Integrated Health Homes (IHH) Frequently Asked Questions from Town Halls

Overview

1. **Question: What is an Integrated Health Home?**
   Answer: An Integrated Health Home is a new, fully-integrated form of care coordination for all members of Illinois Medicaid. The Integrated Health Home will coordinate physical, behavioral, and social healthcare for its members, either as a single entity or through collaborative agreements with multiple entities. An Integrated Health Home is responsible for care coordination for members but would not be responsible for provision of all services and treatment to members. An Integrated Health Home is not a gatekeeper for services and will still be required to seek prior approval for services when necessary.

2. **Question: What populations can an Integrated Health Home serve?**
   Answer: Integrated Health Homes (IHH) are designed for all Medicaid members in Illinois except for select technical exclusions (i.e., members with partial benefits, MMAI duals, and members with high third-party liabilities). Additionally, members enrolled in long-term care for more than 90 days will have their Integrated Health Home care coordination suspended. IHH enrollment for members in Tiers A, B andC is targeted to begin January 1, 2019. Members in Tier D will be enrolled at a later date.

3. **Question: Will the IHH model include both children and adults?**
   Answer: Yes, Illinois' Integrated Health Home (IHH) model includes both populations. Federal CMS felt strongly that an IHH must be able to serve a family, without family members being required to enroll with different IHH providers. However, IHH's may decide to employ different strategies for different populations in their design.

Provider Requirements, Expectations and Staffing Ratios

4. **Question: Are any providers excluded from enrolling as an IHH?**
   Answer: Any provider or practice enrolled in the Medical Assistance Program is eligible to be an Integrated Health Home as long as they meet all of the requirements of an IHH (such as required staff) and sign a supplemental provider agreement.

5. **Question: Must an IHH serving Tier A members, also serve Tiers B, C and D?**
   Answer: Yes, IHHs serving Tier A members must also serve Tiers B, C, and D. IHHs serving Tiers B members must serve Tier D as well. IHHs serving Tier C members, must serve Tier D as well. Specifics on Tier D IHHs will be provided later after approval of a separate State Plan Amendment. The Department encourages partnering with other providers / entities to cover required populations outside your area of specialty.

6. **Question: Some organizations may already have agreements and linkages with multiple service providers. Is this allowable?**
   Answer: To be enrolled as an IHH, the IHH must have all required staff secured either through contracts or through collaborative agreements. The IHH must enroll as a new Provider Type with

a new NPI. Agreements and linkages with other providers may be advantageous for an IHH but is not required.

7. **Question: If an IHH has a memorandum of understanding or agreement with an underperforming provider, how can they address this problem?**
   Answer: The IHH (with assistance from the MCO) should work with that provider to try to improve his or her performance. If that does not work, the IHH may choose to work with the MCO to encourage referrals to another provider. The IHH must notify HFS of any changes in provider associations on IMPACT.

8. **Question: What if the member continues to choose the underperforming provider?**
   Answer: As the care coordinator, the IHH has the responsibility to work with an underperforming provider to improve their services, as well as with the member to help him or her understand the potential consequences of their choice.

9. **Question: What is impact on smaller providers that might not have infrastructure?**
   Answer: The expectation is that smaller providers who are offering quality services to members will continue to do so. Smaller providers may want to join with other entities to create IHHs that can offer care coordination to members. However, this project is designed to drive relationship development between care coordination and providers, not to force all providers to become IHHs. We will need IHHs and we will need quality providers offering direct services to members. MCOs, IHHs and providers are all necessary as we work toward the same goal for better outcomes for members.

10. **Question: What if required staff are affiliated with a different IHH?**
    Answer: That is OK. This is a collaboration model. Required staff can be affiliated with multiple IHHs. The IHH's main concern is that they have agreements that cover all required staff members. If required staff have the capability, they may be involved in multiple IHHs.

11. **Question: Will there be requirements for IHHs established by MCOs separate from HFS?**
    Answer: 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.

12. **Question: Does an MCO have to contract/enroll all IHHs in their network?**
    Answer: No. MCOs must demonstrate network adequacy but are not required to contract with all IHHs. Members have ability to change MCO based on IHH selection during annual choice process.

13. **Question: Can IHH choose geographic region?**
    Answer: Yes

14. **Question: What is contractual relationship between PCP and MCO if PCP is not enrolled in client's IHH?**
    Answer: 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 members.

15. **Question: Are there staffing requirements?**
    Answer: Information regarding the staffing requirements may be found in the IHH Town Hall Presentation located on the IHH Web site

16. **Question: Is there an expectation that IHHs will monitor provider performance?**
    Answer: It is in the best interest of the IHH to engage with collaborating providers to achieve desired outcomes. Provider performance will affect the outcomes and value-based payments to any IHH, as well as to any MCO. The approach to monitoring any individual provider should be worked out between the MCO in its role as the care monitor and the IHH in its role as the care coordinator.

17. **Question: Can the IHH subcontract care coordination activities if the subcontractor can do it better?**
    Answer: Yes. It is important to ensure that members' needs and those of their family are met, so if a subcontractor is better suited to perform this task, that contractual relationship should be established by the IHH.

18. **Question: Will/could physician groups lose their panel of patients to IHHs?**
    Answer: No. IHHs will only be providing care coordination, not direct services. Physician groups member panels should not be impacted.

19. **Question: How is high fidelity wraparound handled in the IHH model?**
    Answer: It is not specifically required in the model. However, IHH may certainly use that model for appropriate populations, but it will not be dictated by HFS.

20. **Question: Some providers already do care coordination. Must they still have collaborative agreements?**
    Answer: To be enrolled as an IHH, the IHH must have all required staff secured either through contracts or through collaborative agreements. The IHH must enroll as a new Provider Type with a new NPI.

Enrollment in the IMPACT System

21. **Question: What will the IHH contract with the State look like?**
    Answer: Providers seeking to become IHHs will be credentialed through the IMPACT system and will have to sign a specific provider agreement with the State (see slides on IMPACT enrollment link), not a contract. Organizations will need a new NPI and will only bill for care coordination services that qualify for reimbursement under one of five care coordination codes under the new NPI. IHHs will need to bring associated entities together through contracts or collaborative agreements outlining which entity handles which aspect of the IHH requirements and how funding is distributed amongst the IHH entities. A contract will also need to be signed between the MCO and the IHH to serve participants in MCOs.

22. **Question: IHHs serving individuals in Tiers A, B and C must have a new NPI, provider agreement and enroll in IMPACT?**
    Answer: Yes, IHHs serving individuals in Tiers A, B and C must secure a new NPI, provider agreement and enroll in IMPACT. In addition, they must also contract with one or more Managed Care Organizations (MCOs). An IHH will only need one contract per MCO, meaning they do not have to have a separate contract for each tier that they are prepared to serve.

23. **Question: How is agency with multiple locations registered in IMPACT?**
    Answer: The Department will be conducting topic specific webinars in the near future. One of the topic specific webinars will be regarding IMPACT enrollment. The schedule for the webinars is posted on the Department's Public Notice Web page

24. **Question: Will IHHs have to provide associated relationships?**
    Answer: For purposes of IMPACT enrollment and billing/payment, HFS will need to be informed of any changes in the required IHH core team professionals through the enrollment and certification process (IMPACT).

25. **Question: If organizations are not ready by January 1, 2019, can IHH enroll later?**
    Answer: Like any Medicaid provider, the IHH may enroll at any time. It would be to the advantage of the IHH to participate during the initial rollout as members are participating in the HealthChoice Illinois open enrollment period. This may give the IHH maximum opportunity to enroll members.

Attribution, Tiering and Assignment

26. **Question: How will HFS tier children?**
    Answer: The Department has developed a model grouping individuals by their level of need across two domains: physical health and behavioral health. Members with high levels of need across both domains will receive the highest levels of support. Member tier assignment will be determined based on behavioral health and physical health needs. Behavioral health needs definitions will be determined based on Illinois-specific data analysis. Physical health needs will be defined using commercially-available risk-adjustment software (e.g., 3M CRG™).

27. **Question: Can we get the geographic location of Illinois Medicaid members currently attributed to Tier A?**
Answer: Yes, HFS will provide those details as soon as they are available.

28. **Question: How often will members be re-evaluated or re-tiered?**
Answer: Retiering will occur on a quarterly basis using claims data received during the previous quarter. Additionally the IHH or MCO could request that a member be retiered outside of the regular schedule if a "triggering event," such as a hospitalization or other significant change in the member's condition, occurred.

29. **Question: How will providers know what tier a member is in?**
Answer: An IHH indicator will replace the PCP indicator on the HealthChoice Illinois Plan card. MEDI will allow for viewing of tiers.

30. **Question: Children identified with complex medical needs by the Department may not match the MCO's tiering. Can children be retiered?**
Answer: The Department will be retiering on a quarterly basis. MCOs who feel a member is not in the appropriate tier may submit an appeal to the Department.

31. **Question: When will clients be tiered? Will provider know?**
Answer: HFS will do preliminary tiering soon and share geographic distribution during the webinar regarding tiering. The schedule for the webinars is posted on the Department's Public Notice Web page. The MCO and the IHH will know their tier to which a member is attributed and may choose to share with collaborating providers.

32. **Question: Are there other factors such as social determinants of health and justice involvement as part of tiering?**
Answer: Social determinants are not factored in tiering at this time but could be considered at a later date. Certainly, we hope the IHH will focus on these issues for their membership.

Billing, Claiming and Payment

33. **Question: There are five care coordination procedure codes that an IHH may bill. How does the "face to face" requirement work within that billing structure?**
Answer: This will be discussed in the topic specific webinars regarding Billing, Claiming and Payment. The schedule for the webinars is posted on the Department's Public Notice Web page

34. **Question: If my organization is a Federally Qualified Health Center (FQHC), can I bill for both services and care coordination?**
Answer: In order to receive reimbursement for care coordination, FQHCs must be enrolled as an IHH with a new Provider Type, a new NPI and all required staff. The IHH would be reimbursed for coordinating the care of the enrollees. The FQHC would be reimbursed separately for any physical or behavioral health services provided to enrollees.

35. **Question: What if the IHH did not see the member on a face to face basis during the month?**
Answer: The IHH would not qualify to receive the PMPM payment that month, as a minimum of one contact must be face to face.

36. **Question: What are the codes and rates for the IHH care coordination services?**
    Answer: IHHs must submit a claim for the appropriate care coordination G-code. The care coordination G-code will be viewed in the HFS billing system as an encounter, and will be paid at $0. The encounter will set a trigger for the appropriate PMPM payment for the IHH based on the members tier. The PMPM will be paid to the IHH (fee-for-service) or passed through the MCO to the IHH as a "directed payment."
    The IHH allowable codes are as follows:
    G9004 – Comprehensive Care Management
    G9005 – Care Coordination and Health Promotion
    G9007 – Transitional Care
    G9010 – Patient and Family Support
    G9011 – Referral to Social Services

37. **Question: Will the care coordination rates be the same for IHHs for enrollees in MCOs and individuals in Fee-For-Service?**
    Answer: Yes. The IHH rates established by the Department are the same for enrollees in MCOs and individuals in FFS.

38. **Question: Will HFS accept collaborative care codes?**
    Answer: The IHH allowable codes are as follows:
    G9004 – Comprehensive Care Management
    G9005 – Care Coordination and Health Promotion
    G9007 – Transitional Care
    G9010 – Patient and Family Support
    G9011 – Referral to Social Services

39. **Question: Can care coordination codes be billed by any required professionals who are part of the core team of the IHH?**
    Answer: The care coordination codes must be billed under the IHH's NPI. 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.

40. **Question: Why is PMPM so much higher for complex children than adults?**
    Answer: If children have complex needs, the expectation is that family is involved and should be served as well. Also, service costs for these children on average are higher than adults – more moving parts/services to coordinate.

Quality Indicators, Incentive Payments and Reporting

41. **Question: Will "shared savings" be triggered by the MCO and IHH?**
    Answer: The potential for shared savings will not go into effect until Year Three of the program, and will result from evaluations by both the State and the MCOs.

42. **Question: What is incentive for billing additional codes after PMPM is met?**
    Answer: Billing additional codes will likely improve IHH outcomes on metrics for value based payment, as well as determine which providers and provider types are producing results for their members. It may help both the state and the IHH to measure cost-effectiveness of the model over time.

43. **Question: Why is there a lag in metric reporting?**
    Answer: Providers have 180 days to bill. While most bill within a few months, processing of lagged billing will continue to impact the metrics. HFS will be generating reports, as will the MCOs.

44. **Question: How are bonuses calculated? What are bonuses calculated upon/**
    Answer: The Department will be conducting topic specific webinars in the near future. One of the topic specific webinars will be regarding Quality indicators, incentive payments and reporting. The schedule for the webinars is posted on the Department's Public Notice Web page

45. **Question: Are value-based metrics excluded where there is not a valid pool (e.g. 30 members for 6 months)?**
    Answer: Yes

Member Engagement/Freedom of Choice

46. **Question: Members are mobile. Can a member change their IHH selection if they move? How often can a member request to switch their IHH?**
    Answer: Yes. Members may choose a different IHH if they relocate. Regardless of the situation, members may change IHHs as frequently as once per month. Members are also free to opt of the IHH program at any time.

47. **Question: Will a member be assigned to an IHH and a PCP?**
    Answer: In fee-for-service, Tier A, B and C members will no longer have a PCP assigned by the Department. Instead, members will choose an IHH or be auto-assigned if no IHH is selected. The member will continue to receive care from their physician of choice as long as the physician is an enrolled provider and, if enrolled in an MCO, the provider is part of the network. MCOs may choose to also retain PCP relationships as well as IHH.

48. **Question: Will DCFS clients be enrolled in HealthChoice Illinois as of October 1, 2018?**
    Answer: No. The official date for DCFS enrollment in HealthChoice Illinois has not been determined but it will not be October 1, 2018.

49. **Question: Can individuals have choice of their providers once enrolled in IHH?**
    Answer: Yes. Members are not limited to IHH collaborating providers. However, different MCOs may encourage this to varying degrees.

50. **Question: Will there be a list of IHH providers?**
    Answer: Yes. The Department will publish a listing of IHHs. MCOs will be responsible for communicating to their members the IHHs available for selection based on their tier assignment. The client enrollment broker will also be involved in choice of MCO / IHH.

51. **Question: If individual is receiving case management billed through Medicaid, are they excluded from IHH?**
    Answer: Yes. 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 care management PMPM.

52. **Question: How do we get members to engage? Some might be homeless or not engaged.**
    Answer: While outreach efforts to this population may be difficult, IHHs should make every attempt to find and engage members. This is why the face to face contact is so important each month.

53. **Question: How do members know that there is IHH available?**
    Answer: Members will receive letter in the mail informing them of their ability to select IHH - just like PCP today. Members will be informed of all eligible IHHs in their MCO network as well as how to choose.

54. **Question: How might family members be impacted by IHH assignment?**
    Answer: IHHs will be able to serve all members of a family regardless of the family member's tiers. This arrangement will allow families to all be enrolled in the same IHH, if they choose to be. However, if one family member wants to choose another IHH, that is also acceptable.

EHR/ADT

55. **Question: Many vendors have EHR and ADT systems. Is the state setting up an HIE platform for exchanging data?**
    Answer: The Department's immediate goal is to implement a state-wide Admission, Discharge and Transfer (ADT) alerting notification system to advance our care coordination objectives. The Department is currently in the procurement process for an ADT system.