Illinois Health and Hospital Association

August 29, 2018

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M

TO: Chief Executive Officers, Member Hospitals and Health Systems
Chief Financial Officers
Government Relations Personnel
Behavioral Health Constituency Section

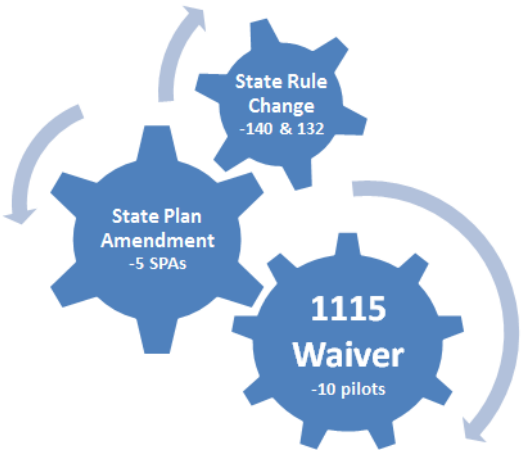
FROM: A.J. Wilhelmi, President & CEO
Lia Daniels, Manager, Health Policy

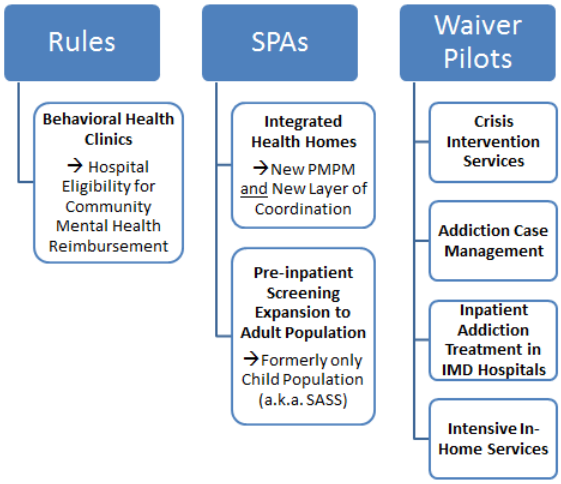
SUBJECT: UPDATE #1: Integrated Health Homes

The Illinois Department of Healthcare and Family Services (HFS) is launching a new program, Integrated Health Homes (IHHs), which it describes as a new, fully-integrated form of care coordination for all members of the Illinois Medicaid population. Each member in the Medicaid population will be linked to an IHH provider based on their level of need and the provider's ability to meet those needs. The IHH will be responsible for care coordination for members across their physical, behavioral, and social care needs. IHHs would not, however, be responsible for provision for all services and treatment to members.

The following background on IHHs reflects the latest information shared by HFS under its approved State Plan Amendment. In a July 17 comment letter, IHA sought clarification from HFS on several IHH issues, and will continue to seek guidance from IHA members to target key areas for advocacy. Current and future information on IHHs from HFS can be found on the IHH webpage, Public Notices and Provider Notices. HFS will release an IHH provider manual later this year.

Background
The goal of the *Better Care Illinois Behavioral Health Initiative* is to comprehensively coordinate services for Medicaid beneficiaries across 13 state agencies, integrate physical and behavioral health services and promote more care in the home and community rather than costlier services in institutions. Many of these program components reflect recommendations made in IHA's 2017 Strategic Plan: Medicaid Behavioral Health Delivery & Payment System Reform. Of the roughly 17 major changes HFS has planned, the following may be of greatest interest for hospitals and health systems:





Provider Requirements

On August 8-10, HFS held three Town Hall meetings in Springfield, Downers Grove and Chicago to provide initial details on the approved State Plan Amendment implementing IHHs. The aim of the statewide implementation is to enhance care coordination for Medicaid beneficiaries across their physical, behavioral and social care needs. **At the IHH Town Halls, HFS shared a goal of beginning provider enrollment by mid-September, beneficiary choice of IHH assignment by November 1 and beneficiary auto-enrollment by January 1.** Providers seeking to enroll as an IHH must enroll as a new provider type with a new National Provider Identifier (NPI) under Illinois Medicaid Program Advanced Cloud Technology (IMPACT) and have agreements with at least one Managed Care Organization (MCO). Other general requirements for IHH enrollment include:

- One face-to-face encounter each month in order to achieve the per-member, per-month (PMPM) reimbursement for the initial beneficiary tiers (A-C);
- Collaborative and/or cooperative agreements with required professionals;
- Maintaining appointment standards, detailed below and **connected to bonus payments**;
- Establishing relationships and participating in discharge planning with hospitals, residential settings, other treatment centers and other care providers;
- Facilitating direct access to services 24 hours and 7 days a week, achieved at minimum via answering service, direct notification, or other preapproved arrangement (e.g., secure electronic messaging system or video conference system to offer interactive clinical advice to beneficiaries);
- Facilitating and participating in interdisciplinary team meetings;
- The ability to receive notification on beneficiary status from rendering providers (e.g., via Admission, Discharge and Transfer feeds), with electronic health record use by the end of the first IHH year; and
- Developing capacity for a **minimum panel size of 500 Medicaid beneficiaries across all ages.** HFS has indicated flexibility to achieve these requirements, especially for IHHs in rural areas that may not be able to achieve the minimum until the enrollment is complete. However, the minimum panel is needed to qualify for participation in the bonus program.

HFS is seeking clarification with the Centers for Medicare & Medicaid Services on whether a face-to-face encounter can be achieved via telehealth, in addition to more traditional in-person encounters. At minimum, the IHH as a coordination entity must maintain the following professional staff:

- Licensed physician with referring capability to appropriate medical specialists;
- Appropriately licensed or certified psychiatrist/psychologist or mental health specialist (e.g., Licensed Practitioner of the Healing Arts);
- Licensed substance use disorder specialist;
- Social worker or social service specialist with, at minimum, a relevant bachelor's degree;
- Registered nurse care manager; and,
- Appropriately licensed or certified clinical care coordinator with, at minimum, a relevant bachelor's degree and case management experience.

Required staff can be affiliated with multiple IHHs. Agreements with other providers may be advantageous for an IHH, but is not required. Examples of IHH structures can be found in the IHH webinar focusing on provider requirements.

Beneficiaries will be placed into four tiers, determined based on behavioral health and physical health needs. Behavioral health tiers will be determined based on Illinois-specific data analysis. Physical health tiers will be defined using commercially-available risk-adjustment software (e.g., 3M CRG™). Re-tiering will occur on a quarterly basis using claims data received during the previous quarter. Additionally, the IHH or MCO could request that a beneficiary be re-tiered outside of the regular schedule if a "triggering event," such as a hospitalization or other significant change in the beneficiary's condition, occurred. Beneficiaries will also be able to switch IHHs as frequently as once a month, if desired. The following tiers represent approximately 250,000 to 300,000 of the 3.1 million Medicaid beneficiaries estimated to participate in the IHHs beginning January 1:

Beneficiary Tier	Description
Tier A	high behavioral health needs / high physical health needs
Tier B	high behavioral health needs / low physical health needs
Tier C	low behavioral health needs / high physical health needs

Further estimates on the population size of each tier will be released in the coming weeks, although Tier A was described as being only one or two percent of the overall Medicaid population. Tier D, which will consist of low behavioral and physical health needs and represent approximately 2.8 to 2.85 million beneficiaries, is being planned for a later rollout, projected by HFS to take place within six months of the initial implementation. The full Medicaid population will be included in the program, with exceptions of those in long-term care facilities after 90 days, Medicare-Medicaid Alignment Initiative duals, partial eligible, American Indians and Alaska Natives, or Third Party Liability status. 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 PMPM. IHHs can choose preferred geographic regions to serve.

IHHs will be expected to maintain appointment standards, including:

Type of Appointments	Tiers A & B	Tier C
Routine/preventative for adults	Within 3 weeks	Within 5 weeks
Routine/preventative for infants less than 6 months	Within 1 week	Within 2 week
Urgent care non-emergencies	Within 24 hours	Within 24 hours
Problems/issues deemed as not being serious	Within 2 weeks	Within 3 weeks
Prenatal 1st trimester	Within 1 week	Within 2 week
Prenatal 2nd trimester	Within 5 days	Within 1 days
Prenatal 3rd trimester	Within 2 days	Within 3 days

These expectations should be reviewed alongside mandated quality reporting listed later in this memo, which directly impacts bonus payments for IHH providers estimating the financial impact of becoming an IHH.

Primary care providers (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 beneficiaries.

Reimbursement & Quality Reporting Requirements

Funding would include a PMPM graduated fee to the IHH that would support care coordination through a two-year, 90 percent Federal Medical Assistance Percentage (FMAP) from Section 2703 of the Affordable Care Act. The program's continuity beyond the two-year federal match period is tentative at this time.

The PMPM will be paid to the IHH (fee-for-service) or passed through the MCO to the IHH as a "directed payment." MCOs will maintain a role as "care monitors" moving forward and still determine the provider network for direct care of its attributed beneficiary population. MCOs must demonstrate network adequacy, but are not required to contract with all IHHs. Beneficiaries have ability to change MCO based on IHH selection during annual choice process. 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. HFS has clarified that no MCO has chosen to become an IHH.

Initial details on PMPM reimbursement for an integrated health home is outlined in the table below for each age group:

Age Group	<19	19 to 21	>21
Tier A	$240	$240	$120
Tier B	$80	$60	$48
Tier C	$48	$48	$48
Tier D	Unknown	Unknown	Unknown

Upon enrollment in the IMPACT system, providers enrolling to become an IHH must specify which tiers of beneficiaries it is able to address. **If IHHs choose to serve a more complex tier, they must serve the less complex tiers below it (e.g., those serving Tier A must serve B, C and D), although IHHs serving lower tiers are not required to serve higher tiers.** An IHH indicator will replace the PCP indicator on the HealthChoice Illinois Plan card. MEDI will allow for viewing of tiers. IHHs are not intended to act as a gatekeeper to approve or deny care sought by the beneficiary. 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.

Only five Healthcare Common Procedure Coding System (HCPCS) encounter codes will be billed under the affiliated IHH NPI to trigger the appropriate PMPM payment based on a beneficiary's tier, including:

Code	Description	Examples
G9004	Comprehensive care management	• Complete/revise plan of care with beneficiary to identify needs/goals • Consult with multidisciplinary team on client care plan/needs/goals
G9005	Care coordination and health promotion	• Coordinate with providers and health plans as appropriate to secure care, share crisis intervention provider and emergency information • Coordinate with treating clinicians to assure services are provided and changes in treatment/medical conditions are addressed
G9007	Transitional care	• Facilitate discharge planning from ER/hospital/residential/rehab setting to a safe setting where care needs are in place • Link client with needed community supports at discharge
G9010	Patient and family support	• Develop/review/revise the individual's plan of care with client/family • Refer client/family to peer supports, support groups, social services, entitlement programs as needed
G9011	Referral to social services	• Identify resources and link client with community supports as needed • Collaborate/coordinate with providers to support utilization of services based on client/family need

IHHs only have to bill one of the above G-codes to trigger the PMPM. However, billing additional codes may improve IHH outcomes on metrics for value-based payment, determine

which providers and provider types are producing results for their beneficiaries, and help both the state and the IHH to measure cost-effectiveness of the model over time.

To support data exchange, HFS' immediate goal is to implement a statewide Admission, Discharge and Transfer (ADT) alerting notification system to advance its care coordination objectives. HFS is currently in the procurement process for an ADT system.

Quality measures, submitted quarterly, will be used to determine additional bonus payments an IHH can earn beyond the PMPM with direct payment from HFS. There will be 18 quality measures required for reporting, with only 10 measures directly influencing outcomes-based bonus payments detailed below. For any measures with sub-metrics, reporting must be performed on each sub-metric. Initial details shared at the Town Halls indicate a minimum of 30 beneficiaries of the 500 minimum must be enrolled for at least 6 months continually in order for these metrics to qualify for outcomes-based bonus payments.

HFS plans to provide bonus payments to IHHs directly at the end of each year, rather than passing these payments through MCOs like the PMPM, with the minimum criteria as follows:

Metric Status Level	Metric Criteria	Bonus Payment
Bronze IHH	Average 40th percentile with no individual measure lower than 20th percentile	10% of total amount of IHH's care coordination per-member, per-year payment
Silver IHH	Average 60th percentile with no individual measure lower than 40th percentile	25% of total amount of IHH's care coordination per-member, per-year payment
Gold IHH	Average 80th percentile, with no individual measure less than 50th percentile	25% and potential to share savings IHH has achieved with HFS and MCOs, as determined via proxies for the total cost of care

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

The list of quality measures includes the following:

Quality Measure Description	Outcomes-Based Measures	CMS-Required Measures	HFS-Required Measures
Plan all-cause readmission rate		X	
Follow-up after hospitalization for mental illness		X	
Controlling high blood pressure		X	
Metabolic monitoring for children/adolescents on antipsychotics		X	
Prenatal and postpartum care			X
Medication management for people with asthma			X
Potentially preventable readmissions for behavioral health			X
Behavioral health related ED visits per 1000			X
Initiation and engagement of alcohol and other drug dependence treatment	X	X	
Screening for clinical depression and follow-up plan	X	X	
Chronic condition hospital admission composite - PQI	X	X	
Adult BMI assessment	X	X	
Follow-up after hospitalization	X		X
ED visits per 1000	X		X
Immunization combo 3	X		X
Breast cancer screening	X		X
Diabetes management (Hb1AC testing)	X		X
Antidepressant medication management	X		X

The potential for shared savings will not go into effect until the tentatively planned third year of the program, which will result from evaluations by both the State and the MCOs. As a reminder, the 90 percent FMAP only supports the first two years of the IHHs, requiring the State to take on significant costs in future program years. MCO staff designated to begin work immediately on IHH development include the following:

- **Blue Cross Blue Shield**:
  - Joanne O'Brien, Contracting: Joanne_obrien@bcbsil.com, 312.653.2413
  - Kimberly Dean, Project Manager: Kimberly_J_Dean@bcbsil.com,

- **CountyCare:**
  - Crissy Turino: cristina.turino@cookcountyhhs.org
  - Andrea McGlynn: amcglynn@cookcountyhhs.org
- **Harmony:**
  - Nancy Byrne: Nancy.Byrne@wellcare.com

- **IlliniCare:**
  - Hector Hernandez: HHERNANDEZ@illinicare.com
- **Meridian:**
  - Gregory A. Lee, LCSW: gregory.lee@mhplan.com, p. 312-665-0065 or 313-324-3700 x22187; f. 312-508-7273
- **Molina:**
  - Natalie Kasper: Natalie.Kasper@molinahealthcare.com
  - Matt Wolf: Matthew.Wolf@molinahealthcare.com
- **NextLevel Health:**
  - Garfield Collins: Garfield.Collins@nlhpartners.com
  - Theodore Dixon: Theodore.Dixon@nlhpartners.com

IMPACT Enrollment

Each Integrated Health Home must enroll through HFS' Provider Enrollment System (IMPACT). HFS has indicated that providers seeking to enroll should select the following under IMPACT:

- 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 and NPI combination for this enrollment and will be assigned a new HFS provider ID. The IHH owner's Tax ID may be used, but 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. The enrollment checklist in IMPACT for providers seeking enrollment as IHHs includes the following:

- ❑ 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

For general questions on IMPACT or provider enrollment, members are encouraged to reach out to IMPACT.Help@Illinois.gov or 1-877-782-5565 (select option #1).

For the most updated summary on the broader Initiative, please see the IHA Behavioral Health webpage. As additional background, recent summaries of HFS action and IHA advocacy on the *Better Care Illinois Behavioral Health Initiative* at the time of this report's release include:

- July 20 Member Memo – Illinois Medicaid Behavioral Health Initiative
- July 17 Comment Letter – Better Care Illinois Behavioral Health Initiative
- June 21 Member Memo – IHA Update: Illinois Medicaid 1115 Waiver
- April 6 Comment Letter – Proposed Medicaid Reimbursement Comment Letter
- March 27 Comment Letter – Medicaid Rule 140 Comment Letter
- December 15 Comment Letter – Strategies to Address Opioid Epidemic
- May 26 Comment Letter – Rule 132-140 Revisions
- March 10 Comment Letter – Integrated Health Home Quality Measures

Next Steps

Further summaries and updates on the IHHs will be shared through IHA Update Memos as information is shared by HFS. IHA will continue to summarize reimbursement and practice changes determined by the *Better Care Illinois Behavioral Health Initiative* as they are systematically shared by HFS in Provider Notices, webinars and public meetings.

Members are encouraged to reach out to Lia Daniels at ldaniels@team-iha.org or 630-276-5461 if they have questions or targeted feedback for IHA's continued advocacy.