Illinois Health and Hospital Association

February 18, 2020

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

SUBJECT: IHHs Delayed – Comments to IHA Extended to Feb. 19

On Feb. 5 and 6, the Illinois Dept. of Healthcare and Family Services (HFS) held two Medicaid Integrated Health Homes (IHHs) town hall-style meetings, where agency staff announced that the two-year program will be delayed from Apr. 1 to Jul. 1. **Slides from the meetings can be found here.** The IHHs, funded with 90% federal matching funds, would create a comprehensive system of care coordination services for Medicaid individuals, with chronic conditions, **who will be able to opt out of the program**.

HFS has directed all questions or comments concerning the proposed changes in reimbursement methods and standards to be submitted in writing by Sun., Feb. 23 (see Public Notice for submission instructions). **Members are urged to send any comments and concerns for inclusion in IHA's comment letter to IHA by Wed., Feb. 19.**

As noted in a Jan. 29 IHA Memo, HFS plans to implement two IHH models: one child-focused IHH and one adult-focused IHH, under which the requirements for child-based IHHs will be more stringent. A key detail at the town halls regarded per member per month rates for the IHH population, which include the following:

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

Managed Care Organization Responsibilities
The Medicaid managed care organizations (MCOs) will negotiate contracts with IHH providers. HFS is currently working with the MCOs to finalize contract language, which will set a "floor" for reporting requirements, incentives and care plans. IHHs and MCOs may negotiate on additional aspects of their contract, as the latter will be facilitating monthly pass-through payments and administrative oversight, including any staff approval, for the new IHH entities. IHHs will be paid according to the members enrolled with their entity. **Fee-for-service beneficiaries in an IHH will have this role facilitated by a third-party administrative organization that HFS will assign.**

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; and,
- The state creating an administrative services organization to carry about these responsibilities for individuals served under fee-for-service.

Health plan staff designated to work on IHH development are listed in the town hall meeting presentation (see slide 30). Provider contracting is expected to begin immediately.

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; and,
- Collect, analyze and report health status, financial and other measures and outcome data to HFS.

Requirements for the IHH Adult Model are listed in the town hall meeting presentation on slides 16-19, while the requirements for the IHH Child Model are listed on slides 20-27.

Eligibility 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. Eligibility criteria will be based on targeted conditions and 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 HFS. 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. Examples of chronic conditions that would trigger eligibility standards are listed in the town hall meeting presentation (see slide 6).

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.

CMS & State Incentivized Outcome Measures
The Centers for Medicare & Medicaid Services (CMS) IHH core measures that will be used in Illinois include:

- 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; and
- Adult Body Mass Index (BMI) Assessment.

**Measures added to the 2020 Health Home Core Set*

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 IHHs 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); and
- Employment (Adult's IHH).

HFS 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 HFS or MCOs to IHHs.

Next Steps

Additional town hall meeting dates are being planned to continue public feedback on the IHHs, while a webinar will be posted soon to repeat the recent town hall series. Frequently asked questions will be published on the IHH webpage in the coming months. Further webinars should be expected on specific topics (e.g. provider contracting, high-fidelity process, etc.). Member engagement and enrollment will begin in May. HFS also provided limited details on the program through the Public Notice posted on Jan. 24.