Health and Human Services Transformation

Learning and Advocacy for Behavioral Health – Primary Care Integration

Integrated Health Homes

June 25, 2018

INTEGRATED HEALTH HOMES

What an Integrated Health Home is and is not

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:

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

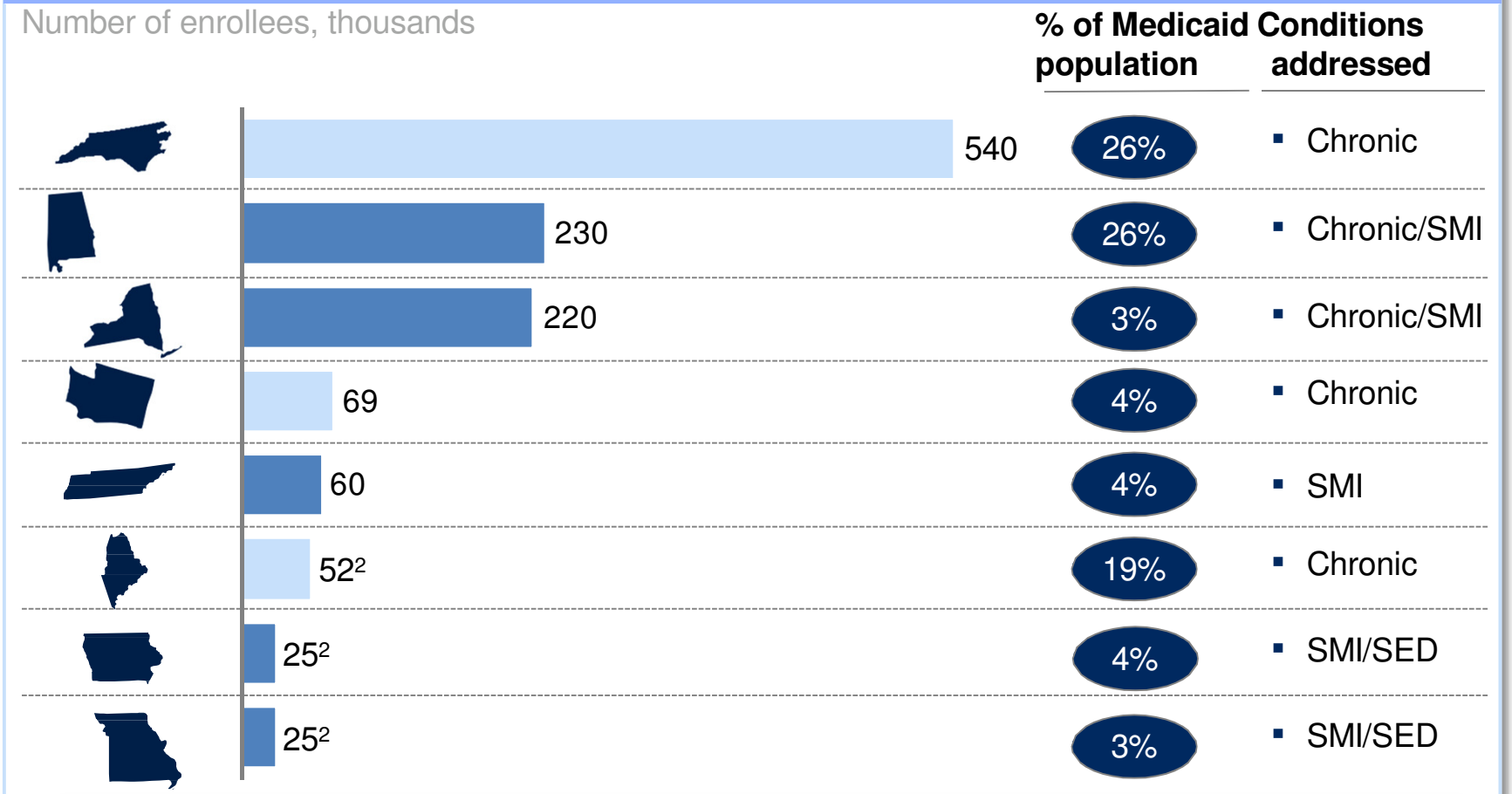
- **Provider of all services for members**
- **A gatekeeper** restricting a member's choice of providers
- **A physical place** where all Integrated Health Home activities occur
- **A care coordination approach that is the same for all members** regardless of individual needs

Profiles of ACA Health Homes launched to date

Illinois would be the first fully integrated Health Home

Includes members with SMI/SEDs[1]

Largest Medicaid Health Home programs developed as of February 2017



Many states also employ Patient-Centered Medical Home programs to coordinate the physical health needs of their members separately, but **Illinois model would coordinate both physical and behavioral health care for all ~3.1m Medicaid members**

1 Only includes members who are part of the state's largest Health Home program

2 SMI = Serious

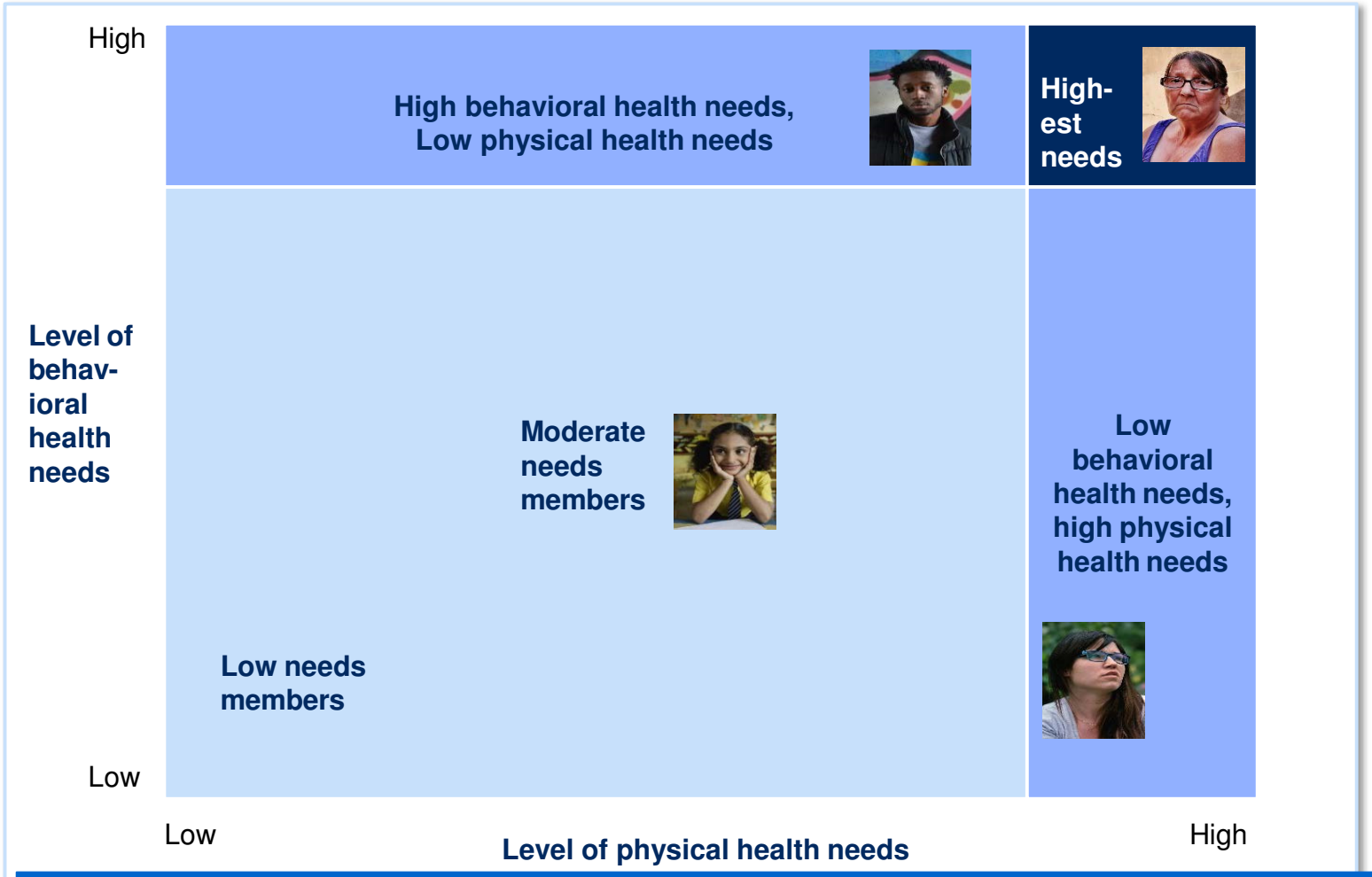
SOURCE: CMS Health Home IRC

Principles for developing care delivery model

- Develop a **person- and family-centered care delivery model for the whole Medicaid population, regardless of match status,** that encourages member and family engagement
- Evolve toward **full clinical integration of behavioral, physical, and social healthcare**
- Craft a flexible care delivery approach that reflects **the diverse needs of members in Illinois** and recognizes that member needs change over time
- Acknowledge and accommodate **geographical variation in provider capabilities, readiness, and priorities**
- Strike an **appropriate balance between provider flexibility and accountability** to enable capabilities and readiness
- Prioritize **economic sustainability of care delivery model** at both the systemic and provider levels

A Overview of potential approach to IHH member stratification

ILLUSTRATIVE



- Full Medicaid population will be included in the model, with exception of those receiving duplicative care coordination, in LTC facilities after 90 days, or with MMAI dual, partial eligibile, or TPL status
- Approach to tiering adopted to ensure members with similar needs receive comparable care coordination support, and to focus resources on those members who need greatest support

Integrated Health Home Implementation and Next Steps

- Reimbursed through a per-member, per-month (PMPM) case management fee
- Model includes outcomes-based payment model rewarding measurable, positive outcomes associated with integrated care
- Developed in consultation with input and feedback from the HFS Medicaid Waiver Advisory Committee and sister state agencies
- HFS will continue collaboration with interested parties through learning collaboratives, provider forums and in-person meetings
- Anticipated Effective Date for Integrated Health Homes is October 1, 2018
- Questions?