Illinois Health and Hospital Association

November 21, 2018

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

Dear Mr. Gange:

On behalf of the Illinois Health and Hospital Association's (IHA) more than 200 member hospitals and nearly 50 health systems, I am writing to provide comments on the proposed amendment published on October 12 in the *Illinois Register* that would modify Rule 140 (89 Ill. Adm. Code 140, pp.18242-18284) to create the Integrated Health Homes (IHHs), scheduled to begin on January 1, 2019.

Overall, 112 IHA members provide inpatient and outpatient mental health treatment; 85 provide inpatient and/or residential services; and 10 are dedicated, freestanding psychiatric hospitals. Approximately 80 hospitals provide outpatient mental health treatment, including flexible partial hospitalization services.

The Integrated Health Home proposal has great potential to ensure patients receive physical and behavioral health services in a more streamlined and integrated manner. Although we appreciate flexibility shown in allowing IHHs to get up to speed, IHA has serious concerns with the compressed timeline. Compliance with the program requirements, especially the need for IHHs to develop contractual and collaborative partnerships with a wide range of healthcare providers and Medicaid managed care organizations, will be critical for programmatic success. Additionally there are some structural design issues that IHA members have raised that may limit participation in the program. In particular, payment levels may not be adequate to provide the desired level of coordination based on the multiple levels of staffing ratios. Following are other concerns IHA has identified within the proposed amendments to Rule 140:

- IHHs effectively replace the primary care case management (PCCM) program, 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.
- 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.

1151 East Warrenville Rd.
P.O. Box 3015
Naperville, IL 60566
630.276.5400

700 South 2nd St.
Springfield, IL 62704
217.541.1150

400 North Capitol St. N.W.
Suite 585
Washington, DC 20001
202.624.7899

833 West Jackson Blvd.
Suite 610
Chicago, IL 60607
312.906.6150

www.team-iha.org

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 and 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 ten 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 to at least a 30-day period.
- 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.

Thank you for your interest in expanding Medicaid service eligibility for care coordination and further integrating medical and behavioral healthcare. If you have any questions or comments, please contact me at pgallagher@team-iha.org or 630-276-5496, or Lia Daniels at ldaniels@team-iha.org or 630-276-5461.

Sincerely,

Patrick Gallagher, Senior Vice President, Health Policy and Finance

cc: Patricia Bellock, HFS
Teresa Hursey, HFS
Lia Daniels, IHA