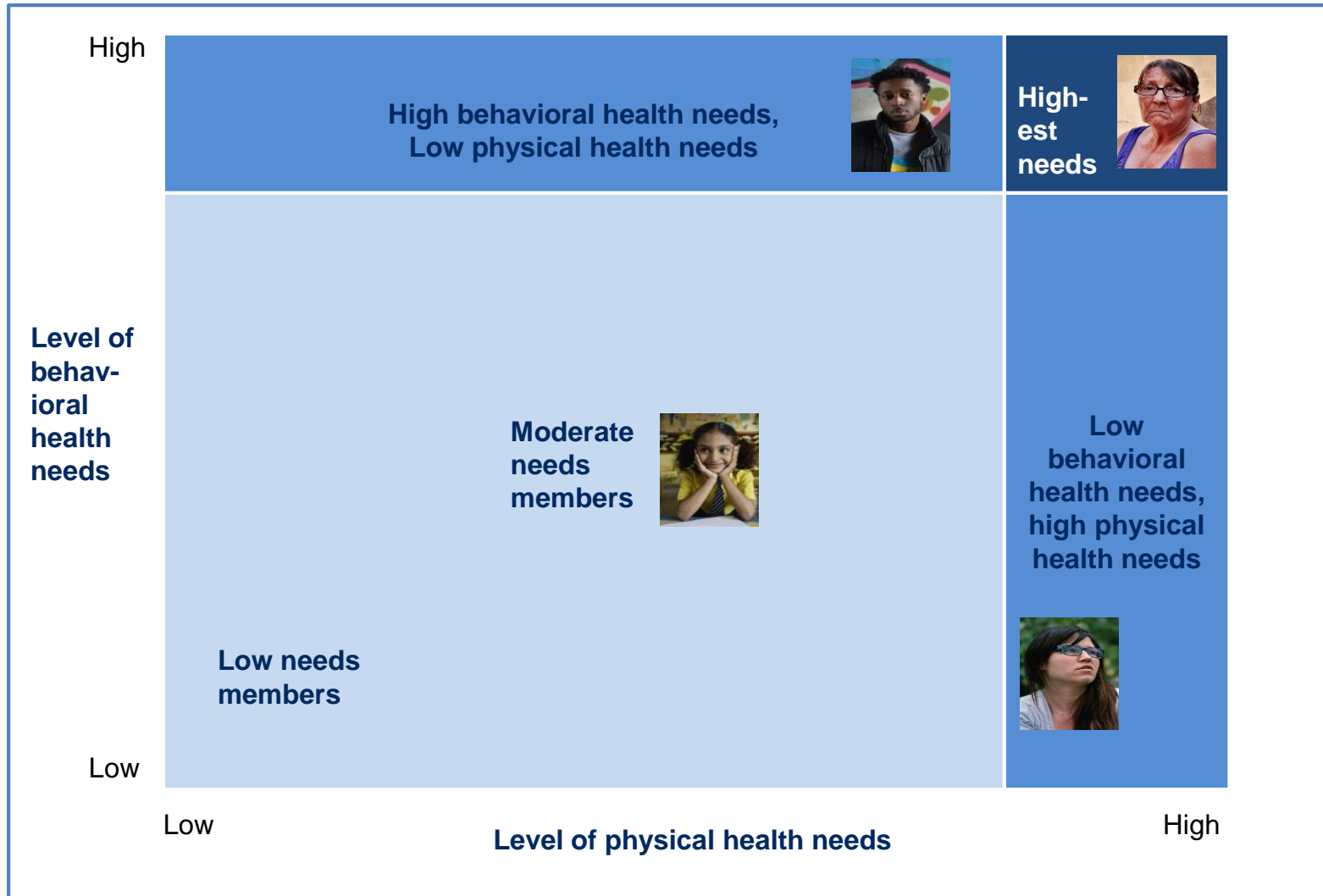
- A means of facilitating **high intensity, wraparound care coordination**
- An opportunity to obtain **enhanced match for care coordination needs**
- **Identifying enhanced support** to help these members and their families manage complex needs (e.g., housing, justice system)

## Integrated Health Homes in Illinois are NOT:

... and NOT on the **provision of all services**

- **Provider of all services for members**
- **A gatekeeper** restricting a member's choice of providers
- **A physical place** where all Integrated Health Home activities occur
- **A care coordination approach that is the same for all members** regardless of individual needs

# Overview of Tiering





# What do the tiers mean?

Each IHH member will be attributed to a tier based on **physical and behavioral health information** in the medical history and/or a review of claims. Each tier has specific criteria. This information will be shared with the member's health plan by HFS.



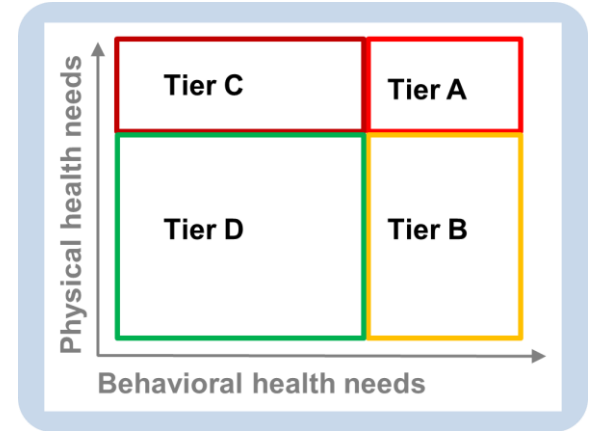
\* Full Medicaid population will be included in the model, with exception of those in LTC facilities after 90 days, or with MMAI dual, partial eligible, or TPL status

# Focus: Determining member tier and provider

## Stage

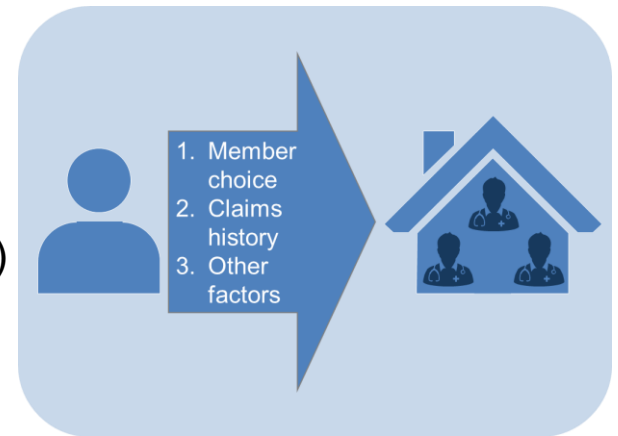
### Attribution to tier

- **Determine member Tier A, B, C, or D based on:**
  - CRG status for physical conditions (high = A, C)
  - Behavioral health claims analysis for behavioral health conditions (high = A, B)



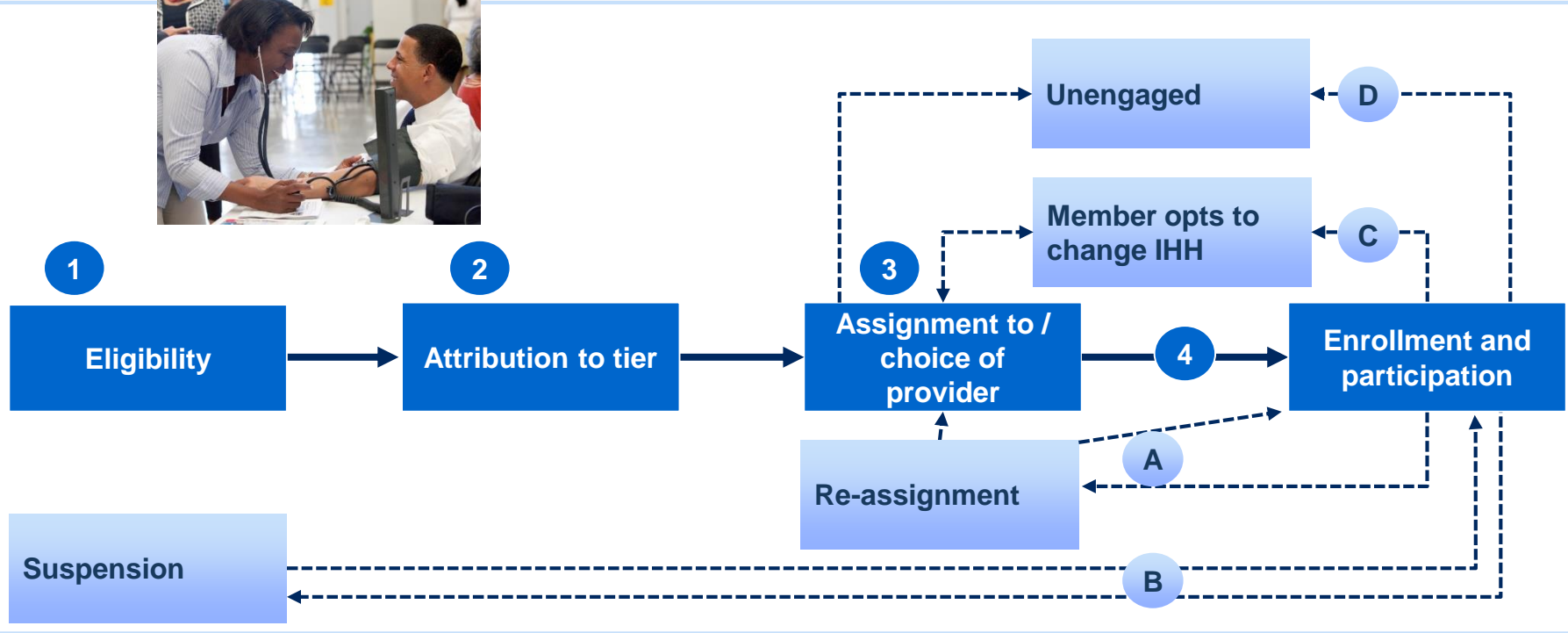
### Assignment to / choice of provider

- **Assign member** to a provider able to meet their needs based on tiering above, based on following hierarchy:
  - Member choice
  - Claims history (if no member choice)
  - Other factors (e.g., closest provider geographically) (if no member choice or claims history)



# Typical IHH member journey

➔ Typical path  
 - - - ➔ Exception path



- 1** Member is assessed by State to meet IHH program eligibility criteria

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- 2** Member is attributed to a tier on basis of medical history, by State or MCO

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- 3** Member is assigned to an IHH following State-set parameters, by State or MCO

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- 4** Member is engaged and enrolled by IHH and begins receiving regular care coordination

- A** MCO/State and IHH deem level of need to have changed; member tier is changed (potentially involving reattribution)

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- B** Member begins receiving duplicative form of care coordination or enters LTC for 90+ days; IHH membership is suspended for duration

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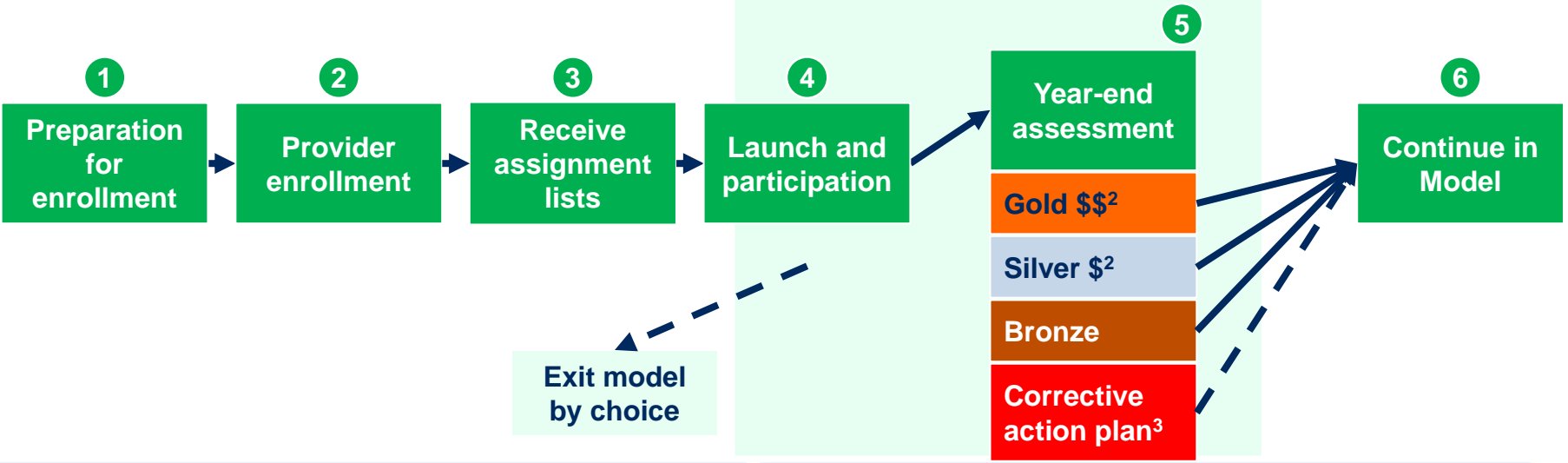
- C** Member opts to change IHH and is promptly reassigned

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- D** Member is not successfully engaged by IHH for a period of time, either before or after enrollment

# Typical IHH provider journey

*Formal launch of Integrated Health Homes  
January 2019 for first wave (Tier A,B and C)*



**1** Provider decides to enroll in Integrated Health Homes and forms agreements with collaborating providers (e.g., primary care provider and behavioral health clinic)

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**2** Provider applies for enrollment in Integrated Health Homes and specifies which tier of members it is able to address. Upon approval, provider amends contracts with MCOs

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**3** Provider receives first list of assigned members (including member tiers) from MCOs and/or State

**4** Launch of first wave

- Regular attribution/tiering refresh
- Quarterly reporting (~April 2019)<sup>1</sup>

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**5** Year-end assessment

- Determination of bonus level based on performance outcomes
- Determination for need of corrective action plan

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**6** Continue in the Model

1 First report cycle would include very minimal information  
 2 Performance payment  
 3 In future years, providers may be removed from model

# How can we become an IHH?

## Who can enroll as an IHH?

As long as the requirements are met, **any provider** can enroll as an IHH.

**Must be able to provide coordination of care across physical, social and behavioral health and enroll with Medicaid in **IMPACT** as well as have agreement with MCO(s).**

## General Requirements

- Required Professionals – Collaborative and/or Cooperative Agreements
- Maintain Appointment Standards
- Establish relationships with hospitals, residential settings, other treatment centers, and other care providers
- Facilitate Direct Access
- Facilitate and participate in interdisciplinary team meetings
- Ability to receive notifications on member status from rendering providers
- Develop capacity for a minimum panel size of 500

# Required Professionals

## Required Professionals

- Physician: Must have appropriate clinical licenses and/or professional certification (and be able to refer to appropriate medical specialists)
- Psychiatrist/Psychologist/Mental Health Specialist: Must have one Psychiatrist/Psychologist/Mental Health Specialist with appropriate clinical license and/or professional certification.
- Substance Use Disorder (SUD) Specialist: Must have one SUD Specialist with an appropriate clinical license.
- Social Worker/Social Service Specialist: Must have one Social Worker who must possess at a minimum of a bachelor's degree in a relevant subject.
- Nurse Care Manager : Must have one qualified RN
- Clinical Care Coordinator: Must possess a minimum of a bachelor degree with previous case management experience and appropriate clinical licenses and/or professional certification.

## Other Requirements

- Building capacity to receive electronic records or notification.
- Panel size requirements

# Enrollment of an IHH: General Requirements

## Maintain Appointment Standards

Type of Appointments	Tiers A & B	Tier C
<b>Routine/Preventative for adults</b>	<b>Within 3 weeks</b>	<b>Within 5 weeks</b>
<b>Routine/Preventative infants less than 6 months</b>	<b>Within 1 weeks</b>	<b>Within 2 week</b>
<b>Urgent Care Non emergencies</b>	<b>Within 24 hours</b>	<b>Within 24 hours</b>
<b>Problems/Issues deemed as not being serious</b>	<b>Within 2 weeks</b>	<b>Within 3 weeks</b>
<b>Prenatal 1<sup>st</sup> Trimester</b>	<b>Within 1 weeks</b>	<b>Within 2 weeks</b>
<b>Prenatal 2nd Trimester</b>	<b>Within 5 days</b>	<b>Within 1 week</b>
<b>Prenatal 3rd Trimester</b>	<b>Within 2 days</b>	<b>Within 3 days</b>

# General Requirements

## Facilitate Direct Access for Members

- 24 hours, 7 days a week
- At a minimum, an answering service/direct notification/other preapproved arrangement, such as a secure electronic messaging system and/or video conferencing system to offer interactive clinical advice to members

## Inter-Disciplinary Meetings

- Facilitate and participate / both behavioral and physical health
- Meeting the needs of the member for the coordination of care

## Communication

- Bi-directional communication with members and appropriate service providers
- Develop protocols for ongoing communication and prompt notification as member's transition from residential to community
- Ability to receive notification on members' status from rendering providers (e.g. ADT feed, working toward EHR).



# HFS IMPACT Enrollment

- Each Integrated Health Home must enroll through HFS' Provider Enrollment System (IMPACT): <https://www.illinois.gov/hfs/impact/pages/default.aspx>
- Selections as follows:
  - Enrollment type = Facility, Agency or Organization (FAO)
  - Provider type = Integrated Health Home
  - Specialty = Integrated Health Home
  - Sub-specialty = IHH-Tier A, IHH-Tier B, IHH-Tier C, IHH-Tier D
- Providers must have a unique Tax ID / NPI combination for this enrollment and will be assigned a new HFS provider ID
- The IHH owner's Tax ID may be used, but remember, there is only one Pay-To address per Tax ID in IMPACT
- HFS is drafting a new provider agreement/attestation outside of IMPACT for the IHH to submit the contracted/collaborative providers in the IHH

# IMPACT Enrollment Checklist

- Complete and sign the IHH Provider Agreement
- Provide copies of all contracts and cooperative agreements with required partner entities
  - Should include operating policies and procedures, staffing expectations, organizational / decisional chart
  - Funding distribution agreements
- Ensure facilities, staff and services are culturally competent as required by HHS Office of Minority Health
- Maintain appropriately trained and credentialed staff required to deliver care coordination
- Use an EHR or commit to adopt / demonstrate progression
- Attest to meeting and maintaining staffing ratios

# Reimbursement

- IHHs will be paid according to the members enrolled with their entity
- Payments are PMPM, based on tiers
- Payments made to MCOs and then directed to the IHH
  - IHH Codes: G9004 – Comprehensive Care Management  
G9005 – Care Coordination and Health Promotion  
G9007 – Transitional Care  
G9010 – Patient and Family Support  
G9011 – Referral to Social Services

# PMPM rates by Tier

Tier-based payments *	Child PMPM	19-21 PMPM	Adult PMPM
Tier A	\$240	\$240	\$120
Tier B	\$80	\$60	\$48
Tier C	\$48	\$48	\$48

\* Paid once per month for each member in applicable group and when one of five (5) service codes is billed by the IHH.

# Guiding principles for measure selection

## Description

### Simple

- **Straightforward to operationalize**, and based on readily available sources of data
- **Restricted in number** to direct provider focus on what matters and what they can control
- **Reasonable in making demands on providers' capabilities**

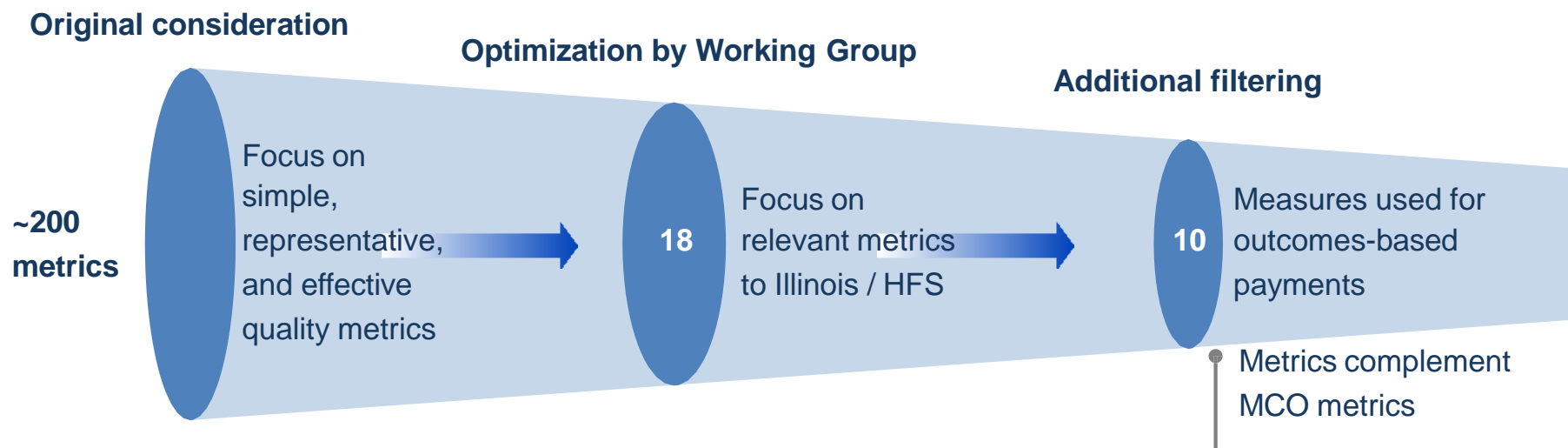
### Representative

- **Tailored to reflect members' different needs**, with particular attention given to the variation in the profiles of members with high behavioral and physical health needs, and to the needs of children
- **Attentive to transitions between different settings of care**
- **Aligned with CMS and HFS priority measures**

### Effective

- **Focused on outcomes as much as process**
- **Complementary, rather than duplicative, with activity requirements** and other performance monitoring processes
- **Reported to providers in such a way that there are clear actions or paths to improvement**, potentially tied to provider education and support efforts
- **Evaluated for efficacy as they are used**, with the potential to be replaced with other measures as provider performance progresses

# Overview of outcomes metrics selected



## Guiding principles for metrics selection

- **Initial consideration** of over 200 metrics by Working Group
- Working Group held session to **prioritize metrics** based on:
  - Simplicity (e.g., straightforward to operationalize)
  - Representativeness (e.g., tailored for high / low behavioral health needs and the needs of children)
  - Effectiveness (e.g., focused on both outcomes and process)
- **Additional consolidation** based on consistency with CMS and MCO metrics

# List of quality measures

## Measures for reporting only

- Plan All-Cause Readmission Rate
- Follow-up After Hospitalization for Mental Illness
- Controlling High Blood Pressure
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Prenatal and Postpartum Care
- Medication Management for People with Asthma
- Potentially preventable readmission for Behavioral Health
- Behavioral Health related ED visits per 1000

## Measures impacting outcomes-based payments

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Screening for Clinical Depression and Follow-Up Plan
- Chronic Condition Hospital Admission Composite – PQI
- Adult BMI Assessment
- Follow-up After Hospitalization
- ED Visits per 1000
- Immunization Combo 3
- Breast Cancer Screening
- Diabetes Management (Hb1AC testing)
- Antidepressant Medication Management

■ CMS health home core measures

- **Reporting required on all 18 measures**
- **Outcomes-based payments impacted by the 10 selected measures**

# Description of podium metrics

## Minimum criteria to achieve bronze, silver, and gold status



**Bronze  
IHH**

### Bronze criteria

- Average 40th percentile, with no individual measure lower than 20th percentile



**Silver  
IHH**

### Silver criteria

- Average 60<sup>th</sup> percentile, with no individual measure lower than 40th percentile



**Gold  
IHH**

### Gold criteria

- Average 80th percentile, with no individual measure lower than 50th percentile

- IHHs may receive either a bronze, silver, or gold brand by surpassing the color's level for any single measure once all 18 measures are reported on



# Overview of approach to outcomes-based payment stream

Eligibility for outcomes-based payments requires reporting on all activities

Eligible practices stratified by level of performance

Payment amount based on level of performance

- To be eligible for outcomes-based payments, IHH **must report on all 18 quality measures**
  - All Health Homes -- intensive and non-intensive IHHs -- are eligible for payment
- **Performance levels are:**
    - **Bronze:** Average [40<sup>th</sup>] percentile, with no individual measure lower than [20<sup>th</sup>] percentile
    - **Silver:** Average [60<sup>th</sup>] percentile, with no individual measure lower than [40<sup>th</sup>] percentile
    - **Gold:** Average [80<sup>th</sup>] percentile, with no individual measure lower than [50<sup>th</sup>] percentile
  - IHH must **achieve at least a Bronze** level<sup>1</sup> of performance across 10 selected performance measures to receive any outcomes-based payment
- **Bronze, Silver, and Gold** levels of performance result in ascending levels of payment, respectively:
    - **Bronze:** 10% of total amount of IHH's care coordination PMPY payment
    - **Silver:** 25% of total amount of IHH's care coordination PMPY payment
    - **Gold:** Silver-level bonus AND share of cost of care savings provider has achieved as determined via proxies for TCOC

# MCO Partnership

Health plan staff designated to begin work immediately on IHH development:

- **Blue Cross Blue Shield:**
  - Joanne O'Brien, Contracting: [Joanne\\_obrien@bcbsil.com](mailto:Joanne_obrien@bcbsil.com), 312.653.2413
  - Kimberly Dean, Project Manager: [Kimberly\\_J\\_Dean@bcbsil.com](mailto:Kimberly_J_Dean@bcbsil.com), 312.653.4359
- **CountyCare:**
  - Crissy Turino: [cristina.turino@cookcountyhhs.org](mailto:cristina.turino@cookcountyhhs.org)
  - Andrea McGlynn: [amcglynn@cookcountyhhs.org](mailto:amcglynn@cookcountyhhs.org)
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  - Nancy Byrne: [Nancy.Byrne@wellcare.com](mailto:Nancy.Byrne@wellcare.com)
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  - Theodore Dixon: [Theodore.Dixon@nlhpartners.com](mailto:Theodore.Dixon@nlhpartners.com)

# Next Steps / Timeline

- Three town halls this week
- Work with provider partners and MCOs on operational and contractual relationships
- Webinar soon repeating Town Hall
- FAQs published on website
- Further webinars on specific topics (e.g. provider enrollment, choice, etc.)
- Provider enrollment begins in September
- Choice process will begin in November