

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 is served by the Integrated Health Home for individuals with a serious mental illness?

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

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 provides 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 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.

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

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?

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.

Does the Per Member Per Month rate for an Integrated Health Home assume a lower staff to client ratio than is 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 does Integrated Health Homes keep this vulnerable population safe?

Integrated Health Homes are 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 are 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.

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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.) are not eligible for the Integrated Health Home and will continue to receive Targeted Case Management services. Effective as of July 1, 2013, these individuals receive services through the HCBS waiver, and NOT 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 is provided through the Integrated Health Home.

Does an IHH affect the access to critically needed services?

Integrated Health Homes increase and improve access to mental health services. The IHH 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.

Is the IHH responsible for overseeing the quality of the services the individual receives?

Yes, the IHH is 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.

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Do people lose the right to choose their own services?

Choice provided in the IHH is similar to that currently provided in TCM. IHHs are 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 have a choice of several IHHs.

Does an IHH help individuals with the paper work and application process for benefits such as Medicaid, housing, etc?

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

Are IHH staff paid significantly less than TCMs?

IHHs are 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.

Does 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 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 given to service providers and medical providers regarding the IHH?

The Department issues informational letters to Managed Care Organizations, service providers and the medical community. The Department and Managed Care Organizations present IHH at association meetings, community meetings, and provider meeting as requested. IHH is also presented at annual provider training sessions offered throughout the state.

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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.

How does 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 does the IHH work with jail diversion teams or if the individual is suspended from Title 19? How does 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.

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