Integrated Health Home Overview

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Agenda

1. What is an Integrated Health Home (IHH)
2. Lake County Impact
3. Requirements:
   - -Professionals required
   - -Appointment standards
4. IHH Client Tiering
5. Payments
6. Staffing Ratios
7. LCHD/CHC Strategic Decisions

Integrated Health Home Vision

- Fully-integrated coordinated care including **physical**, **behavioral** and **social** for members of Illinois Medicaid
- **Comprehensive system of care coordination** for Illinois Medicaid individuals with chronic conditions
- **Coordinate with** and paid through **MCOs**
- **Intensive set of services** for a small subset of members who require coordination at the highest levels
- Will have collaborative agreements with multiple entities / service providers to ensure service coordination
- Rewarded for outcomes

What is an Integrated Health Home?

Integrated Health Homes in Illinois are:

Primary focus is on coordination of care…

- **Integrated, individualized care planning and coordination resources,** spanning physical, behavioral and social care needs
- An opportunity to **promote quality** in the core provision of physical and behavioral health care
- 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

For members with the highest needs:

- A means of facilitating **high intensity, wraparound care coordination**
- An opportunity to obtain **enhanced match for care coordination needs**
- **Identifying enhanced support** to help these members and their families manage complex needs (e.g., housing, justice system)

Integrated Health Homes in Illinois are NOT:

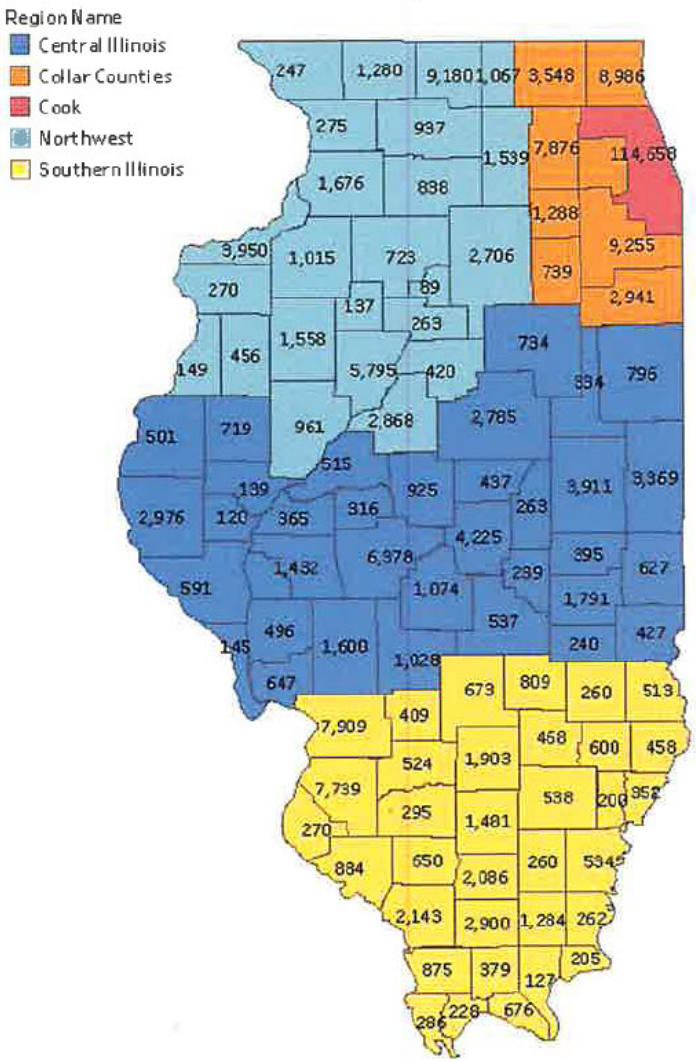
…NOT on the **provision of all services**

- **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

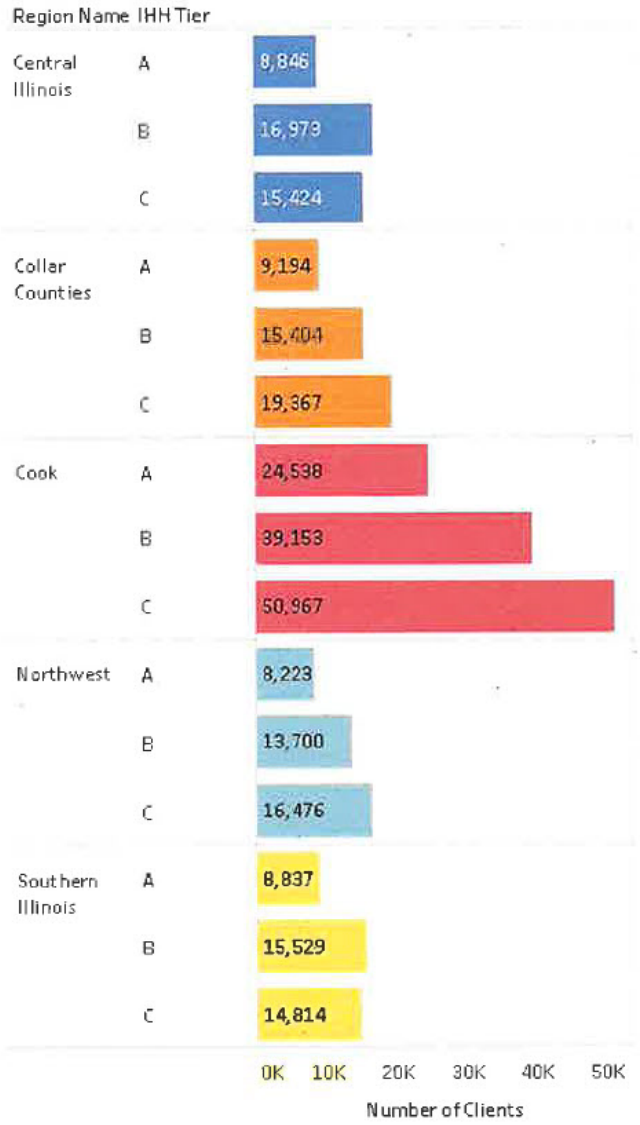
Required IHH Activities to Meet System Transformation Goals

Barriers to integrated care		Integrated care facilitated by IHH care coordination
Infrequent data sharing and communication between providers **Siloed care planning**	**Integrated care planning and monitoring**	Providers take **holistic view of health,** supplying full set of services appropriate to members' needs **Comprehensive care plans** developed with member and caregivers, supported by ongoing communication with behavioral and physical healthcare providers
Frequent barriers to attendance to medical appointments **Little continuity in care delivery** across providers	**Physical health provider engagement**	**Improved access** to providers for routine appointments and time-sensitive support Integrated experience with **seamless connections and communication across providers**
Frequent barriers to attendance to behavioral health appointments **Little continuity in care delivery** across providers	**Behavioral health provider engagement**	**Improved access** to providers for routine appointments and time-sensitive support Integrated experience with **seamless connections and communication across providers**
Limited provider engagement with community supports in the care and recovery process	**Supportive service coordination**	**Access to and collaboration with community supports** is prioritized Member **needs are communicated to community partners**
Infrequent follow-ups and outreach to members and their caregivers (e.g., partners, foster parents,) **Reactive treatment programs,** with little emphasis on self-care, education, and independent living skills	**Member engagement & education**	Support for **treatment and medication adherence** Enhanced **social skills training, emphasis on independent living and engagement with supports**
Providers take a **case-by-case view of population health** Member **focus determined based on episodes** Providers make **limited use of screening tools**	**Population health management**	Improved dialogue among providers **on quality outcomes across panel** Continuous **stratification of panel and use of standardized assessment processes to identify highest-needs members**

IHH Summary



IHH Clients by Region



LakeCounty
Health Department and
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General Requirements

Required Professionals

The IHH must maintain the following categories of professional staff:

1. **Physician:** Appropriate clinical license and/or professional certification and referring capabilities to appropriate medical specialists
2. **Psychiatrist/Psychologist/Mental Health Specialist:** Appropriate clinical license and/or professional certification, e.g., Licensed Practitioner of the Healing Arts (LPHA)
3. **Substance Use Disorder (SUD) Specialist:** Appropriate clinical license.
4. **Social Worker/Social Service Specialist:** Possess, at minimum, a bachelor's degree in a relevant subject
5. **Nurse Care Manager:** One lead nurse care manager (qualified RN) per practice, with further nurse care managers as needed.
6. **Clinical Care Coordinator:** Possess, at minimum, a bachelor's degree with previous case management experience and appropriate clinical licenses and/or professional certification

Enrollment of an IHH: General Requirements

Maintain Appointment Standards

Type of Appointments	Tiers A & B	Tier C	Current MCO appointment standards (pre-IHH)
Routine/Preventative for adults	Within 3 weeks	Within 5 weeks	Within 5 weeks
Routine/Preventative infants less than 6 months	Within 1 week	Within 2 weeks	Within 2 weeks
Urgent Care Non emergencies	Within 24 hours	Within 24 hours	Within 24 hours
Problems/Issues deemed as not being serious	Within 2 weeks	Within 3 weeks	Within 3 weeks
Prenatal 1st Trimester	Within 1 week	Within 2 weeks	Within 2 weeks
Prenatal 2nd Trimester	Within 5 days	Within 1 week	Within 1 week
Prenatal 3rd Trimester	Within 2 days	Within 3 days	Within 3 days

Client Population

Target Population

4 tiers, reflecting acuity of behavioral and physical health needs:

- Tier A: High behavioral and high physical health needs
- Tier B: High behavioral and low to moderate physical health needs
- Tier C: High physical and low to moderate behavioral health needs
- **Tier D:** Low to moderate behavioral and low to moderate physical health needs

Exclusions

- **Full Medicaid population except:**
  - MMAI
  - Individuals with partial benefits
  - High TPL
  - Residents in a specific set of LTC facilities, e.g., SNFs (90+ days)

Clients are tiered using the CRG software and a series of behavioral health diagnosis codes or a triggering event

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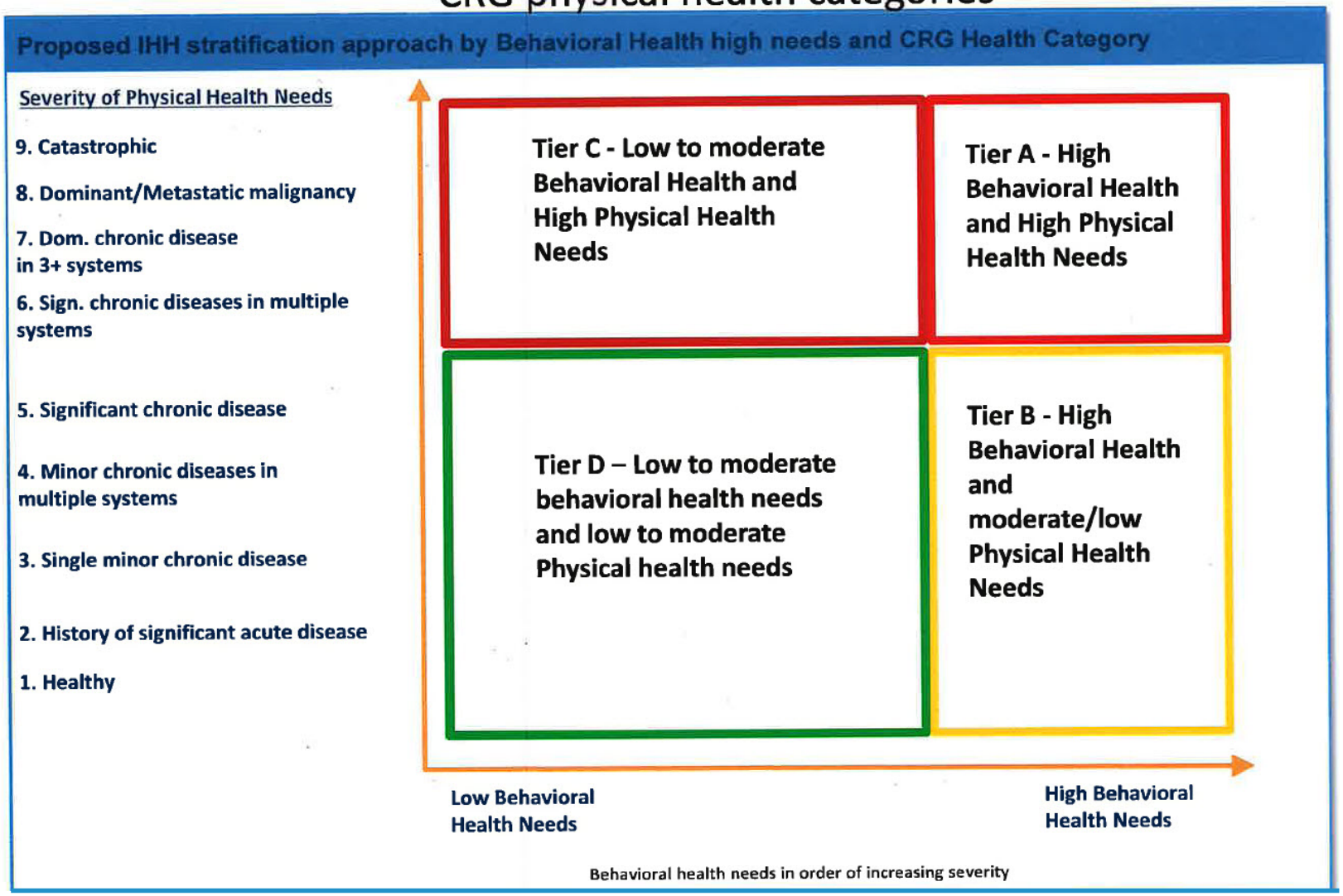
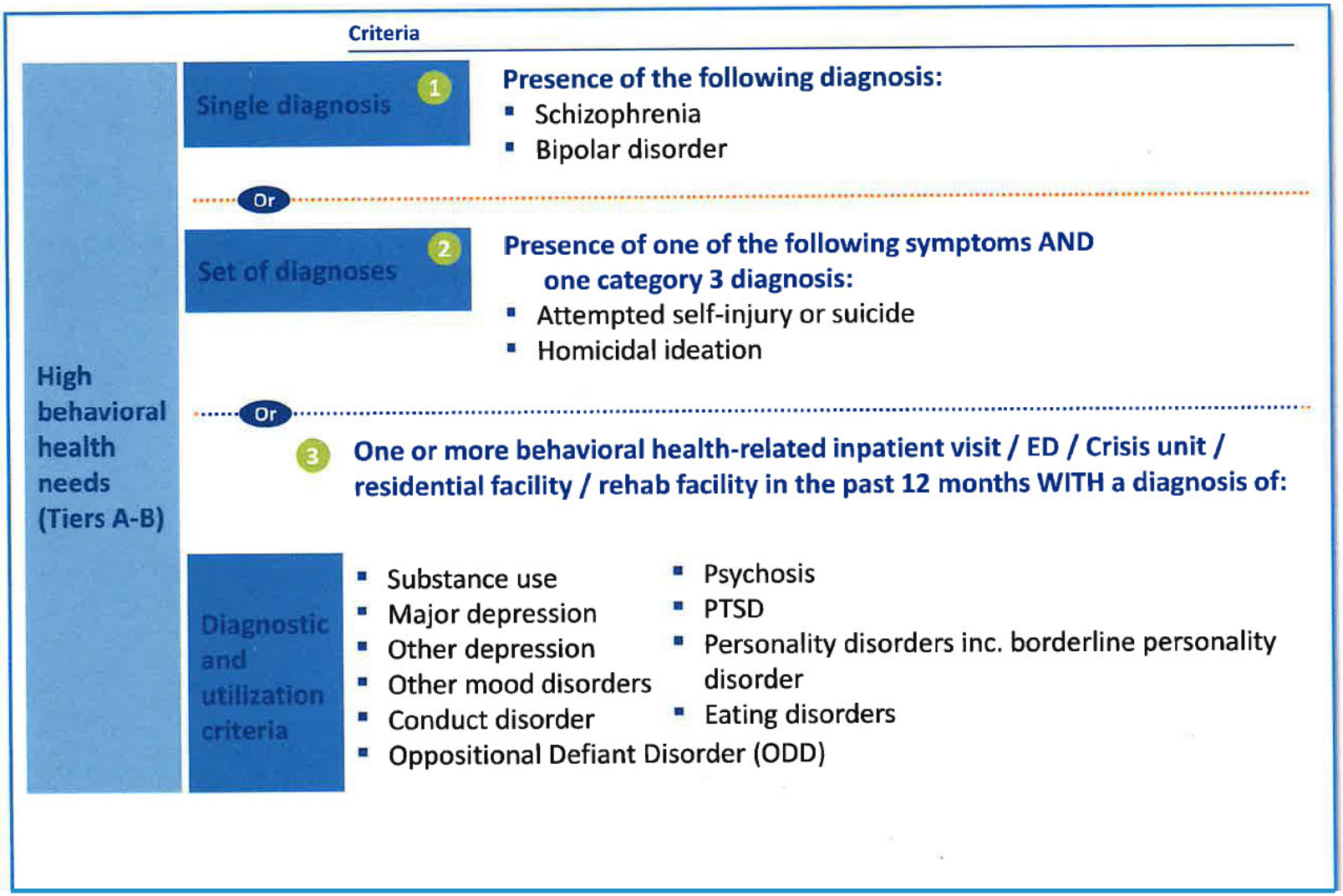
IHH stratification approach by levels of behavioral health needs and CRG physical health categories



High behavioral health need members are identified based on diagnosis and utilization



PMPM rates by Tier

Tier-based payments *	Child PMPM	19-21 PMPM	Adult PMPM
Tier A	$240	$240	$120
Tier B	$80	$60	$48
Tier C	$48	$48	$48

* Paid once per month for each member in applicable group and when one of five (5) service codes is billed by the IHH.

List of Quality Measures

Measures for reporting only

- Plan All-Cause Readmission Rate
- Follow-up After Hospitalization for Mental Illness
- Controlling High Blood Pressure
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Prenatal and Postpartum Care
- Medication Management for People with Asthma
- Potentially preventable readmission for Behavioral Health
- Behavioral Health related ED visits per 1000

Measures impacting outcomes-based payments

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Screening for Clinical Depression and Follow-Up Plan
- Chronic Condition Hospital Admission Composite – PQI
- Adult BMI Assessment
- Follow-up After Hospitalization
- ED Visits per 1000
- Immunization Combo 3
- Breast Cancer Screening
- Diabetes Management (Hb1AC testing)
- Antidepressant Medication Management

CMS health home core measures

- **Reporting required on all 18 measures**
- **Outcomes-based payments impacted by** the 10 selected measures

Integrated Health Homes

Staffing FTEs per 500 members

		Nurse Care Manager	Clinical Care Coordinator	Physician	Psychiatrist/ Psychologist/ Mental Health Specialist	SUD Specialist	Social Worker/ Social Service Specialist
Tier A	Under 18	1.50	20.00	0.15	0.20	0.74	0.51
	18-20	1.50	20.00	0.15	0.20	0.74	0.51
	21+	0.80	10.30	0.07	0.10	0.37	0.25
Tier B	Under 18	0.51	6.80	0.05	0.07	0.25	0.17
	18-20	0.38	5.10	0.03	0.05	0.19	0.13
	21+	0.31	4.10	0.03	0.04	0.15	0.10
Tier C	Under 18	0.31	4.10	0.07	0.02	0.07	0.10
	18-20	0.31	4.10	0.07	0.02	0.07	0.10
	21+	0.31	4.10	0.07	0.02	0.07	0.10

LCHD/CHC Strategic Decisions

Opportunities

- Increased care coordination and improved services for Lake County residents
- Enhanced partnerships (contractual)
- Ability to receive external electronic health information on members' status from rendering providers (e.g. ADT feed)
- Enhanced capacity and potential new revenue
- Potential to be the only IHH in Lake County

LCHD/CHC Strategic Decisions

Risks

- Unknown patient population by tier
- Potential to be the only IHH in Lake County
- Unrealistic HFS application and implementation dates
- Lack of willing partners to contract with
- Patients may select another IHH (loss of patients)
- No seed money to increase staffing ratios
- Lack of physical space to house new employees

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