



# Integrated Health Homes: For Individuals with Serious Mental Illness

## FREQUENTLY ASKED QUESTIONS

### ***What is an Integrated Health Home?***

An Integrated Health Home (IHH) is a team of professionals working together to provide whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). Care coordination is provided for all aspects of the individual's life and for transitions of care the individual may experience.

### ***Who will be served by the Integrated Health Home for individuals with a serious mental illness?***

The Integrated Health Home will serve individuals that are enrolled in Medicaid. Adults who meet the criteria for an SMI or children who meet the criteria for an SED will be eligible for IHH. This includes individuals currently receiving Targeted Case Management (TCM) and Case Management through Medicaid- funded Habilitation. It will also include additional individuals who are not currently receiving care coordination.

### ***How many people are expected to enroll in Integrated Health Homes?***

Starting July 1, 2013 adults with an SMI and children with an SED will be enrolled in an Integrated Health Home in five Iowa counties, **Linn, Polk, Warren, Woodbury and Dubuque for children** (adults in Dubuque will begin IHH January 1, 2014). The remaining Iowa counties will be phased in over the next 12 to 18 months. Projected Integrated Health Home enrollment for individuals with an SMI or an SED is based on claims analysis and provider network capacity in each area:

<u>Phase</u>	<u>Estimated Date</u>	<u>SMI</u>	<u>SED</u>	<u>Total</u>
Phase 1	July 2013	3,489	3,352	<b>6,841</b>
Phase 2	January 2014	5,736	3,376	<b>9,112</b>
Phase 3	July 2014	<u>5,028</u>	<u>3,154</u>	<b>8,182</b>
<b>Total</b>		<b>14,254</b>	<b>9,881</b>	<b>24,135</b>

### ***Are the individuals served by an Integrated Health Home the same as those currently served by Targeted Case Management?***

The Integrated Health Home will serve a greater number of people than are currently served through Targeted Case Management.

	<u>SMI</u>	<u>SED</u>	<u>Total</u>
Projected IHH enrollment	14,254	9,881	24,135
Currently receiving TCM*	4,642	983	5,625
Percentage receiving TCM*	32.5%	9.9%	23.3%

\* Based on 4/30/12 data

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## ***How is an Integrated Health Home different from Targeted Case Management?***

Targeted Case Management provides an individual staff person to help coordinate care while an individual is receiving community-based services. An Integrated Health Home provides care coordination through a team of professionals including access to Family and Peer Support services. The Integrated Health Home provides care coordination across all aspects of an individual's life, including coordination of physical health care and successful transitions from inpatient and other residential treatment.

## ***Who will provide Integrated Health Home services?***

Integrated Health Home providers must have the capability of forming a team of professionals required to provide comprehensive care coordination. This includes, but is not limited to, such entities as community mental health centers, federally qualified health centers, child health specialty clinics, etc.

## ***Do current Targeted Case Managers have a role in the Integrated Health Home?***

Integrated Health Homes will provide all care coordination directly, or by contract. However, the IHH is fully responsible for the management of the member's care, with the goal to provide care coordination that leads to better overall health outcomes for the member.

## ***Will an individual stop receiving Targeted Case Management when the individual is assigned to an Integrated Health Home? How and when will that happen?***

After a six month transition period, all care coordination will be the responsibility of the Integrated Health Home. While individuals will continue to receive all needed care coordination, this will occur through the Integrated Health Home and not through the specific Medicaid service called "Targeted Case Management."

## ***Can an individual keep their Targeted Case Management?***

After a transition period, individuals assigned to an Integrated Health Home will not be permitted to access the Medicaid service "Targeted Case Management." They will instead receive all of their care coordination through the Integrated Health Home.

## ***How will the staff ratios of an Integrated Health Home compare with Targeted Case Management?***

Staffing ratios of an Integrated Health Home will vary depending on the needs of the individual. However, for persons with the greatest needs, including individuals now receiving Targeted Case Management and Case Management through Habilitation, the staffing ratios will be similar to those individuals have experienced in the past.

## Integrated Health Homes: For Individuals with Serious Mental Illness



***Does the lower payment rate that is currently being discussed assume a lower staff to client ratio than is currently provided through Targeted Case Management and reduce the amount of care coordination individuals receive?***

No. This will not be the case for the following reasons:

- The Integrated Health Home rate is based on a much larger number of persons, many of whom do not need the intensive care coordination currently being provided to those receiving Targeted Case Management. Seventy-seven percent (77%) of the individuals receiving Integrated Health Home services are not receiving Targeted Case Management Services.
- The intensity of care coordination individuals need vary more with a larger group of individuals than do the needs of individuals currently receiving Targeted Case Management.
- An IHH is composed of a team of health care professionals. Access to Care Coordinators, Nurse Care Managers, peer support specialists/family support specialists, and MD/DOs will improve efficiencies.

***How will Integrated Health Homes keep this vulnerable population safe?***

Integrated Health Homes will be required to achieve performance and outcome standards that result in individuals experiencing recovery and living safe, healthy, successful lives in their homes and communities. Training, guidance, and coaching will be provided to ensure the Integrated Health Home staff has the skills and expertise to achieve these requirements. Iowa Medicaid is committed to keeping individuals safe.

***Will an individual lose their waiver services if they go into an Integrated Health Home?***

No, individuals will not lose their waiver services when they are served by an Integrated Health Home. This includes habilitation services. The Integrated Health Home will be responsible for coordinating those waiver services.

***Do these changes apply to Targeted Case Management for persons with Intellectual Disabilities and receiving case management through the Intellectual Disabilities Waiver?***

No. Individuals that are receiving services through the Home and Community Based Services waiver for persons with an intellectual disability will not be eligible for the IHH services.

***Can you clarify how these changes will impact members who receive both Habilitation services as well as services through another HCBS Waiver program?***

Individuals who receive BOTH Habilitation and services through another HCBS Waiver (e.g. Intellectual Disabilities, Physical Disabilities, Brain Injury, etc.) will not be eligible for the Integrated Health Home and will continue to receive Targeted Case Management services. Effective July 1, 2013, these individuals will receive services through the HCBS waiver, and NOT through Magellan Targeted Case Management or through Habilitation Targeted Case Management. The exception to this is individuals receiving services through the Children's Mental Health Waiver. In counties where the Integrated Health Homes are operating, case coordination for children on the CMH waiver will be provided through the Integrated Health Home.

# Integrated Health Homes: For Individuals with Serious Mental Illness



## ***Will IHH affect the access to critically needed services?***

Integrated Health Homes will increase and improve access to mental health services. The IHH is a change in our current health delivery system that focuses on demonstrating better outcomes for individuals with an SMI or SED. National studies show that IHHs achieve these improved outcomes.

## ***Are IHHs intended to cut mental health costs?***

IHHs must ensure services are wrapped around individuals with an SMI or an SED and to access needed services. Research has shown that as a result, there will likely be savings, primarily in physical health care, not necessarily mental health services.

## ***Will Magellan receive additional profit from any cost savings resulting from IHH?***

Magellan cannot and does not financially benefit from cutting services. Magellan is paid an administrative fee and the rest goes to services. Therefore, Magellan cannot make more money by spending less on services.

## ***Will the IHH be responsible for overseeing the quality of the services the individual receives?***

Yes, the IHH will be responsible to ensure all of the individual's services are high quality, meet the individual's needs and results in measurable improved outcomes in the individual's life.

## ***Will people lose the right to choose their own services?***

Choice provided in the IHH will be similar to that currently provided in TCM. IHHs will be assigned regions to serve individuals on Medicaid just like TCM are currently serving individuals within their assigned county. The individual still has a choice within the IHH for who delivers the care for community medical and behavioral health providers, which is identical to the choice currently offered within TCM. In some areas of the state, individuals will have a choice of several IHHs.

## ***Will IHH help individuals with the paper work and application process for benefits such as Medicaid, housing, etc?***

The IHH will be required to assist individuals with their paper work and guide them through the application process for the benefits for which they qualify.

## ***Will IHH staff be paid significantly less than the current TCMs?***

IHHs will be paid sufficiently to pay their staff competitive wages. The State requires that the IHH team include the following professional staff, all licensed by the State of Iowa: Physicians, Nurse Care Coordinators, Social Workers and Behavioral Health Professionals. Additionally, the State requires that the IHH have trained Peer Support Specialists and Family Support Specialists.

## Integrated Health Homes: For Individuals with Serious Mental Illness



***Some have seen draft financial plans that show the cost of IHH being significantly less than TCM. Will reimbursement be cut that much and will that result in higher “caseloads” than TCM experiences today?***

Today, TCM serves about 5,625 individuals with the most intense need. Therefore, the cost per individual is high. The IHH will serve many more individuals with a broader array of individuals with mental illness (projected enrollment 24,135 individuals), who will have a wide range of needs from minimal to intensive. The new rate for IHH assumes this broad range of needs for a much larger population. Because of that, the cost per individual appears to be lower. Individuals currently receiving TCM will receive the equivalent level of services they are currently receiving.

***Will shifting care coordination from TCM provided primarily by county and state staff to IHH provided primarily by private agencies result in diminished services and loss of quality?***

TCM is currently provided in Iowa by both public employees and private providers. The entire Iowa Medicaid program depends on the private health care delivery system of physicians, hospitals, pharmacists, Community Mental Health Centers, etc. This is not an effort to privatize service delivery, but develop a team of professionals to improve coordination and integration of needed services to improve outcomes for the individuals served.

***What information is being given to service providers and medical providers regarding the IHH?***

The Department will issue informational letters to service providers and the medical community. The Department and Magellan have been presenting IHH at association meetings, community meetings, and provider meeting as requested. This will continue with both service providers and the medical community. IHH will also be presented at annual provider training sessions offered throughout the state.

***Why does the Rule Package (ARC 0667C) reference collaboration with Targeted Case Managers?***

The rule package effectuates Health Home services for two different populations. One eligible population group is based on the presence of two or more chronic health conditions or one chronic health condition and at risk of a second, as described in the rules. The second eligible population group has an SMI or an SED.

Those individuals eligible for the chronic condition Health Home, are served by primary care providers that meet the requirements of a designated provider of Health Home services. The 0667C rule change requires that a Health Home designated provider serving a member that receives targeted case management must collaborate, at least quarterly, with the targeted case manager, case manager or DHS service worker.

Those individuals eligible for the SMI or SED health home are served by the IHH. The IHH is responsible for coordinating all medical, behavioral, and community services.



## **Integrated Health Homes: For Individuals with Serious Mental Illness**

***If a member identified for the IHH, living in a phase one county, moves to a phase two or phase three county, will they be able to get TCM services once they move?***

Yes. This should be coordinated by the TCM entity, IHH and Magellan to assure a smooth transition for the member to a TCM or another IHH.

***Will individual members lose the targeted case manager they currently have?***

The IHH will provide the care coordination previously provided by the TCM and a member's services will continue. The IHH provides the member with a team of health care professionals to coordinate medical, behavioral and community services. That team includes a care coordinator operating with the same capacity as the current TCM, but embedded in a team trained to provide more support. There will be a transition period where the IHH and TCM will work with the member to assure the care plan and services are in place.

***How will the Integrated Health Home support youth transitioning from the child system to the adult mental health system?***

The IHH for SED should be preparing a child and their family or support system for the transition. This includes identification of service needs for physical and behavioral health care and community supports. Collaboration should occur between the SMI and SED IHH to assure a seamless transition. The IHH is responsible for positive outcomes for the health and quality of life for members.

***How will the IHH work with jail diversion teams or if the individual is suspended from Title 19? How will the follow along program work within the IHH?***

The IHH is required to assist individuals with their paper work and guide them through the application process for benefits for which they qualify. The IHH is required to coordinate all services for an individual, including medical, behavioral, and community services regardless of the funding sources for those services.

***Will the state consider waiving the chapter 24 and chapter 90 requirements for TCM providers during the six month transition period to the IHH, in order to allow case managers to carry out the functions that will be expected upon full implementation of the IHH and allow a smoother transition for both members and staff?***

The chapter 24 and chapter 90 requirements will remain intact during the transition period and after. The IHH will also follow these requirements.

***Will individuals enrolled in the IHH lose their TCM service within six months?***

Individuals will continue to receive care coordination. The care coordination provided by the TCM will transition to the IHH.

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