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POLICY BRIEF

INTEGRATED HEALTH HOME DEMOGRAPHICS BRIEF
July 2013 - June 2017

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BACKGROUND

Under Section 2703 of the Patient Protection and Affordable Care Act (ACA) of 2010, states were given the option to submit a State Plan Amendment (SPA) for the establishment of 'health homes' targeting Medicaid enrollees with chronic health conditions. As defined by the Centers for Medicare and Medicaid (CMS), the health home model provides care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.[1] The Iowa Integrated Health Home (IHH) initiative was launched on July 1, 2013 as a partnership between the Iowa Department of Human Services (DHS) and Magellan Behavioral Care of Iowa (Magellan), a private health management company managed the Iowa Plan for Behavioral Health (Iowa Plan) from 1995 through 2015. The original SPA was granted to begin on July, 2013 with Magellan as the lead entity. Upon the privatization of Medicaid on April 1, 2016, amendments to the SPA were requested and were granted by CMS on July 13, 2016. These amendments changed the role of the previous lead entity (Magellan) to reflect the activities of the Managed Care Organizations (MCOs). The purpose of an IHH is to provide whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). The IHH represents an adaptation of the evidence-based practices of the health home model to incorporate a focus on behavioral care for individuals with serious psychological conditions.

Enrollment in an IHH is intended to mitigate some barriers to care among this population—namely, the challenges involved with navigating fragmented systems of care which often lack adequate coordination between behavioral and primary care medical services. Many primary care providers may lack the specialized training needed to help patients manage a mental health diagnosis, while behavioral health providers are limited in the scope of primary care services they can provide to patients. The IHH initiative attempts to create a singular point-of-access for individuals with a mental health diagnosis to obtain coordinated, comprehensive healthcare services across a spectrum of needs and conditions.

To be credentialed as an IHH, providers must meet criteria related to behavioral health accreditation and establish the team of healthcare professionals needed to provide comprehensive care coordination. IHH care is provided by community-based health homes across the state. IHH health homes were originally contracted with Magellan (these contract arrangements ended when Magellan left the state on December 31, 2015). Currently, IHH health homes are credentialed through the Managed Care Organizations (MCOs) and the state Medicaid program and provide statewide coverage for IHH services.

SCOPE AND SERVICES

The goal of an IHH is to provide whole-person, patient-centered, coordinated care for individuals with SMI or SED to improve overall health outcomes. Under the stipulations of the program, an IHH is responsible for the activities outlined below.

1. Comprehensive Care Management
    a. Prevention and management of physical and behavioral health problems
2. Care Coordination
    a. Establishment of a team of healthcare professionals who support an integrated system of care for the patient
    b. Involvement of the individual and family in the creation of a goal-oriented and person-centered care coordination plan (CCP)
    c. Collaboration as needed with community-based or other supportive services
3. Health Promotion
    a. Empowerment of individuals and families to make healthier decisions and engage in self-management and monitoring of health status
4. Comprehensive Transitional Care
    a. Establishment of a comprehensive discharge plan after emergency department admission or hospital stays, including but not limited to the development of a safety/crisis plan, review of medications, identification of linkages between long-term care and home and community-based services, and ongoing follow-up
5. Individual and Family Support Services
    a. Facilitated access to a network of peer and family peer support specialists
6. Referral to Community and Social Support Services
    a. Involvement of and coordination with community agencies and other partners to provide services and supports to individuals and their families

1 Agency for Healthcare Research and Quality. (2013). Defining the PCMH. Retrieved from http://pcmh.ahrq.gov/

LEAD ENTITY

Under the original SPA, IHH providers operated under a ‘lead entity’, Magellan Behavioral Care of Iowa (Magellan), a private health management company that had managed the Iowa Plan for Behavioral Health (Iowa Plan) from 1995 through 2013. The Iowa Medicaid program was privatized on April 1, 2016 with the majority of Medicaid members being assigned to one of three Managed Care Organizations (MCOs) that replaced Magellan as the lead entity.

PROVIDER ELIGIBILITY

To be credentialed as an IHH, providers must be accredited under the Iowa Administrative Code as one of the following:

- A community mental health center
- A mental health service provider
- A residential, licensed group care setting
- A psychiatric medical institution for children (PMIC) facility

Providers that meet national accreditation standards that apply to mental health rehabilitative services as determined by the Council on Accreditation (COA), the Joint Commission, or the Commission on Accreditation of Rehabilitation Facilities (CARF) are also eligible. Providers must also demonstrate the provision of community-based mental health services to the target population and meet other requirements as laid out by the SPA.

The IHH is a team-based model for healthcare delivery and the core IHH team includes the following.

- Nurse care managers
- Care coordinators
- Peer support specialists (for adults) & family peer support specialists (for children)
- IHH Director
- Supervisor(s)

Table 1 lists IHH providers in Iowa as of July, 2017 indicating whether the IHH serves adults only, children only, or both.

Table 1. IHH providers in Iowa by population (adult, child, or both) as of July, 2017

Provider	Street	City	Zip	Adult or Child provider
ABBE CENTER FOR COMM MENTAL HEALTH	520 11TH STREET NW	CEDAR RAPIDS	52405	Adult
BERRYHILL CENTER IHH	720 KENYON ROAD	FORT DODGE	50501	Adult
BLACK HAWK-GRUNDY MHI CTR	3251 WEST 9TH STREET	WATERLOO	50702	Adult/Child
BRIDGEVIEW COMMUNITY HEALTH	638 S BLUFF BLVD	CLINTON	52732	Adult
BROADLAWNS MEDICAL CENTER	1801 HICKMAN RD	DES MOINES	50314	Adult
CAPSTONE BEHAVIORAL HEALTH	306 N 3RD AVE E	NEWTON	50208	Adult
CENTER ASSOCIATES	9 N 4TH AVE	MARSHALLTOWN	50158	Adult/Child
CHILDRENS AND FAMILIES OF IOWA	111 AVE O WEST	FORT DODGE	50501	Child
CHILDRENS SQUARE USA	N 6TH AND AVE E	COUNCIL BLUFFS	51502	Child
COMMUNITY SUPPORT ADVOCATES	6000 AURORA AVE STE B	DES MOINES	50322	Adult/Child
COUNSELING ASSOCIATES	1013 AVE I, STE 1	FORT MADISON	52627	Adult
CROSSROAD BEHAVIOR HEALTH	1003 COTTONWOOD RD	CRESTON	50801	Adult/Child
EYERLY BALL	945 19TH ST	DES MOINES	50309	Adult
FAMILIES FIRST COUNSELING	120 WEST WATER ST STE A2	DECORAH	52002	Child
FAMILY RESOURCES	2800 EASTERN AVE	DAVENPORT	52803	Child
FOUR OAKS FAMILY & CHILDREN SERVICE	5400 KIRKWOOD BLVD SW	CEDAR RAPIDS	52404	Adult/Child
HEARTLAND FAMILY SERVICE	1515 AVE J	COUNCIL BLUFFS	51501	Adult
HILLCREST FAMILY SERVICES	220 W 7TH STREET	DUBUQUE	52001	Adult/Child
LUTHERAN SERVICES IN IOWA	904 W 4TH STREET	WATERLOO	50702	Adult
NORTHEAST IOWA MENTAL HEALTH CENTER	905 MONTGOMERY STREET	DECORAH	52101	Child
ORCHARD PLACE CHILD GUIDANCE CENTER	925 SW PORTER AVE	DES MOINES	50315	Child
PATHWAYS BEHAVIOR HEALTH SERVICES	3362 UNIVERSITY AVE	WATERLOO	50701	Adult/Child
PLAINS AREA MENTAL HEALTH	180 10TH STREET SE STE 201	LAMARS	51031	Adult/Child
PRAIRIE RIDGE INTERGRATED SERVICES	320 N EISENHOWER	MASON CITY	50401	Adult
ROBERT YOUNG CENTER	4600 3RD STREET	MOLINE	61265	Adult/Child
SIOUXLAND MENTAL HLTH CTR	625 COURT STREET	SIOUX CITY	51101	Adult/Child
SOUTHERN IOWA MENTAL HEALTH CENTER	110 EAST MAIN STREET	OTTUMWA	52501	Adult/Child
SOUTHWEST IOWA MENTAL HEALTH CENTER	1500 E 10TH STREET	ATLANTIC	50022	Adult/Child
TANAGER PLACE	1030 5TH AVE SE STE LL100	CEDAR RAPIDS	52403	Child
UIHC CHSC	100 HAWKINS DRIVE 230 CCD	IOWA CITY	52242	Active
VERA FRENCH COMMUNITY	1441 W CENTRAL PARK AVE	DAVENPORT	52804	Adult/Child
WAUBONSIE MENTAL HLTH CTR	216 W DIVISION STREET	CLARINDA	51632	Adult/Child
YOUNG HOUSE FAMILY SERVICES	400 SOUTH BROADWAY	BURLINGTON	52601	Child
YOUTH & SHELTER SERVICES INC	125 SOUTH 3RD STREET	AMES	50010	Child
YOUTH EMERG SVCS & SHELTER OF IOWA	918 SE 11TH STREET	DES MOINES	50309	Child

MEMBER ENROLLMENT

Process

In the original SPA, the lead entity (Magellan) identified adults and children as eligible for IHH services based on a review of behavioral and medical claims. Members who were fully Medicaid-eligible meeting the diagnostic criteria were IHH-eligible. In this sense, potentially eligible Medicaid members were "passively" enrolled into the IHH program with an opt-out option (see SPA page 3). Eligible member information was shared with an IHH provider whose staff met with the member to determine whether IHH services would be beneficial and to verbally confirm their enrollment into the IHH. Eligible members could also be identified by IHH providers, community providers, or could be self-referred.

Beginning July 1, 2016, the Medicaid MCOs had a reduced role in the identification of IHH eligible Medicaid members. The program switched from automatic assignment Opt-Out to Opt-In. Within the Opt-In approach, eligible members agree to participate in the health home at the initial engagement of the provider in a health home practice. A provider presents the qualifying member with the benefits of a health home and the member agrees to opt-in to health home services. The State or MCO may also attribute members to a health home. In either situation, the member will always be presented with the choice to opt-out at any time (See SPA approval, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IA/IA-16-013.pdf). This mechanism results in IHH providers and members taking a more active role in initiating enrollment.

Adults

Adults (18 or older) in Iowa are eligible for IHH services if they are fully enrolled in Medicaid and have a diagnosis meeting the criteria for a serious mental illness (SMI). SMI refers collectively to a subset of diagnosable mental disorders and may include major depressive disorder, schizophrenia and related schizoaffective disorders, bipolar disorder, obsessive-compulsive disorder (OCD), and psychotic disorders. SMI is characterized by extended impairment in functioning and reliance on psychiatric treatment, rehabilitation, and supports exceeding that required by less severe mental disorders.

Children

Children and youth, up to age 18, in Iowa are eligible for IHH services if they are enrolled in Medicaid and meet criteria for a serious emotional disturbance (SED). A SED is defined as a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet criteria as specified by the most current edition of the Diagnostic and Statistical Manual of mental disorders (DSM) that has resulted in “functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities.”[2] A diagnosis of SED may co-occur with substance abuse disorders, learning disorders, or intellectual disorders that may also be a focus of clinical attention.

IHH implementation phases

Beginning July 1, 2013, five Iowa counties (Linn, Polk, Warren, Woodbury, and Dubuque) began offering services as part of Phase I, with the remaining sites phased in as part of Phase II (April 2014) or Phase III (July 2014) over the succeeding 18 months. The program is currently in Phase IV, having become statewide. Individuals with an SMI or SED already receiving community-based care coordination through the Medicaid service known as Targeted Case Management (TCM) were given a transition period of six months after assignment to an IHH during Phases I and II for the complete transfer of care over to the IHH. As of June 2017, more than 26,000 individuals are enrolled in the program.

PREVIOUS RESULTS

Evaluation results from the first study period can be found in three reports encompassing results from a consumer survey, qualitative interviews with providers and analyses of costs and outcomes. These reports are available on the Public Policy Center website for review and download http://ppc.uiowa.edu/health/study/evaluation-iowas-integrated-health-homes-individuals-serious-mental-illness.

2 Substance Abuse and Mental Health Services Administration. (1993). Final notice establishing definitions for (1) Children with a serious emotional disturbance, and (2) adults with a serious mental illness. Federal Register, 58(96), 29422-29425.

ENROLLMENT TRENDS

STUDY CAUTION

The data within this report should be interpreted with care. From July 1, 2013 through March 31, 2016, we were able to determine IHH eligibility through Medicaid monthly enrollment files. Beginning on April 1, 2016, the MCOs were responsible for providing IME with monthly listings of IHH members, this information was no longer maintained on the IME enrollment database. Though there were clear specification for the MCO provision of IHH enrollment data, only AmeriGroup provided the data on a monthly basis in the format requested. Both AmeriHealth and UnitedHealthcare provided a single file, sporadically with limited information. Due to these changes and discrepancies in data timing and format, the data for the period April 1, 2016 through September 30, 2016 should be interpreted with care.

Figure 1 and Figure 2 show the IHH enrollment by month and group for adults and children/youth. In the first year the program had large numbers of enrollees who were counted has being part of the program, despite not having received any services. This issue was addressed by IME and Magellan in April 2014 resulting in a downward adjustment of the enrollment to reflect those actually participating in the program. From May 2014 through August 2014 IHH enrollment is fairly static, but beginning in September 2014 enrollment begins to climb steadily reaching over 19,000 by December 2015. During the interim period from January-March 2016 enrollment falls, but then begins to build again once all members are enrolled with an MCO. Enrollment builds steadily until March 2017 when the 're-enrollment' of IHH members is occurring, at which time there is a one month dip in enrollment that returns to previous month levels in April 2017. It is unclear whether IHH members were provided with services by IHH providers at this time. This pattern is the same for adults and children/youth.

Figure 1. Number of members by month and group, adults

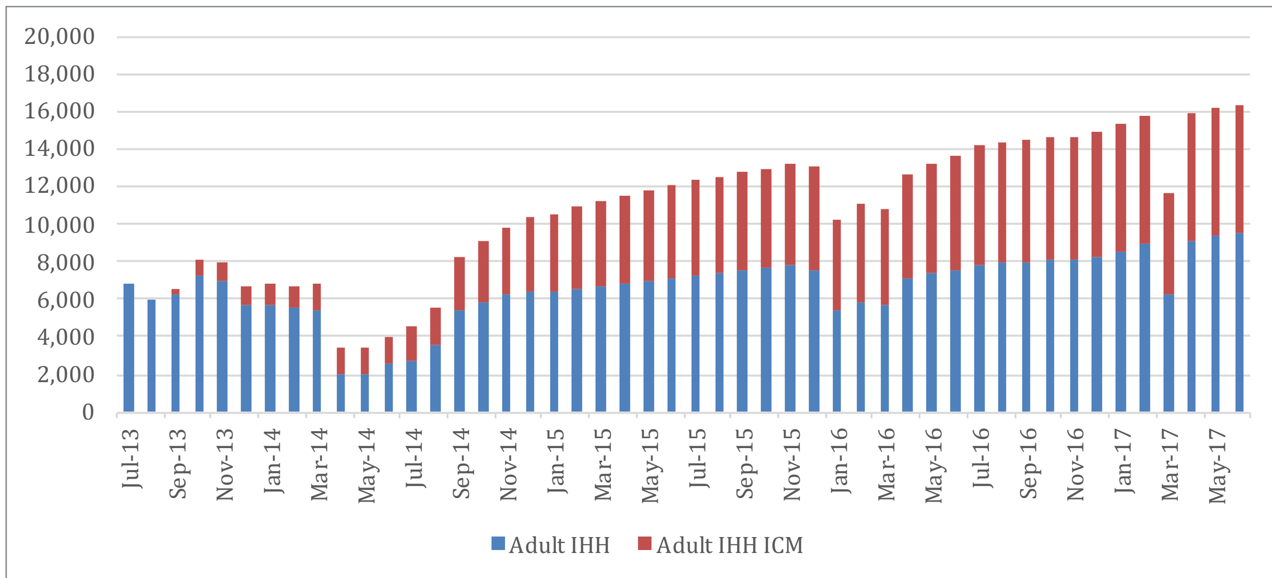
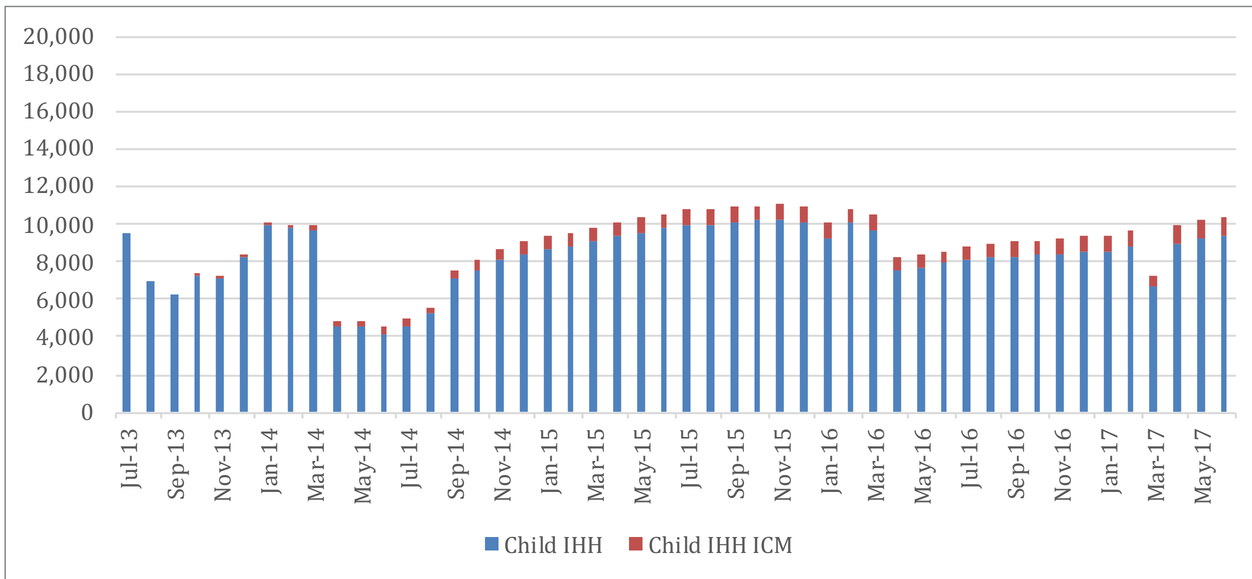


Figure 2. Number of members by month and group, children and youth



CHURN

Figure 3 and Figure 4 provide the rates of change in status for IHH members during the first 4 years of the program, July 2013-June 2017. The blue and red portions of the lines indicate the number of members who entered (blue) or left (red) the IHH. The green and purple portions of the table indicate the number of IHH members who were moved from intensive case management (ICM) to non-ICM (purple) or from non-ICM to ICM (green). The first significant shift in members occurs in December 2013. Many members were initially enrolled in the IHH program in July 2013, however; by December 2013 many had not accessed services causing the program to reassess enrollment and adjust the status of members who were not actually being served by an IHH provider.

For the purposes of this report, the bars describing what happened in April 2016 and March to April 2017 are of particular interest. Changes in IHH program participation in April 2016 provides insight into the transitional experience of members as the MCOs took over the IHH program enrollment and management. The number IHH members fell dramatically, by more than 2,400 children and youth and nearly 3,000 adults as of April 2016, approximately the same number of members who left the program in the previous 6 months. It is important to note, that nearly all of these members (2,323 children and youth and 2,820 adults) were still eligible for the Medicaid program, so they were not removed from the IHH enrollment due to Medicaid ineligibility. In addition, at the point of MCO transition, nearly 300 children and youth and 600 adults are transitioned in ICM, indicating a recognition of increased service needs, while 51 children and youth and 191 adults are moved out of ICM indicating a recognition of reduced service needs.

Figure 3. Changes in IHH status for children and youth, July 2013-June 2017

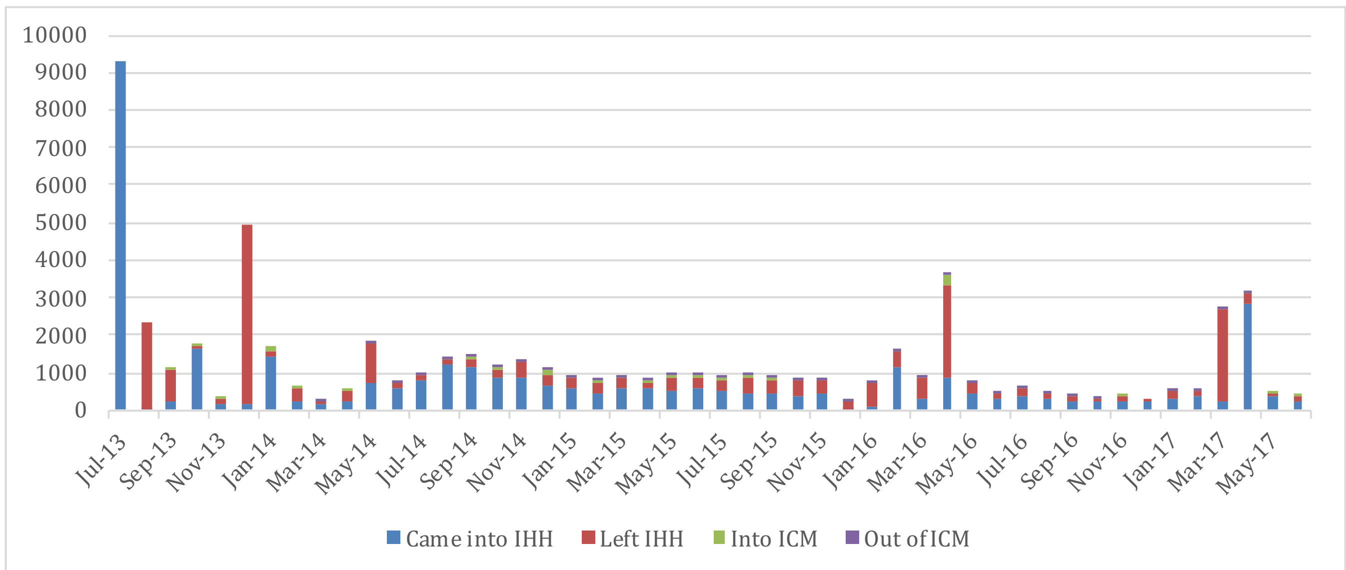
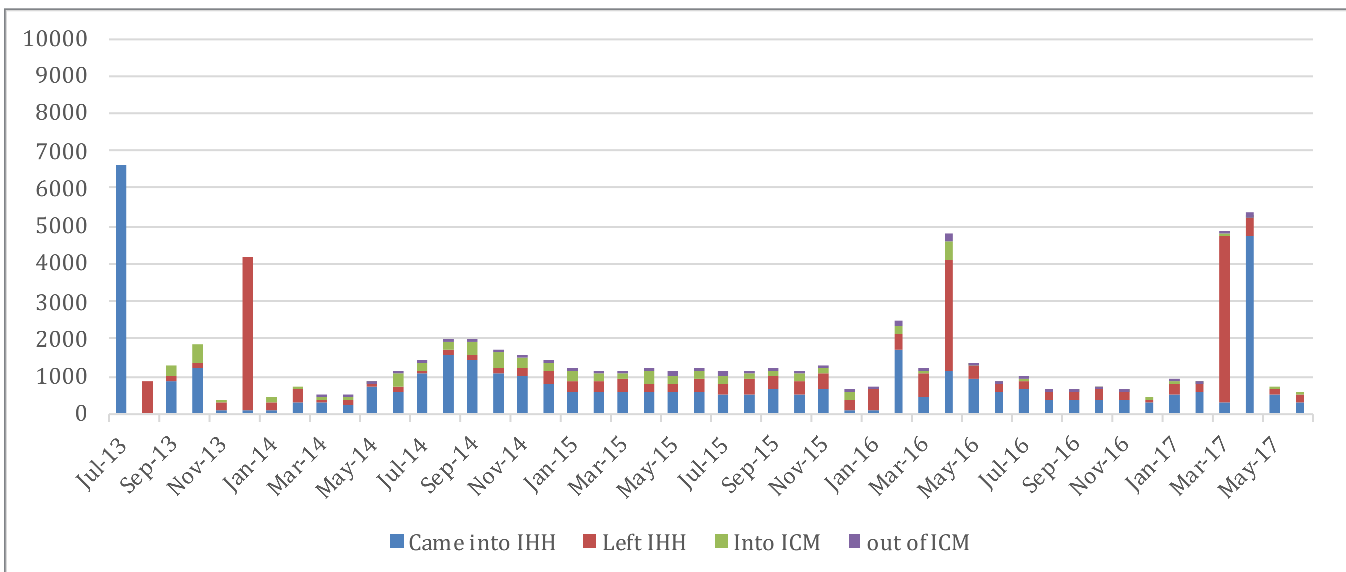


Figure 4. Changes in IHH status for adults, July 2013-June 2017



March 2017 represents a reassessment period for the IHH program. Though it is not clear from the eligibility data why individuals lost their enrollment in the IHH, most members who lost enrollment in March 2017 were re-enrolled in April 2017. Of 2,512 child and youth who lost IHH enrollment in March, 2,501 were re-enrolled in April, 2017. For adults, 4,356 of the 4,442 members who were disenrolled were re-enrolled in the next month. There is no mechanism to determine whether this one month loss of coverage interrupted access to needed services.

DEMOGRAPHIC TRENDS

IHH MEMBERS ENROLLED FOR AT LEAST 1 MONTH DURING THE YEAR

Over the four years of the IHH program there have been changes in the demographic characteristics of the enrolled population (Table 2). The distribution of IHH members enrolled for at least 1 month by sex and the distribution of IHH members enrolled for at least 1 month by race remained the stable over time, however; the proportion of members enrolled for at least 1 month varied by age and whether they were receiving ICM services. The proportion of children and youth enrolled for at least 1 month increased over time, while the proportion of members enrolled for at least 1 month aged 18-64 years decreased. The proportion of members enrolled for at least 1 month receiving ICM services rose over the four year period, while the proportion not receiving ICM services declined, reflecting the increasing need for services as members age.

Table 2. Demographic characteristics of IHH members who were enrolled for at least 1 month, FY 2014-2017

Demographics	Measure	FY 2014	FY 2015	FY 2016	FY 2017
Sex					
Female	Count	11,856	13,272	15,813	15,043
	%	50%	49%	50%	50%
Male	Count	12,061	13,578	15,805	14,817
	%	50%	51%	50%	50%
Race					
White	Count	14,295	17,653	20,733	19,685
	%	60%	66%	66%	66%
Black	Count	2,103	1,867	2,240	2,156
	%	9%	7%	7%	7%
American Indian	Count	416	311	374	147
	%	2%	1%	1%	<1%
Asian	Count	104	74	91	94
	%	<1%	<1%	<1%	<1%
Hispanic	Count	767	617	733	680
	%	3%	2%	2%	2%
Pacific Islander	Count	40	56	73	74
	%	<1%	<1%	<1%	<1%
Multiple Hispanic	Count	466	473	563	513
	%	2%	2%	2%	2%
Multiple Other	Count	517	486	538	500
	%	2%	2%	2%	2%
Undeclared	Count	5,209	5,313	6,273	6,011
	%	22%	20%	20%	20%
Age					
0-17 years	Count	12,694	11,989	13,116	11,234
	%	53%	45%	42%	38%
18-64 years	Count	10,495	14,475	17,999	18,100
	%	44%	54%	57%	61%
over 65 years	Count	728	386	503	526
	%	3%	1%	2%	2%
Status					
Not receiving ICM	Count	21,628	20,723	23,534	21,855
	%	91%	77%	74%	73%

Demographics	Measure	FY 2014	FY 2015	FY 2016	FY 2017
Receiving ICM	Count	2,289	6,127	8,086	8,005
	%	9%	23%	26%	27%

Figure 5. IHH members enrolled for at least 1 month by age and year, FY 2013-FY 2017

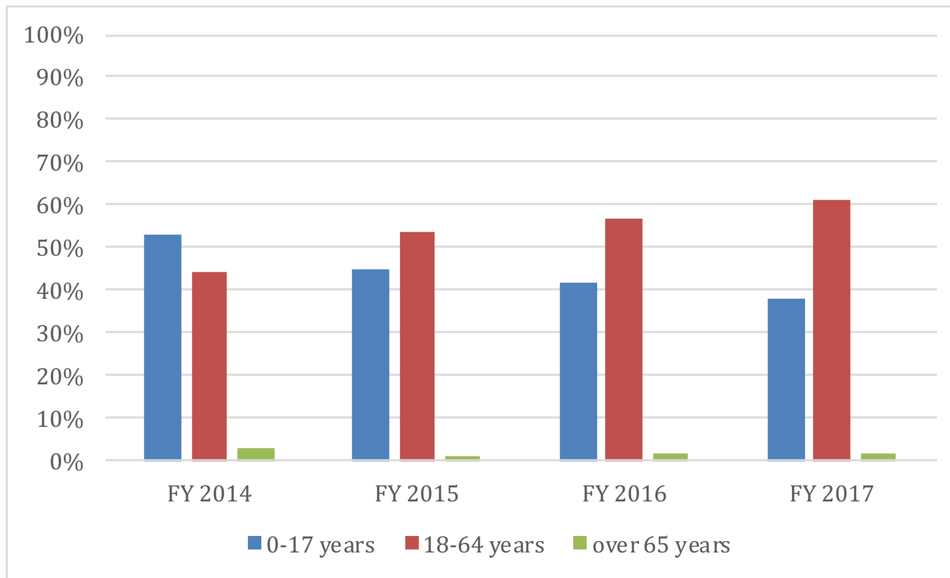
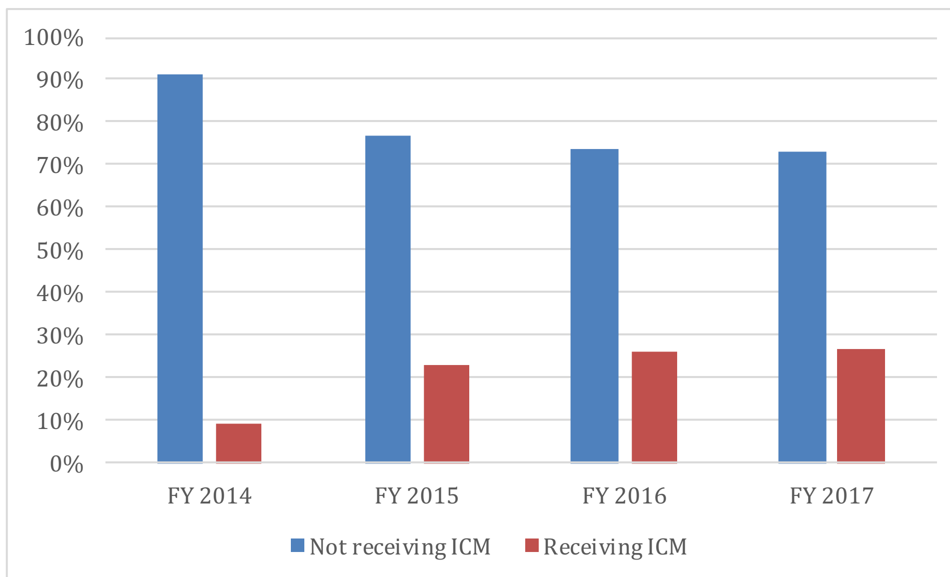


Figure 6. IHH members enrolled for at least 1 month by ICM services and year, FY 2013-FY 2017



IHH MEMBERS ENROLLED FOR AT LEAST 11 MONTHS DURING THE YEAR

The demographic trends seen over time for members enrolled for at least 11 months during FY 2013-FY 2017 are similar to those for members enrolled for at least 1 month though the increase in members receiving ICM services over time is less pronounced.

Table 3. Demographic characteristics of IHH members who were enrolled for at least 11 months, FY 2013-FY 2017

Demographics	Measure	FY 2014	FY 2015	FY 2016	FY 2017
Sex					
Female	Count	2,012	5,322	7,454	10,060
	%	49%	50%	50%	50%
Male	Count	2,077	5,373	7,593	10,095
	%	51%	50%	50%	50%
Race					
White	Count	2,486	6,890	10,115	13,374
	%	61%	64%	67%	66%
Black	Count	397	785	1,030	1,368
	%	10%	7%	7%	7%
American Indian	Count	34	108	35	86
	%	1%	1%	<1%	<1%
Asian	Count	23	38	44	61
	%	1%	<1%	<1%	<1%
Hispanic	Count	76	179	292	413
	%	2%	2%	2%	2%
Pacific Islander	Count	5	17	24	44
	%	<1%	<1%	<1%	<1%
Multiple Hispanic	Count	68	183	226	317
	%	2%	2%	2%	2%
Multiple Other	Count	82	191	253	310
	%	2%	2%	2%	2%
Undeclared	Count	918	2,304	3,028	4,182
	%	23%	22%	20%	21%
Age					
0-17 years	Count	1,905	4,692	6,127	7,564
	%	47%	44%	41%	38%
18-64 years	Count	2,125	5,845	8,697	12,202
	%	52%	55%	57 %	61%
Over 65 years	Count	59	158	223	389
	%	1%	1%	1%	2%
Tier					
Not receiving ICM	Count	2,921	7,519	9,955	13,738
	%	72%	70%	66%	68%
Receiving ICM	Count	1,168	3,176	5,092	6,417
	%	28%	30%	34%	32%

Figure 7. IHH members enrolled for at least 1 month age by year, FY 2013-FY 2017

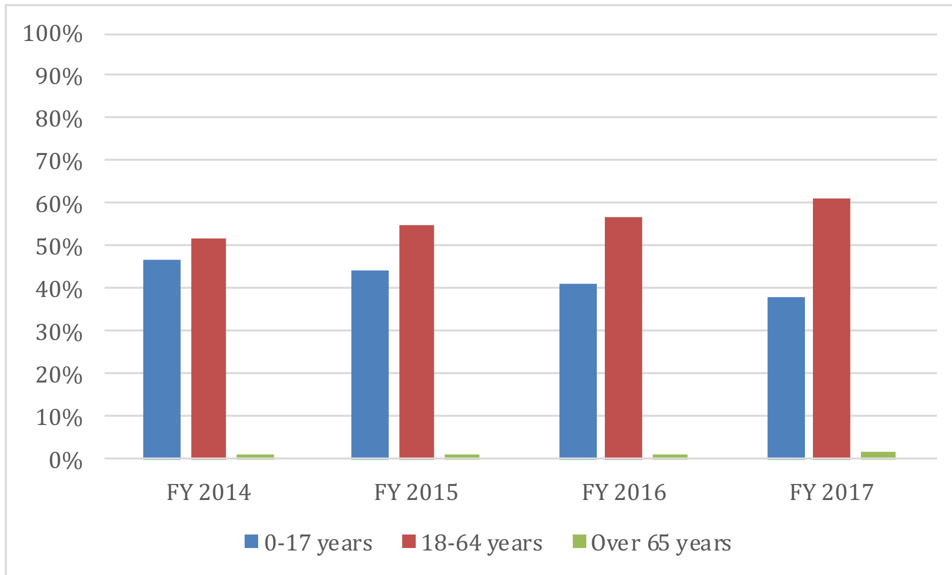
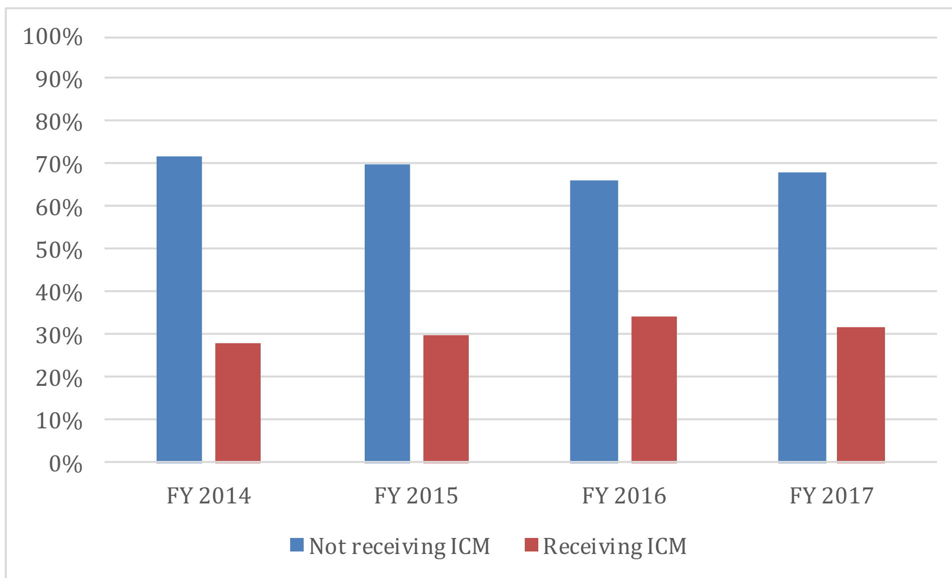


Figure 8. IHH members enrolled for at least 1 month by ICM services and year, FY 2013-FY 2017



COVERAGE GAPS

Gaps in IHH coverage may result from members losing eligibility for Medicaid programs, a failure of the system to maintain eligibility due to poor case management, or a disruption in enrollment due to changes in the care provider (Figure 4 and Figure 5). During the first 4 years of the IHH, 16,084 members experienced 19,794 gaps in IHH coverage (Table 4 and Table 5). Over 50% of the gaps were 1 month, and may not represent a serious disruption to IHH services. However, 23% were from 2-6 months and another 11% were from 7-12 months, which may indicate a lack of IHH services for members (Table 5). Most of these gaps occurred while members were still eligible for Medicaid. 49% of these gaps occurred after the MCOs assumed responsibility for IHH activities (April 1, 2016-December 31, 2017), with over 1,600 reflected in the 1 month gap during March-April, 2017 (Figure 3).

Table 4. Number of members with gaps during first 4 years of IHH

Number of gaps	Number of members
1 gap	12,889
2 gaps	2,733
3 gaps	414
4 gaps	44
5 gaps	3
6 gaps	1

Table 5. Number and percent of gaps during the first 4 years of IHH

Time span	Number gaps	Percent of gaps
1 month	10,959	56%
2-6 months	4,592	23%
7-12 months	2,249	11%
more than 1 year	1,994	10%
Total	19,794	100%

CONCLUSION

Over the first two years of the IHH, enrollment rose, at first quickly and they more slowly over time. Following introduction of the MCOs there were changes in IHH enrollment including a decrease in the number of members with IHH coverage, slower growth in IHH enrollment, and apparent disruptions to IHH membership. With the data caution in mind, it is important to continue to monitor enrollment to determine whether the possible disruptions in IHH membership and slow growth continue over time.