



Integrated Health Homes

Town Halls

February 5 and February 6, 2020

Integrated Health Home Program

- The Integrated Health Home (IHH) program is intended to be a high quality, person-centered fully-integrated form of care coordination for beneficiaries in the Illinois Medicaid population with chronic conditions.
- The IHH will be responsible for care coordination for members across their physical, behavioral and social care needs.



Integrated Health Homes: Overall Goals

- ✓ Develop **person- and family-centered coordinated care delivery models for adults and children with complex physical and behavioral health needs**
- ✓ Craft a flexible care delivery approach that reflects **the diverse needs of members in Illinois** and recognizes that member needs change over time
- ✓ Strike an **appropriate balance between provider flexibility and accountability** to enable capabilities and readiness
- ✓ Prioritize **economic sustainability of care management models** for high need adults and children



What is an Integrated Health Home?

Integrated Health Homes in Illinois are:

Focus is on improving patient engagement and coordination of care...

- **Integrated, individualized care planning and coordination resources**, spanning physical, behavioral and social care needs
- 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
- A means of facilitating **high intensity, wraparound care coordination**
- An opportunity to bring additional resources to the state through **enhanced match for care coordination services**
- **Identifying enhanced support** to help these members and their families manage complex needs (e.g., housing, justice systems)

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

Medicaid Integrated Health Home: Population Criteria

To the extent elected by the State in its approved State plan, Medicaid beneficiaries are eligible for health homes if they have:

- (1) two or more chronic conditions;
- (2) one chronic condition and are at risk for a second; or
- (3) a serious and persistent mental health condition.

The Illinois IHH program will cover all three groups, with an emphasis on persons with high costs, high risks and high utilization who can benefit from increased care coordination and care management.



Integrated Health Homes – Chronic Conditions List (Examples)

| Physical Health | Behavioral Health |
|--------------------------|---|
| Asthma/COPD | Substance Use Disorder |
| Diabetes | Major Depression |
| Hypertension | Bipolar Disorder |
| Congestive Heart Failure | Anxiety Disorder |
| Coronary Artery Disease | Psychotic Disorders (including Schizophrenia) |
| Chronic Liver Disease | Personality Disorders |
| Chronic Renal Disease | Cognitive Disorders |
| Chronic Musculoskeletal | Post-Traumatic Stress |
| HIV/AIDS | |
| Seizure Disorders | |
| Cancer | |
| Sickle Cell Disease | |

IHH Eligibility and Assignment

- Eligibility criteria will be based on: a) targeted conditions, and b) specified acuity level as determined by risk analysis software and/or administrative utilization data.
- Tiering will be determined by the beneficiary's medical history and profile. Specific criteria for eligibility for each tier will be defined by the Department.
- In the absence of a claim for a condition qualifying a member for eligibility for the program, providers (including hospitals) may refer beneficiaries they reasonably believe to have such a condition and level of need to an MCO (or state's agent), who may assign them to an IHH on establishing contact.



Tiering: Adults

Patient acuity and intensity of service needs will inform tiering of Medicaid beneficiaries as follows:

- **Tier A** individuals who have both high physical and high behavioral health needs;
- **Tier B** individuals who have high behavioral health needs and low physical health needs; and
- **Tier C** individuals who have high physical health needs and low behavioral health needs.



Tiering: Children

Patient acuity and intensity of service needs will inform tiering of Medicaid beneficiaries as follows:

- **Tier A1** individuals who have high behavioral health needs and low physical health needs;
- **Tier A2** individuals who have both high physical and high behavioral health needs;
- **Tier B1** individuals who have moderate behavioral health needs and low physical health needs;
- **Tier B2** individuals who have moderate behavioral health needs and high physical health needs; and
- **Tier C1:** individuals who have high physical health needs and low behavioral health needs.



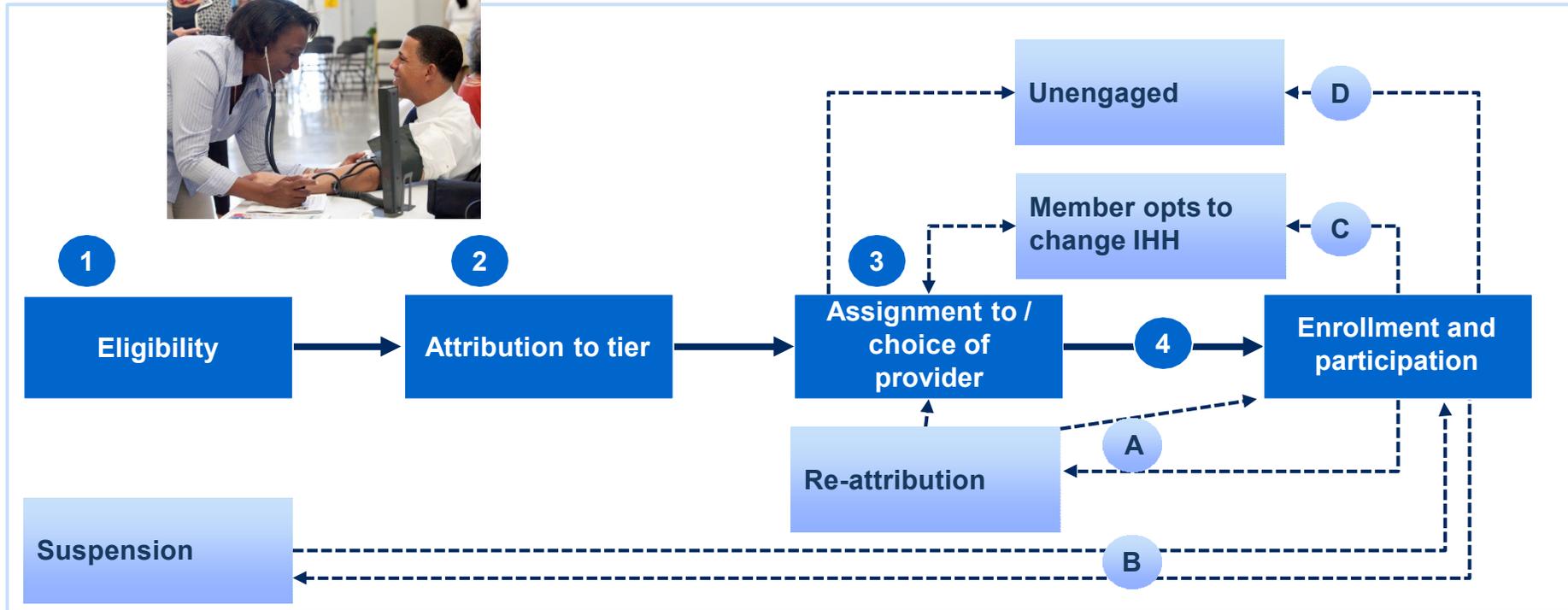
IHH Eligibility and Assignment

- Once a beneficiary is eligible for an IHH, the MCO (or state's agent) will notify the beneficiary of his or her place within the program and his or her prospective IHH provider, together with rights to opt out of the program or request a different provider.
- Likewise, the IHH to which the beneficiary has been assigned will be alerted to this assignment, so that the IHH may begin outreach and engagement.



Typical IHH member journey

➔ Typical path
 - - - ➔ Exception path



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

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

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

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

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

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

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

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

Incentivized IHH Outcomes

While federal CMS has a core set of health home quality and utilization measures, which will be used for ongoing monitoring and evaluation purposes for Illinois' health home program, HFS will be focusing monitoring and reimbursement of the IHH's on key member outcomes, including:

- School attendance (Children's IHH)
- Justice system involvement (Children's and Adult's IHH)
- Child welfare system involvement (Children's and Adult's IHH)
- IM-CANS Improvement (Children's and Adult's IHH)
- Housing Stability (Children and Adult's IHH)
- Employment (Adult's IHH)

The Department will use the quality measures reported during the first year of IHH operations to determine the terms and conditions for any outcomes-based incentive payments that may be authorized by the Department.



CMS Health Home Core Measures

- Plan All-Cause Readmission Rate
- Follow-up After Hospitalization for Mental Illness
- Controlling High Blood Pressure
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Use of Pharmacotherapy for Opioid Use Disorder*
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*
- Screening for Clinical Depression and Follow-Up Plan
- Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite
- Adult Body Mass Index (BMI) Assessment

*Measures added to the 2020 Health Home Core Set



Integrated Health Homes: MCO Responsibilities

The MCOs will negotiate contracts with IHH providers. MCO responsibilities will include the following:

- Contracting with qualified entities to provide and oversee IHH services
- Assigning eligible members to IHHs to coordinate their care
- Notifying IHHs of inpatient admission and emergency department visits/discharges
- Tracking and sharing data with IHH providers regarding members' health history
- Developing training tools and reporting capabilities for IHH providers
- Providing IHH customer service and member grievance resources
- Locating hard to engage enrollees
- Overseeing care team staffing and the delivery of IHH services
- Working with members and care team to develop and update the Individual Plan of Care
- The State will create an Administrative Services Organization to carry about these responsibilities for individuals served under Fee-For-Service



Integrated Health Homes: IHH Responsibilities

IHHs must have the ability to perform the following duties:

- Use in person interactions to engage members with their care team
- Manage referrals, coordination and follow-up to necessary services and supports
- Support members and their personal support system during discharge from hospital and treatment facilities
- Accompany members to appointments when needed
- Conduct regular auditing and monitoring to ensure IHH requirements are met
- Collect, analyze and report health status, financial and other measures and outcome data to HFS.



Illinois Medicaid Integrated Health Home for Adults – Overall Model

Medicaid Managed Care Organizations

- Maintain overall responsibility for the IHH network, including administration, network management and availability of health information for IHH members.
- Receive health home payment from the state which flows to IHH provider



Integrated Health Homes

- Responsible for providing core health home services
 - ✓ Comprehensive care management
 - ✓ Care coordination and health promotion
 - ✓ Comprehensive transitional care
 - ✓ Patient and family support
 - ✓ Referral to community and social support services
- Engagement Specialist/Care Coordinator are located within this entity
- Entity receives payment for health home services via a contract with MCO
- Makes referrals to community partners for non-Medicaid funded services



Community Social Support Services

- Provide Services that meet members' broader needs (e.g. supportive housing services, employment and training assistance, social services and supports).

Medicaid Integrated Health Homes: Adult Model

- An IHH serving members ages 19 and over will include a team of healthcare professionals anchored by an **Engagement Specialist/Care Coordinator** with access to other professionals to assist in beneficiaries accessing needed physical and behavioral health services.
- The Illinois model is built from the ground up with the emphasis of the IHH being on Engagement Specialists (and Peer Advocates) having the bulk of direct contact with IHH members.
- Although the IHH must have access to clinical care consultants, the goal is to have the IHH engage the member's primary care provider(s), specialty care providers and behavioral health service providers in the IHH's team approach to care coordination.



Medicaid Integrated Health Homes: Adult Model

Engagement Specialist/Care Coordinator must be able to:

- Communicate with professionals who are involved in the treatment of the beneficiary
- Identify gaps in the care, obtain feedback from other professionals in the IHH related to the beneficiary's care
- Preferably, have lived experience with mental health, substance use or physical health disorders.



Medicaid Integrated Health Homes: Adult Model

Engagement Specialist/Care Coordinator responsibilities include:

- Finding hard to locate beneficiaries
- Engaging them in developing a plan of care
- Bringing together appropriate professionals needed to address beneficiary issues
- Encouraging and assisting beneficiaries to go to physical and behavioral health appointments and ensuring the appointments are available for members
- Coordinating information between providers to ensure all providers have required information
- Communicating with MCOs about the member's needed service
- Identifying areas of progress for the members and adjusting the care plan when progress is not being made



Illinois Medicaid Integrated Health Home for Children – Overall Model

Medicaid Managed Care Organizations

- Maintain overall responsibility for the IHH network, including administration, network management and availability of health information for IHH members.
- Receive health home payment from the state which flows to IHH provider



Integrated Health Homes

- Responsible for providing core health home services utilizing High Fidelity Wraparound and Intensive Care Coordination
 - ✓ Comprehensive care management
 - ✓ Care coordination and health promotion
 - ✓ Comprehensive transitional care
 - ✓ Patient and family support
 - ✓ Referral to community and social support services
- Wraparound Facilitators and Intensive Care Coordinators certified as qualified to provide IHH services and employed by this entity
- Entity receives payment for health home services via a contract with MCO



Community Social Support Services

- Provide Services that meet members' broader needs (e.g. supportive housing services, employment and training assistance, social services and supports).

Children's IHH: Behavioral Health Needs

- Integrated Health Homes (IHH) for children with high behavioral health needs reflect current best practice approaches and System of Care principles including interagency collaboration; individualized strengths-based care; cultural competence; child and family involvement; community-based services; and accountability.
- System of Care values and practices establish an organizational framework for providing supports and services for children, youth, and young adults with a serious emotional disturbance and their families/guardians/caregivers.
- System of Care philosophy encourages collaboration across agencies and promotes the active involvement of families, children, youth, and young adults in the design and implementation of individualized, strength-based Individual Plans of Care.



Children's IHH: High Fidelity Wraparound

Most Intensive Level of Care Coordination

- High Fidelity Wraparound is a structured approach to service planning and care coordination that adheres to specified procedures for engagement, individualized care planning, identifying and leveraging strengths and natural supports, and monitoring progress and process.
- The High Fidelity Wraparound approach incorporates a dedicated full-time Wraparound Facilitator working with a small number of children and families with access to family peer support, as needed for the family.



Children's IHH: Highest Behavioral Health Needs

High Fidelity Wraparound

- 1:10 staff to family ratio
- Minimum monthly in person Wraparound Child and Family Team meetings
- In person and phone contact with family
- Review Individual Plan of Care every 30 days
- Development, implementation, and monitoring of Crisis Safety Plan
- Wraparound facilitators and supervisors trained and certified in High Fidelity Wraparound



Children's IHH: Intensive Care Coordination

Moderate Intensive Level of Care Coordination

- Intensive Care Coordination will also be built on System of Care principles including interagency collaboration; individualized strengths-based care; cultural competence; child and family involvement; community-based services; and accountability.
- Intensive Care Coordination level will serve Children that do not meet the medical necessity for High Fidelity Wraparound but will benefit from an intensive level of care coordination to assist them in maintaining stability in the community.



Children's IHH: Moderate Behavioral Health Needs

Intensive Care Coordination

- 1:25 staff to family ratio
- Fidelity to Intensive Care Coordination Model
- In person Child and Family Team meetings every 60 days
- In person and phone contact with family
- Review Individual Plan of Care at least every 60 days
- Development, implementation, and monitoring of Crisis Safety Plan
- Intensive care coordinators and supervisors trained and certified in Intensive Care Coordination Model



Children's IHH: Behavioral Health Needs

Activities in High Fidelity Wraparound and Intensive Care Coordination fit into the five core services required by federal regulations:

- Comprehensive Care Management
- Care Coordination/Health Promotion
- Comprehensive Transitional support
- Individual and Family Support
- Referral to Community and Social Support Services



Children's IHH: High Physical Health Needs

- Care Coordination will focus on ensuring that child is connected to all medically necessary physical health services
- Family Support and Home Visits key components to ensuring child is receiving proper care and family is able to support
- Care Team lead by medical professionals (e.g., Nurse Care Manager)
- Referrals made to behavioral health services if need arises



IHH Reimbursement

- IHHs will be paid according to the members enrolled with their entity
- Payments are PMPM, based on tiers
- Payments are made to MCOs but directed to the IHH



IHH PMPM Rates by Tier

| IHH Tier | Member Needs | Rate |
|-------------------|-----------------------------------|----------|
| Tier A: Adults | High Behavioral/High Physical | \$197.44 |
| Tier B: Adults | High Behavioral/Low Physical | \$197.44 |
| Tier C: Adults | Low Behavioral/High Physical | \$159.78 |
| Tier A1: Children | High Behavioral/Low Physical | \$621.12 |
| Tier A2: Children | High Behavioral/High Physical | \$976.93 |
| Tier B1: Children | Moderate Behavioral/Low Physical | \$318.12 |
| Tier B2: Children | Moderate Behavioral/High Physical | \$531.60 |
| Tier C1: Children | Low Behavioral/High Physical | \$162.86 |



MCO Partnership

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

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Next Steps / Timeline

- Two town halls this week, with additional dates being planned
- 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 contracting, high fidelity process etc.)
- Provider contracting begins immediately
- Member engagement and enrollment will begin in May

