Illinois Health and Hospital Association

January 14, 2019

IHA Update #4: Integrated Health Homes

As described in a Dec. 3 IHA Memo, the Illinois Department of Healthcare and Family Services (HFS) is delaying the Integrated Health Home (IHH) program until administrative rules are adopted. HFS describes the IHHs as a new, fully-integrated form of care coordination for all members of the Illinois Medicaid population. This update builds upon that previous memo with new information on:

- A Jan. 2 HFS Public Notice seeking questions or comments on the development of a new service definition and code for activities related to provider consultations with IHHs, which faces potential revisions as the state seeks approval from the federal Centers for Medicare and Medicaid Services (CMS);
- The Second Notice for the IHH rulemaking, which was accepted by the Joint Committee on Administrative Rules (JCAR) for consideration at JCAR's Feb. 19 meeting;
- Issues identified by IHA that still need to be addressed in the rules with a request for member feedback; and
- Instructions for submitting individual written comments in response to the HFS Public Notice, or submitting comments to IHA regarding the Public Notice or IHH rulemaking.

Details on HFS Public Notice & IHH Rules

Federal requirements specify that HFS release a public notice that provides an opportunity for written comments when planning any significant proposed change in its methods and standards for setting payment rates for services (42 CFR 447.205). HFS did not share any new details in the Public Notice on IHH service or rate details. However, in 2018 HFS proposed:

- Care coordination procedure codes and descriptions for IHHs;
- Corresponding per member, per month rates for tiers representing 276,000 Medicaid beneficiaries; and
- Annual incentive payments IHHs may potentially earn.

Tier D rates, representing 2.2 million beneficiaries, have not yet been shared publicly and the IHH timeline to incorporate this population is currently unknown. The Second Notice for the IHH rulemaking included:

- Changes that HFS made in response to public comment on the proposed IHH rule (pp. 3-4; IHA comments can be found here);
- A summary of public comments and HFS' response to them in a table (pp. 9-20); and,
- A list of commenters on the First Notice of IHH rulemaking (pp. 20-22).

IHA has edited the First Notice for the IHH rulemaking to incorporate language changes indicated in the Second Notice for ease of member review of the most up-to-date information. This comprehensive rule language can be found here. IHA comments impacted some changes in the IHH rules, but IHA has highlighted a selection of the outstanding issues that remain in the rules:

- Tier D, representing 89percent of the Medicaid population, is still not part of the initial rollout of the IHH program, which only benefits from a substantial federal match for a period of two years. After this period, the state must contribute 50 percent of funds to the program. HFS has indicated the proposed rulemaking for Tier D will be separate from this rulemaking, even though initial provider feedback has indicated incorporating this population into the IHH program with appropriate rates would create stronger probability of operating a viable IHH. Continued member feedback on the exclusion of Tier D is encouraged.

- The face-to-face or telehealth encounter has been shifted to once every six months, with monthly telephonic encounters required instead. However, the telehealth allowance for face-to-face encounters should be clarified to include natural environments, such as the home, to address transportation barriers often faced by the Medicaid population.
- IHHs will now be required to provide oversight that there will be no duplication of services and payment for similar services provider under Medicaid authorities, such as Community Mental Health Center case management, even though MCOs and HFS are the only bodies with access to this comprehensive billing data. HFS or MCO oversight of this federal requirement is recommended.
- Although it was clarified that Medicaid beneficiaries can opt out of IHH participation to receive case management services provided by a Community Mental Health Center, HFS must ensure case management reimbursement will not be interrupted during this enrollment and opt out period.
- IHHs serving beneficiary Tiers A, B and C are now all required to operate through a single organization or the use of contractual/collaborative agreements, which previously proposed to separate the type of agreement by Tier. However, clarification is now needed as to whether either type of agreement or both are required for submission to HFS prior to formal IHH approval. Member feedback is encouraged providing any preference on agreement requirements.
- IHHs are now responsible for notifying HFS within 10 business days of any change to an IHH required professional or partner entity and submit a contractual/collaborative agreement with a new partner within 60 days, previously 3 and 10 days. However, the extensions should be lengthened to 30 and 90 days to accommodate typical operational and hiring timelines. Member feedback is encouraged.

Although the Second Notice for the IHH rulemaking indicated an anticipated annual increase of $309 million on State expenditures, the most recent Public Notice from HFS clarifies that rates are expected to be budget neutral over the life of the IHH program based on current utilization patterns for providers enrolled as community mental health centers or behavioral health clinic. Unlike budgetary projections, the IHH program has been described in previous HFS webinars as open to a broader spectrum of Medicaid providers, including hospitals and federally qualified health centers. IHHs are also expected to coordinate care across behavioral and physical health services.

Submitting IHH Questions or Comments
Any interested party may submit questions or comments concerning these proposed changes in reimbursement methods and standards. All questions or comments must be submitted in writing directly to HFS by January 29 and addressed to:

Bureau of Program and Policy Coordination
Division of Medical Programs
Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763-0001
E-mail address: HFS.bpra@illinois.gov

The proposed rule on IHHs 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. The IHA comment letter on the proposed rule can be found here.

Members are also encouraged to submit questions or comments on (1) the HFS Public Notice or (2) the Second Notice changes for the IHH rulemaking to Lia Daniels, Manager, Health Policy, by January 22, for inclusion in IHA comments to HFS.