



November 12, 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: IHA Update #2: Integrated Health Homes

As described in an [Aug. 29 IHA memo](#), the Illinois Department of Healthcare and Family Services (HFS) is launching the Integrated Health Home (IHH) program, which it describes as a new, fully-integrated form of care coordination for all members of the Illinois Medicaid population. This update builds upon that memo with new information on:

- A [proposed amendment](#) that would modify Rule 140 (89 Ill. Adm. Code 140, pp.18242-18284) to create the IHHs, IHA's draft comments and information on how members can comment directly to HFS on the proposed rule;
- Resources from an IHA-facilitated webinar and discussion featuring HFS leadership on Oct. 4; and,
- Updates to the HFS [IHH](#) webpage, including hyperlinks to new webinar presentations, frequently asked question, specific taxonomy codes, and staffing ratios.

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 of all services and treatment to members. Integrated Health Homes are scheduled for implementation Jan. 1, 2019, and beneficiaries will be able to select an IHH provider in mid-December.

HFS is encouraging interested parties to begin the IHH application process **immediately** for the initial implementation date. **However, on November 2 at a Medicaid Advisory Committee meeting, HFS Director Patricia Bellock announced auto-enrollment has been pushed back to March 1.** IHA is awaiting formal written confirmation of this change. HFS has not yet released an IHH provider manual. It is anticipated that hospitals are well suited to become IHHs, given their current care coordination activities.

Proposed Amendments to Rule 140 Creating Integrated Health Homes

Published in the *Illinois Register* on Oct. 12, 2018, the proposed rule amends the subpart on the primary care case management (PCCM) program to create IHHs and eliminate the PCCM as a managed care program in state rule. **HFS has requested any comments in response to the proposed amendment to Rule 140 be submitted in writing by Monday, Nov. 26 to:**

Christopher Gange
Acting General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield, Illinois 62763-0002
HFS.rules@illinois.gov

We encourage members to submit comments directly to HFS on the IHH proposed rule prior to Nov. 26, and contact [Lia Daniels](#) to support IHA's comments and provide IHA with member comments made directly to HFS.

Following are potential issues IHA has identified within the proposed amendments to Rule 140:

- IHHs effectively replace the PCCM, which currently acts as a managed care model in which Medicaid beneficiaries have a medical home with a primary care provider. Clarification is necessary on whether the PCCM program will be completely phased out, or whether MCOs will still use this program in a separate, but optional capacity. **Member feedback on this change is encouraged.**
- IHHs serving beneficiary Tiers A, B and C are required to operate through a single organization or through the use of *contractual* agreements with partner entities, but IHHs serving Tiers B or C individually are required to operate through a single organization or through the use of *collaborative* agreements with partner entities. Further clarification on why IHHs serving different tiers must be made up of different types of agreements is needed.
- Based on the proposed amendment, only IHHs serving Tier A are required to serve all other tiers. Tiers B & C receive greater autonomy, with no indication IHHs serving these tiers must serve lower tiers as well. Earlier, HFS summaries indicated each higher tier would be required to serve all lower tiers. Clarification is needed to better understand tier requirements.
- Beneficiary Tier D, which HFS has indicated would be initiated after the Jan. 1 rollout, is not included at all in the rules. This group of low behavioral and physical health need beneficiaries represents approximately 89 percent of the Medicaid population in IHHs. Requirements for Tier D must be detailed, including reimbursement rates and rollout dates so IHHs can plan for operational continuity.
- IHHs are responsible for notifying HFS within three business days of any change to an IHH required professional or partner entity and submit a contractual or collaborative agreement with a new partner within 10 days. All care coordination payments after this period will be denied indefinitely until agreements with new partners are submitted.

This is a very short period of time, and should likely be extended. **Member recommendations on an adequate notification period are encouraged.**

- The Department is required to *individually approve* IHHs with less than 500 beneficiaries, due to a limited number of providers or beneficiaries in a region, rather than simply *allowing* IHHs with less than 500 beneficiaries, if these beneficiaries are not assigned by MCOs. The process as proposed may create an unnecessary administrative burden on an IHH intending to serve over 500 beneficiaries, if more are assigned in the future.
- HFS has indicated it may fulfill its responsibilities for the IHH program through the use of agents or contractors. Clarification is necessary to ensure programmatic oversight is maintained by HFS, regardless of other responsibilities potentially fulfilled by agents or contractors.
- Within an IHH's designated care coordination services, there appears to be a requirement that the IHH complete or revise a patient-centered plan with the beneficiary, family members and other supports within 30 days and at least every six months to identify a beneficiary's needs and goals. More detail is needed to understand any structure and content required within this plan, and whether the per-member, per-month fee may be denied if the plan is deemed insufficient by HFS or the beneficiary's MCO.
- Outcomes-based payment eligibility is established based on a continuous period of a minimum number of IHH beneficiaries in each quality measure, but this number is not given. More detail needs to be provided on these minimum thresholds so an IHH can proactively identify enrollment issues and work with HFS and MCOs to ensure they meet adequate numbers for outcomes-based payment.

IHA IHH Webinar & Discussion Resources

On Oct. 4, IHA facilitated a webinar and discussion on IHHs between hospital members and Teresa Hursey, acting director of the Division of Medical Programs, and Kristine Herman, bureau chief of the Bureau of Behavioral Health, at HFS. [Click here](#) for the HFS slide presentation, which was an overview of different resources posted to the HFS IHH website. [Click here](#) for the webinar recording, including a discussion and question and answer session with the department.

HFS IHH Resources

On the [HFS IHH webpage](#), several slide decks are available on aspects of the IHH program, including:

- Provider requirements, expectations, and staffing ratios ([presentation](#), [recording](#));
- Quality indicators, incentive payments and reporting ([presentation](#), [recording](#));
- Beneficiary attribution, tiering and assignment ([presentation](#), [recording](#));
- Provider enrollment ([presentation](#), [recording](#));
- Billing, claiming and payment ([presentation](#), [recording](#));

- [Taxonomy codes](#);
- [Care coordination billing codes](#);
- [Staffing ratios](#) required for the care coordination team; and,
- [Frequently asked questions](#), last updated Sept. 21, 2018.

Provider enrollment for IHHs began in mid-September. Open enrollment letters were scheduled to go to Medicaid beneficiaries by mid-October. As noted by HFS, this beneficiary explanation of IHHs was to those included in Tiers A-C.

Upcoming benchmarks or milestones in the program's implementation that have been shared through HFS include:

- November and December – beneficiary choice scheduled through open enrollment and managed care organizations must report IHH networks to HFS;
- January 1 – implementation is scheduled for beneficiaries who have voluntarily chosen an IHH in advance, of the approximately 11 percent, or 276,000 individuals, within the Medicaid population projected for inclusion in Tier A-C; and
- March 1 – auto-enrollment is scheduled for remaining non-voluntary beneficiaries within the Medicaid population projected for inclusion in Tier A-C that have not chosen an IHH, but are expected to participate, based on claims history or geography.

Patient choice and auto-enrollment for 2.2 million beneficiaries, or approximately 89 percent of the Medicaid population projected for inclusion in Tier D, have not yet been scheduled or described in HFS webinars or the proposed rule on IHHs, although HFS has shared the earliest rollout date estimate to be in April. The following is a general overview of provider requirements, which can be supplemented by detail in the HFS materials:

Documentation

- IHH enrollment in IMPACT and provider agreement with HFS
- Contracts/cooperative agreements with IMPACT-enrolled care coordination staff
- Policies and procedures for coordination staff
- Health Home attestation of staffing ratios
- IHH contracts with managed care organizations
- Usage of, or documentation of progress toward, IHH implementing an EHR

Required Care Coordination

- Face-to-face or telehealth visit to qualify for billing per-member, per-month payment under one of the five service codes (provided in IHA Update #1 Memo)
- Quarterly reporting of 18 quality measures to qualify for annual bonus payment
- Staffing ratios that could support at least 500 beneficiaries per health home

Coordination Staff Recruitment

- Nurse care manager
- Clinical care coordinator (highest ratio required for staffing)
- Physician
- Psychiatrist/psychologist/mental health specialist
- Substance use disorder specialist
- Social worker/social service specialist

Next Steps

Further summaries and updates on the IHHs will be shared through IHA update memos and IHA's *Daily Briefing* as information is shared by HFS. Current and future information on IHHs from HFS can be found on the [IHH webpage](#), [Public Notices](#) and [Provider Notices](#).

Members are encouraged to reach out to [Lia Daniels](#) if you have questions or targeted feedback for IHA's continued advocacy.