

APPENDIX V

VISION FOR INTEGRATED HEALTH HOMES IN ILLINOIS

Introduction

The Integrated Health Home (IHH) program is intended to be a new, fully-integrated form of care coordination for all members of the Illinois Medicaid population. Each member in the Medicaid population would be linked to an Integrated Health Home provider, based on their level of need and the provider's ability to meet these needs. The Integrated Health Home would be responsible for care coordination for members across their physical, behavioral, and social care needs. Integrated Health Homes would not, however, be responsible for provision for all services and treatment to members. The program is intended to launch in July 2017.

Member tiering and attribution

Members would be assigned to one of several tiers based on their level of need, and would be provided with a commensurate level of care coordination. This would be ascertained, first and foremost, with reference to their medical history and profile. Specific criteria for eligibility for each tier of membership would be defined, and members' MCOs would be responsible for the review of their medical history for evidence of these criteria, and the assignment of the member to the appropriate tier of need. MCOs would also transfer them to different tiers of care as their needs change over time, following pre-defined reassignment criteria, and manage the manual assignment of members without available medical history data.

After assignment to a tier of care, members would be attributed to an IHH provider best able to meet their needs, following a pre-determined attribution logic. The member would be notified of their place within the program and their prospective IHH provider, together with rights to opt out of the program or request a different provider. Likewise, the provider to which the member has been attributed would be alerted to this, to permit them to begin outreach. The members' MCO would play a key supporting role in this process.

Potential approach to reimbursement and incentives for improved performance

Two main support streams are under consideration. In order to deliver care coordination (as needed) from a pre-determined set of IHH activities, providers would receive per member per month reimbursements. For members in the highest tiers of membership, submission of claims to generate a reimbursement may be required (as opposed to automatic, prospective transfers). MCOs will play a role in facilitating the payment of the PMPM to the IHH provider in a timely fashion, with appropriate safeguards.

The second stream to which providers would potentially be eligible is an outcomes-based stream, calibrated to incentivize value over volume. As is currently envisaged, provider performance against a set of quality and efficiency measures for their panel would be monitored for the duration of their membership in the program. Strong performance on these measures – without sacrificing quality in the pursuit of cost savings – would be used to determine both eligibility for this stream, and the extent of the value of the remuneration to

providers. Information on provider performance (together with actionable next steps as needed) may be provided to providers via a report card at regular intervals.

Monitoring and Compliance

For initial and ongoing eligibility for the program, providers would be required to comply with a set of basic standards, ranging from technical and staffing requirements, through to adequate performance on core quality measures. Alongside provider attestation to compliance for specific standards, the State and MCOs would work in partnership to deploy a variety of assessment approaches to ensure compliance on a broader set of requirements, and incentives and sanctions to drive changes in the case of underperformance.

Provider Support

In order to ensure providers are able to participate fully within the program and flourish as Integrated Health Homes, the State is considering a range of potential support options. This includes disseminating relevant information and offering guidance during the initial application process through to targeted training for providers on key topics (e.g., member engagement, cultural and linguistic competency) and the establishment of a provider learning collaborative. The State would work closely with its MCO partners in developing these provider support mechanisms.

Role of the MCO Interdisciplinary Care Team (ICT) in supporting, supplementing, and monitoring Integrated Health Homes

MCO Interdisciplinary Care Teams would have responsibilities distinct from those of Integrated Health Homes' care coordination teams. IHHs would hold primary responsibility for individualized care planning, supporting communication between members' providers and providing referrals for specialty services, coordinating access to and collaboration with supportive services, engaging members to support treatment and appointment adherence, and population health management across their entire panels of members.

ICTs would be able to participate in the monitoring of IHHs' performance on each of these aspects of care delivery, provide them with necessary input to support the development of individual plans of care, and ensure that members have access to covered benefits and services for which Integrated Health Homes determine that they have medical need. Additionally, they would be able to help support the successful enrollment of members into IHHs or the transfer of members between Integrated Health Homes (alongside their medical information). For members who choose to opt out of the Integrated Health Homes program or do not have access to an IHH, ICTs may perform primary care coordination services.