

Table of Contents

State/Territory Name: IL

State Plan Amendment (SPA) #: 17-0014

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519



July 20, 2018

Patricia R. Bellock, Director
Illinois Department of Healthcare and Family Services
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Attn: Teresa Hursey

Dear Ms. Bellock:

The Centers for Medicare & Medicaid Services (CMS), has completed its review of Illinois State Plan Amendment (SPA) Transmittal Number (TN) 17-0014. This SPA implements Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act. The state plan pages for this SPA were submitted and approved through the Medicaid and CHIP Program System.

Enclosed for your records is an approved copy of the following State Plan Amendment.

- TN #17-0014 – Authorizes the Medicaid Health Homes Benefit to cover certain physical and behavioral health conditions as outlined in the approved plan pages
- Effective Date: October 1, 2018
- Approval Date: July 18, 2018

This approval is based on the state's agreement to collect and report information required for the evaluation of the health home model. States are encouraged to report on the CMS' recommended core set of quality measures. In accordance with the statutory provisions at Section 1945 (c) (1) of the Social Security Act, for payments made to health home providers under this amendment, during the first eight fiscal quarters that the SPA is in effect, October 1, 2018 through September 30, 2020 the federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers will return to the state's published FMAP rate October 1, 2020. The Form CMS-64 has a designated category of service Line 43 for states to report health home services expenditures for enrollees with chronic conditions.

Page 2
Ms. Bellock

Please share with your staff my appreciation for their time and effort throughout the review process. If you have any questions regarding this Health Home State Plan Amendment, please have a member of your staff contact Courtenay Savage at 312-353-3721 or via email at Courtenay.Savage@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Teresa Hursey, HFS
Sara Barger, HFS
Kimberley Cox, HFS
Mary Doran, HFS

Package Information

Package ID IL2016MH0001O
Program Name Integrated Health Homes
SPA ID IL-17-0014
Version Number 5
Submitted By Mary Doran
Package Disposition



Submission Type Official
State IL
Region Chicago, IL
Package Status Approved
Submission Date 12/5/2017
Approval Date 7/18/2018 11:31 AM EDT

Approval Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850



Date: 07/18/2018

Head of Agency: Felicia Norwood

Title/Dept : Director

Address 1: 201 South Grand Avenue, East

Address 2:

City : Springfield

State: IL

Zip: 62763

MACPro Package ID: IL2016MH0001O

SPA ID: IL-17-0014

Subject

Approval Recommendation for IL-17-0014

Dear Felicia Norwood

This is an informal communication that will be followed with an official communication to the State's Medicaid Director.

The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that we are recommending approval for your request for SPA 17-0014

Reviewable Unit	Effective Date
Health Homes Intro	10/1/2018
Health Homes Geographic Limitations	10/1/2018
Health Homes Population and Enrollment Criteria	10/1/2018
Health Homes Providers	10/1/2018
Health Homes Service Delivery Systems	10/1/2018
Health Homes Payment Methodologies	10/1/2018
Health Homes Services	10/1/2018
Health Homes Monitoring, Quality Measurement and Evaluation	10/1/2018

Please indicate your acceptance of our recommendation.

Sincerely,

Alan Freund

Acting ARA

Approval Documentation

Name	Date Created	
IL-17-0014	7/18/2018 11:52 AM EDT	

Name	Date Created	
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DATE RECEIVED: December 5, 2017 DATE APPROVED: July 18, 2018
PLAN APPROVED – ONE COPY ATTACHED
EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2018
SIGNATURE OF REGIONAL OFFICIAL: /s/
TYPED NAME: Ruth A. Hughes
TITLE: Associate Regional Administrator

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH0001O | IL-17-0014 | Integrated Health Homes

Package Header

Package ID	IL2016MH0001O	SPA ID	IL-17-0014
Submission Type	Official	Initial Submission Date	12/5/2017
Approval Date	7/18/2018	Effective Date	N/A
Superseded SPA ID	N/A		

State Information

State/Territory Name: Illinois

Medicaid Agency Name: Department of Healthcare and Family Services

Submission Component

- State Plan Amendment
- Medicaid
- CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

Package ID	IL2016MH00010	SPA ID	IL-17-0014
Submission Type	Official	Initial Submission Date	12/5/2017
Approval Date	7/18/2018	Effective Date	N/A
Superseded SPA ID	N/A		

SPA ID and Effective Date

SPA ID IL-17-0014

Reviewable Unit	Proposed Effective Date
Health Homes Intro	10/1/2018
Health Homes Geographic Limitations	10/1/2018
Health Homes Population and Enrollment Criteria	10/1/2018
Health Homes Providers	10/1/2018
Health Homes Service Delivery Systems	10/1/2018
Health Homes Payment Methodologies	10/1/2018
Health Homes Services	10/1/2018
Health Homes Monitoring, Quality Measurement and Evaluation	10/1/2018

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

Package ID	IL2016MH00010	SPA ID	IL-17-0014
Submission Type	Official	Initial Submission Date	12/5/2017
Approval Date	7/18/2018	Effective Date	N/A
Superseded SPA ID	N/A		

Executive Summary

Summary Description Including Goals and Objectives 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 with chronic conditions, with provision for high needs members covered through this SPA. 6 care delivery improvement goals have been identified for all IHH members:

- Integrated Care Planning and Monitoring
- Physical Health Provider Engagement
- Behavioral Health Provider Engagement
- Supportive Service Engagement
- Member Engagement and Education
- Population Health Management

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 statewide in October 2018.

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 (or the State, for FFS populations) 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 (or the State, for FFS populations) 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, drawn from a broad pool of potential provider types, 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, if they have one, would play a key supporting role in this process.

Two main support streams are intended for IHHs. In order to deliver care coordination (as needed) from a pre-determined set of IHH activities, providers would receive from MCOs (or the State, for FFS populations) per member per month reimbursements. Submission of claims to generate a reimbursement will be required (as opposed to automatic, prospective off-claims transfers). The second stream to which providers would potentially be eligible is an outcomes-based stream, calibrated to incentivize value over volume. 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. Information on provider performance (together with actionable next steps as needed) may be provided to providers via a report card at regular intervals.

The design of the Integrated Health Home model was led by HFS in collaboration with its sister agencies, including input from the Department of Mental Health, the Department of Alcoholism & Substance Abuse, and the Department of Children and Family Services among other agencies and departments. The Integrated Health Home model also has been informed by ongoing input from the Medicaid Waiver Advisory Group, which reflects input from the stakeholder community including providers.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2019	\$228000000
Second	2020	\$228000000

Federal Statute / Regulation Citation

This document constitutes a proposed SPA for a Health Homes program, authorized under Section 2703 of the Affordable Care Act.

FFY impact: FY19: \$228,000,000; \$223,000,000 (MC), \$5,000,000 (FFS) FY20: \$228,000,000; \$223,000,000 (MC), \$5,000,000 (FFS)

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

Package ID	IL2016MH00010	SPA ID	IL-17-0014
Submission Type	Official	Initial Submission Date	12/5/2017
Approval Date	7/18/2018	Effective Date	N/A
Superseded SPA ID	N/A		

Governor's Office Review

- No comment
- Comments received
- No response within 45 days
- Other

Submission - Public Comment

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

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Name of Health Homes Program

Integrated Health Homes

Indicate whether public comment was solicited with respect to this submission.

- Public notice was not required and comment was not solicited
- Public notice was not required, but comment was solicited
- Public notice was required and comment was solicited

Indicate how public comment was solicited:

- Newspaper Announcement
- Publication in state's administrative record, in accordance with the administrative procedures requirements
- Email to Electronic Mailing List or Similar Mechanism
- Website Notice

Select the type of website

- Website of the State Medicaid Agency or Responsible Agency


Date of Posting: Jun 14, 2018

Website URL: <https://www.illinois.gov/hfs/info/legal/PublicNotices/Pages/default.aspx>

- Website for State Regulations
- Other

- Public Hearing or Meeting
- Other method

Upload copies of public notices and other documents used

Name	Date Created	
6.14.18_IHH_Public_Notice	6/14/2018 5:18 PM EDT	

Upload with this application a written summary of public comments received (optional)

Name	Date Created	
No items available		

Indicate the key issues raised during the public comment period (optional)

- Access
- Quality
- Cost

Payment methodology

Eligibility

Benefits

Service delivery

Other issue

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

Package ID	IL2016MH00010	SPA ID	IL-17-0014
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Approval Date	7/18/2018	Effective Date	N/A
Superseded SPA ID	N/A		

Name of Health Homes Program

Integrated Health Homes

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- Yes
 No

This state plan amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations

- Yes
 No

The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, prior to submission of this SPA

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner

- Indian Health Programs


Name of Program	Date of consultation:	Method/Location of consultation:
American Indian Health Services of Chicago	9/29/2016	Email

- Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

- Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
AIHSC Notification	10/4/2016 10:38 AM EDT	

Indicate the key issues raised (optional)

- Access
 Quality
 Cost
 Payment methodology

- Eligibility
- Benefits
- Service delivery
- Other issue

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH0001O | IL-17-0014 | Integrated Health Homes

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SAMHSA Consultation

Name of Health Homes Program

Integrated Health Homes

The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
5/11/2017

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

Package ID	IL2016MH00010	SPA ID	IL-17-0014
Submission Type	Official	Initial Submission Date	12/5/2017
Approval Date	7/18/2018	Effective Date	10/1/2018
Superseded SPA ID	N/A		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Integrated Health Homes

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

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 with chronic conditions, with provision for high needs members covered through this SPA. 6 care delivery improvement goals have been identified for all IHH members:

- Integrated Care Planning and Monitoring
- Physical Health Provider Engagement
- Behavioral Health Provider Engagement
- Supportive Service Engagement
- Member Engagement and Education
- Population Health Management

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 statewide in October 2018.

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 (or the State, for FFS populations) 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 (or the State, for FFS populations) 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, drawn from a broad pool of potential provider types, 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, if they have one, would play a key supporting role in this process.

Two main support streams are intended for IHHs. In order to deliver care coordination (as needed) from a pre-determined set of IHH activities, providers would receive from MCOs (or the State, for FFS populations) per member per month reimbursements. Submission of claims to generate a reimbursement will be required (as opposed to automatic, prospective off-claims transfers). The second stream to which providers would potentially be eligible is an outcomes-based stream, calibrated to incentivize value over volume. 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. Information on provider performance (together with actionable next steps as needed) may be provided to providers via a report card at regular intervals.

The design of the Integrated Health Home model was led by HFS in collaboration with its sister agencies, including input from the Department of Mental Health, the Department of Alcoholism & Substance Abuse, and the Department of Children and Family Services among other agencies and departments. The Integrated Health Home model also has been informed by ongoing input from the Medicaid Waiver Advisory Group, which reflects input from the stakeholder community including providers.

General Assurances

- The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.

- The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH0001O | IL-17-0014 | Integrated Health Homes

Package Header

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- Health Homes services will be available statewide
- Health Homes services will be limited to the following geographic areas
- Health Homes services will be provided in a geographic phased-in approach

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH0001O | IL-17-0014 | Integrated Health Homes

Package Header

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Superseded SPA ID	N/A		

Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

Medically Needy Eligibility Groups

Mandatory Medically Needy

Medically Needy Pregnant Women

Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

Medically Needy Children Age 18 through 20

Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

Medically Needy Aged, Blind or Disabled

Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

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Superseded SPA ID N/A	

Population Criteria

The state elects to offer Health Homes services to individuals with

Two or more chronic conditions

Specify the conditions included

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI over 25
- Other (specify)

Name	Description
Diabetes and Heart Disease	These two conditions were checked above in order to comply with the MACPro system requirements that two or more conditions must be checked. The chronic conditions that will apply to this IHH model are the 3M CRG categories listed above under "Catastrophic", "Dominant/Metastatic" and "Dominant chronic diseases in 3 or more organ systems".
Catastrophic	Dialysis with Diabetes Dialysis without Diabetes HIV Disease Total Parenteral Nutrition Dependence on a Mechanical Ventilator History of a Major Organ Transplant Congenital Quadriplegia, Diplegia or Hemiplegia Acquired Quadriplegia or Permanent Vegetative State Spina Bifida Progressive Muscular Dystrophy or Spinal Muscle Atrophy Cystic Fibrosis
Dominant/Metastatic	Multiple Dominant Primary Malignancies Multiple Non-Dominant Primary Malignancies Secondary Malignancy Brain and Central Nervous

Name	Description
	System Malignancies Lung Malignancy Pancreatic Malignancy Kidney Malignancy Ovarian Malignancy Digestive Malignancy Chronic Lymphoid Leukemia Chronic Non-Lymphoid Leukemia Multiple Myeloma Acute Lymphoid Leukemia Acute Non-Lymphoid Leukemia Colon Malignancy Other Malignancies Hodgkins Lymphoma Plasma Protein Malignancy Breast Malignancy Prostate malignancy Genitourinary Malignancy Non-Hodgkins Lymphoma
Dominant chronic disease in 3 or more organ systems	Chronic Renal Failure - Diabetes - Other Dominant Chronic disease Chronic Renal Failure - 2 or more Other Dominant Chronic disease Congestive Heart Failure - Diabetes - Chronic Obstructive Pulmonary Disease Congestive Heart Failure - Diabetes - Cerebrovascular Disease Congestive Heart Failure - Diabetes - Other Dominant Chronic Disease Congestive Heart Failure - Chronic Obstructive Pulmonary Disease - Other Dominant Chronic Disease Congestive Heart Failure - Peripheral Vascular Disease - Other Dominant Chronic Disease Congestive Heart Failure - Cerebrovascular Disease - Other Dominant Chronic Disease Congestive Heart Failure - 2 or more Other Dominant Chronic Disease Diabetes - Advanced Coronary Artery Disease -Other Dominant Chronic Disease Diabetes - Cerebrovascular Disease - Other Dominant Chronic Disease Diabetes - Chronic Obstructive Pulmonary Disease - Other Dominant Chronic Disease Diabetes - 2 or More Other Dominant Chronic Diseases Chronic Obstructive Pulmonary Disease - Advanced Coronary Artery Disease - Other Dominant Chronic Disease Chronic Obstructive Pulmonary Disease - 2 or More Other Dominant Chronic Diseases

Name	Description
	Advanced Coronary Artery Disease - Peripheral Vascular Disease - Other Dominant Chronic Disease Advanced Coronary Artery Disease - 2 or More Other Dominant Chronic Diseases Cerebrovascular Disease - 2 or More Other Dominant Chronic Diseases 3 or More Other Dominant Chronic Diseases Diabetes - Cerebrovascular Disease - Hypertension Diabetes - Hypertension - Other Dominant Chronic Disease

One chronic condition and the risk of developing another

Specify the conditions included

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI over 25
- Other (specify)

Name	Description
Catastrophic	Dialysis with Diabetes Dialysis without Diabetes HIV Disease Total Parenteral Nutrition Dependence on a Mechanical Ventilator History of a Major Organ Transplant Congenital Quadriplegia, Diplegia or Hemiplegia Acquired Quadriplegia or Permanent Vegetative State Spina Bifida Progressive Muscular Dystrophy or Spinal Muscle Atrophy Cystic Fibrosis
Dominant/Metastatic	Multiple Dominant Primary Malignancies Multiple Non-Dominant Primary Malignancies Secondary Malignancy Brain and Central Nervous System Malignancies Lung Malignancy Pancreatic Malignancy Kidney Malignancy Ovarian Malignancy Digestive Malignancy Chronic Lymphoid Leukemia Chronic Non-Lymphoid Leukemia

Name	Description
	Multiple Myeloma Acute Lymphoid Leukemia Acute Non-Lymphoid Leukemia Colon Malignancy Other Malignancies Hodgkins Lymphoma Plasma Protein Malignancy Breast Malignancy Prostate malignancy Genitourinary Malignancy Non-Hodgkins Lymphoma

Specify the criteria for at risk of developing another chronic condition

Character of specific chronic conditions within these two CRG risk groupings ("Catastrophic", Dominant/Metastatic Malignancy") are of such severity that, by their nature, they increase the likelihood that the member will develop further acute conditions and increase the risk of developing another chronic condition .

One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition

Members will be eligible for membership for the program should they have a condition (as evidenced by medical history over prior annual reference period) present within any multi-chronic condition subgroup within CRG categories "Catastrophic", "Dominant/Metastatic Malignancy", "Dominant chronic disease in 3 or more organ systems", "Significant chronic diseases in multiple organ systems "

Group 1. Medicaid members with a diagnosis of one or more of the following conditions within the prior annual reference period (as evidenced by a qualifying claim) shall be eligible for the program:

- Schizophrenia
- Bipolar disorder

Group 2. Medicaid members with a diagnosis of one or more of the following conditions AND one or more of the conditions set out within Group 3 within the prior annual reference period (as evidenced by a qualifying claim) shall be eligible for the program:

- Attempted self-injury or suicide
- Homicidal ideation

Group 3. Medicaid members with one or more behavioral-health related inpatient / crisis-unit / residential treatment facility / rehab facility visits AND with a diagnosis of one or more of the following conditions shall be eligible for the program:

- Diagnosed Substance use
- Major depression
- Other depression
- Other mood disorders
- Conduct disorder
- ODD
- Psychosis
- PTSD
- Personality disorders, including borderline personality disorder
- Eating disorders

In the absence of a claim for a condition qualifying a member for eligibility for the program, providers (including hospitals) may refer individuals they reasonably believe to have such a condition and level of need directly to an Integrated Health Home provider, who may enroll them on establishing contact. For the validity of this referral, and for the continuing membership of this individual, to be confirmed, a claim for a qualifying diagnosis must be received by the State or member's MCO within [3] months of start of membership in the IHH.

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

- Opt-In to Health Homes provider
- Referral and assignment to Health Homes provider with opt-out
- Other (describe)

Describe the process used

All members in Managed Care who meet the target population eligibility criteria will be informed of their eligibility for Integrated Health Home membership by the MCO.

The State will inform those members who meet the population criteria and are not enrolled in Managed Care of their Integrated Health Home membership.

Members will be attributed to an Integrated Health Home according to logic set out by the State, reflecting previously expressed member preference (or parental preference, in the case of children), level of member need, and any existing therapeutic relationship. This logic will be primarily claims-driven; for those members without the requisite medical history that would algorithmically allow attribution to a provider, the State and/or member's MCO will attribute directly according to other criteria (e.g., geography, demonstrated provider capabilities).

Eligible members of the IHH population will be assigned into one of three tiers reflecting members' underlying levels of physical and behavioral health needs, and with further sub-segmentation on the basis of age group. A fourth tier (Tier D) will be created separately as a Primary Care Case Management Services SPA for members with low underlying physical and behavioral health needs. The three tiers discussed in this SPA are labeled Tier A, Tier B, and Tier C, with Tier C representing members with low behavioral health needs but high physical health needs, Tier B representing members with low physical health needs but high behavioral health needs, and Tier A representing members with both high physical health needs and high behavioral health needs.

For physical health, the level of need is determined by the specific combination of chronic conditions in a member's claims history (or one chronic condition with risk of developing another). For high physical needs, a member must have a claims history relating the CRG categories "Catastrophic", "Dominant/Metastatic", or "Dominant chronic disease in 3 or more organ systems". The specific condition combinations included in these CRG categories are listed in the section "Population Criteria".

For behavioral health, the State is mandating a diagnosis- and utilization-based approach for determining the level of behavioral health needs of members. High behavioral health needs are considered those outline in the subsection "One serious and persistent mental health condition" in the section "Population Criteria".

As noted, an individual with a claims-history of conditions considered high behavioral health needs and high physical health needs will be designated Tier A, and will receive the requisite care coordination services.

HFS will provide IHH enrollment packets to eligible beneficiaries by direct mail. The enrollment packet will include information on the IHH choices, MCOs that the IHH is affiliated with, tips to assist an individual in selecting an IHH, switch/change periods and timeframes, how to work with their IHH, information on the IHH and an opt-out form. Eligible beneficiaries may request this material in alternate languages or formats.

Members will retain the ability to request a different IHH or to opt out

of the program on an ongoing basis . Integrated Health Homes will be alerted as regards to those members joining their panel, and will be provided a member roster, as appropriate.

Once a member has been attributed to an IHH, the IHH will be responsible for engaging them and formally enrolling them, marking the commencement of health home services. Enrollment must be documented by the provider, and that documentation should at a minimum indicate that the individual has received required information explaining the health home program and has consented to receive the health home services noting the effective date of their enrollment .

The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit

Name	Date Created	
20170719_Opt out letter draft	11/1/2017 11:00 AM EDT	

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

Package ID	IL2016MH00010	SPA ID	IL-17-0014
Submission Type	Official	Initial Submission Date	12/5/2017
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Superseded SPA ID	N/A		

Types of Health Homes Providers

Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

- Physicians
- Clinical Practices or Clinical Group Practices
- Rural Health Clinics
- Community Health Centers
- Community Mental Health Centers
- Home Health Agencies
- Case Management Agencies
- Community/Behavioral Health Agencies
- Federally Qualified Health Centers (FQHC)
- Other (Specify)

Provider Type	Description
All qualifying Integrated Health Home providers	Health homes will be required to be fully integrated. This can be achieved either through the existence of all relevant physical and behavioral health capabilities (including SUD) in a single organization, under one roof, or by a provider making use of collaborative agreement (s) with partner entities with complementary capabilities, to deliver the level of care required by their members. The State will use as a vehicle for the Integrated Health Home Program a range of providers including PCPs, clinical practices/clinical group practices, Rural Health Clinics, physicians and physicians groups employed by hospitals, community mental health centers, home health agencies, community/behavioral health agencies, FQHCs. In addition to these providers or practice types, all other Medicaid enrolled provider/practice

Provider Type	Description
	types that meet the IHH eligibility standards outlined later in this document will be potentially eligible for the program .

- Teams of Health Care Professionals
- Health Teams

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MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The delivery of Illinois's health home service model is based on an inter-disciplinary array of behavioral health care, medical care, and community-based services and supports for children and adult members with high needs. Taken together, this approach will enable the State to improve coordination of care for those members with the highest needs.

The model is designed to cover the entire State of Illinois, and providers across the state will be engaged in the Integrated Health Homes model. Importantly, full integration of physical and behavioral health is required and may be achieved by either:

- A single practice with physical and behavioral health (including SUD) capabilities housed under a single roof. If the lead entity is a fully integrated, responsible provider, the provider must attest to having necessary staff and capabilities and will receive full payment.
- A practice not possessing the full set of physical and behavioral health (including SUD) capabilities housed under a single roof, but with collaborative agreement(s) with practices with complementary capabilities (e.g., a PCP with a collaborative agreement with a CMHC and SUD specialist). The collaborative agreement must contain explicit agreements in line with integration requirements laid out by the State. The lead entity will receive payment, with potential disbursement of funds to partner entity left up to lead provider's discretion.

The following guiding principles were used to determine eligibility of provider types:

- Include provider types already capable of providing fully-integrated physical and behavioral health care
- Ensure provider types can demonstrate capability to collaborate effectively with other providers whose abilities complement their own (e.g., CMHCs and Primary Care Physicians)
- Select provider types whose institutional character ensures ability to maintain long-term relationship with members (e.g., rural health clinics, FQHCs)
- Avoid excluding provider types where significant numbers of members have shown preference for establishing therapeutic and/or coordination relationships
- Prioritize provider types catering to all age-groups, in order to ensure providers will be able to coordinate care for whole families (e.g., Primary Care Physicians who care for children and adults)
- Consider more stringent provider requirements to serve members with the highest demonstrated needs (e.g., social support specialist as part of the care coordination team)

Potential behavioral health providers include:

- Community mental health centers
- Other eligible specialty behavioral provider types as approved by the State (including SUD specialists, community/behavioral health agencies)

Potential physical health providers include, but are not limited to:

- Primary care physicians
- Clinical practices or clinical group practices
- Rural health clinics
- Community health centers
- Home health agencies
- Federally Qualified Health Centers

In addition to a lead entity with integrated physical and behavioral health, all Integrated Health Homes must additionally staff the following:

- Health coordinators, including a lead nurse care manager, supporting nurse care manager(s), and clinical care coordinator(s) as employed by the lead entity
- Clinical experts, including a physician and a psychiatrist (or other behavioral health specialist)

Additional requirements for Integrated Health Homes serving members with high behavioral health needs include:

- Health coordinators as above, with expectation of lower care coordination ratios
- Clinical experts as above, and SUD specialist and psychologist
- Social supports, including a social worker and a recovery support specialist

Providers will be required to serve enrollees in Tiers A, B and C.

Delivery of Health Home services will not vary depending on whether the member is enrolled with a Managed Care Organization or is a fee-for-service member. The State will be responsible for determining the appropriate tier for fee-for-service members and attributing them to Health Homes that meet their levels of need. Enrollees in fee-for-service will be notified of their Health Home provider by the State. The State will be responsible for sharing lists of attributed members with providers. The team structure, eligibility requirements, services provided, standards, and rate structure will not differ for Health Home providers under managed care or fee-for-service.

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

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Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The State and Illinois MCOs will support providers of Health Homes services with regards to the above listed components in the following ways :

State:

- Identifying providers with the potential to become health homes and supporting them through the application process to ensure that all eligibility criteria are met via provision of required evidence
- Supporting the required adoption of EHR capabilities (in line with State-set timeline) with access to relevant information (e.g. on types available and on grants/funding available to facilitate adoption) and exchange of best practice on usage and training at the Learning Collaborative
- Developing stakeholder material outlining roles, responsibilities, and opportunities set out for Health Home providers, including via the creation of a provider manual outlining key aspects of the program (e.g., approach to reimbursement)
- Using transition support funds (as applied for through the current 1115 Waiver package) to enhance provider education and integration efforts - especially by setting up a Learning collaborative and by offering of training on relevant topics (e.g., via webinars, in-person coaching)
- Potentially requiring and rolling-out use of a single provider notification system (e.g., ADT feeds) to enable health homes more easily to track their members
- Aligning on a set State-defined and mandated functional assessment(s) and screening tools (e.g., IM-CANS, SBIRT) to be made available to help health homes track their members' progress over time and their evolving needs

State/MCOs:

- Setting up provider portals through which providers will be able to access relevant information to support members of their panel and to contact relevant support staff
- Monitoring the coordination of care by health homes to ensure that it meets all required standards and is provided in a high-quality, cost effective manner
- Deploying tools for risk stratification and analysis of member-level data to support assignment to tiers
- Providing reports showing provider performance on key quality and efficiency measures (aligned on following stakeholder input and reference to national standards), including actionable next steps and areas of concern
- Maintaining relationship with agency partners with a view to resolving any barriers to care delivery (e.g., communication/administrative blockages), and making available examples of best practice, information, and resources these partner agencies have at their disposal

MCOs:

- Abiding by all contractual responsibilities as articulated through the managed Medicaid procurement process to support providers (including provision of technical support, building awareness and knowledge of the program, maintaining a network of providers for referral purposes, etc.)

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

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Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

In order for a practice to be eligible to participate in the program, they must abide by the following standards:

- (Unless they are fully capable of providing physical and behavioral health services, including SUD, within the bounds of their organization) Possess and demonstrate to the state the existence of a collaborative agreement with a practice whose abilities would complement their own that provides for intensive integration to fully meet the needs of the target population
 - Commit to employ or have regular access to the following personnel as part of the care coordination team (maintaining appropriate staffing ratios with respect to each, as indicated through state guidelines):
 - o One lead nurse care manager per practice, with further nurse care managers as needed. Lead nurse care manager must be a qualified RN, with other nurse care managers needing to be either a qualified RD, a qualified LPN, or a qualified APN.
 - o Clinical care coordinator, possessing at minimum a bachelor's degree in a relevant subject and demonstrated experience of care coordination/case management
 - o Physician, possessing appropriate clinical licenses and/or professional certifications
 - o Psychiatrist or other behavioral health specialist, possessing appropriate clinical licenses and/or professional certifications
 - o SUD specialist, possessing appropriate clinical licenses and/or professional certifications
 - o Psychologist, possessing appropriate clinical licenses and/or professional certifications
 - o Social worker, possessing at minimum a bachelor's degree in a relevant subject
 - o Recovery support specialist, possessing at minimum the appropriate certification for the role
- Each personnel member must be IMPACT-enrolled
- Be a recognized Medicaid provider in good standing
 - Demonstrate ability before joining program to meet the following activity requirements (drawn from the broader set articulated from the Health Home service definitions) to:
 - o Maintain following appointment standards for members (stricter requirements for high behavioral health tier members in brackets):
 - Routine, preventive care available within 5 [3] weeks from request, but within 2 [1] weeks for infants less than 6 months, from the date of request for such care
 - Urgent care appointments not deemed emergency medical conditions triaged and, if deemed necessary, provided within 24 hours
 - Appointments for member problems or complaints not deemed serious available within 3 [2] weeks from the date of request for such care
 - Initial prenatal appointments without expressed problems: 1st trimester within 2 [1] weeks, 2nd trimester within 1 week [5 days], 3rd trimester within 3 days [2 days]
 - o Provide direct access to members for coverage 24 hours a day, seven days a week, at the very least through an answering service/direct notification mechanism or other approved arrangement, e.g., secure electronic messaging system and/or video conferencing system to offer interactive clinical advice to members. In addition, providers must develop emergency contact protocols for members to establish contact with clinical personnel directly during crisis situations, and protocols for timely sharing of information with other providers relevant to members' care
 - o Facilitate and participate in regular interdisciplinary care team meetings, including clinicians from the members' primary behavioral and physical care providers when possible
 - o Establish relationships with hospitals, residential settings, rehabilitation settings, other treatment settings, LTSS, and support providers to facilitate transitions as member moves between levels of care or back into community. This includes developing protocols for prompt notification and ongoing communication
 - o Have ability to receive notifications on member status from rendering providers (e.g., via ADT feeds)
 - Be able to maintain a minimum panel size of 500, as determined by the State/MCO attribution algorithm (this may be relaxed for specific provider types, e.g., acute specialists, and in rural areas)
 - Be able to conduct bi-directional, multimodal outreach and engagement (e.g., via telephone, secure messaging)
 - Use an EHR or commit to adopt or demonstrate progression towards adoption of EHR by State-set adoption timetable
 - Commit to ensure staff receive appropriate training to support highest need members, as defined by the state
 - Commit to participate in and contribute to the IHH learning collaborative
 - Commit to supply all relevant data to state/MCOs as needed for reporting purposes, e.g., for annual program evaluations and required transmittal of data to CMS
 - Commit to support continuous improvement efforts (e.g., supply of data for compilation of practice performance reports as needed and to use such reports once issued to guide own improvement efforts)
 - Commit to maintain all documentation and records supporting the care of members (including consent to such care), making them available for monitoring efforts as needed while ensuring member confidentiality as required by law
 - Commit – as applicable to location – to assist State in implementation of 1115 Waiver pilots through reporting as required relevant information on panel members receiving services via these pilots

Ongoing participation in the program will be contingent on health homes providing consistent, high quality care coordination for their members, with exceptions made on some quality measures for particular provider types. In addition to maintaining the ability to comply with the initial eligibility requirements, IHHs are expected to maintain the ability to provide for members as needed any of the activities and capabilities which, taken together, both comprise the 6 Health Home services outlined above in this document.

Name	Date Created	
092517 Staffing ratios one-page	9/25/2017 3:09 PM EDT	

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

Package ID	IL2016MH00010	SPA ID	IL-17-0014
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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- Fee for Service
- PCCM
- Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

- Yes
- No

Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be avoided

- The current capitation rate will be reduced
- The State will impose additional contract requirements on the plans for Health Homes enrollees

Provide a summary of the contract language for the additional requirements

MCOs will be providing technical support of the IHH, building awareness and knowledge of the program and maintaining a network of providers for referral.

Other

Other Service Delivery System

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

- Fee for Service
 - Individual Rates Per Service
 - Per Member, Per Month Rates
 - Fee for Service Rates based on
 - Severity of each individual's chronic conditions
 - Capabilities of the team of health care professionals, designated provider, or health team
 - Other
 - Comprehensive Methodology Included in the Plan
 - Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Delivery of Health Home services will not vary depending on whether the member is enrolled with a Managed Care Organization or is a fee-for-service member. The State will be responsible for determining the appropriate tier and the initial attribution of all eligible members into an IHH. After the initial attribution, MCOs will be responsible for the tier assignment and IHH attribution of members with the State's review. The State will be responsible for fee-for-service members and attributing them to Health Homes that meet their levels of need. Enrollees in fee-for-service will be notified of their Health Home provider by the State. The State will be responsible for sharing lists of attributed members with providers. The team structure, eligibility requirements, services provided, standards, and rate structure will not differ for Health Home providers under managed care or fee-for-service.

- PCCM (description included in Service Delivery section)
- Risk Based Managed Care (description included in Service Delivery section)
- Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

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Agency Rates

Describe the rates used

- FFS Rates included in plan
- Comprehensive methodology included in plan
- The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description IHH providers will be reimbursed following the submission of a qualifying care coordination claim (listed below) for a member on their panel. The member must be attributed to the IHH submitting this claim and only one claim may be paid for each member, each month. Any additional qualifying claim submissions will pay at \$0. IHH provider claims submission will be through the department's MMIS system.

Qualifying care coordination codes:

- CPT/HCPCS G9004 – Comprehensive Care Management
- CPT/HCPCS G9005 – Care Coordination and Health Promotion
- CPT/HCPCS G9007 – Transitional Care
- CPT/HCPCS G9010 – Patient and Family Support
- CPT/HCPCS G9011 – Referral to Social Services

As appropriate (and subject to final guidelines issued by the State) completed activities may merit a claim not only via direct in-person provision to the member, but also:

- if appropriate, telephonically (or through other means of electronic communication)
- if appropriate, to the member's immediate collaterals and caregivers

As covered by this SPA, the IHH population will be assigned into three tiers reflecting members' underlying levels of physical and behavioral health needs, and with further sub-segmentation on the basis of age group. Consequently, PMPM payments will be tiered, with the value calculated to reflect the anticipated level of care coordination support IHH personnel will be expected to provide members. Levels of support are understood in terms of time that can be potentially spent by care coordination team personnel with a given member as funded by the PMPM (yielding guideline ratios for providers). Illinois-specific labor cost data from the Bureau of Labor Statistics were used for these calculations, which were made with reference to staffing ratios in similar population health management programs. The three tiers A-C are divided into three age groups (children, transition and adults). Each tier with PMPM is as follows.

Tier A children (0-18) = \$240
Tier A transition (18-21) = \$240
Tier A adults (21+) = \$120
Tier B children (0-18) = \$80
Tier B transition (18-21+) = \$60
Tier B adults (21+) = \$48
Tier C children (0-18) = \$48
Tier C transition (18-21) = \$48
Tier C adults (21+) = \$48

Separately from the IHH activities and rates, providers will be able to continue to bill, on a FFS basis, for treatments and services provided to members. The following services, which closely support but are not part of the care planning and coordination process, may be billed for separately on a FFS basis, and are consequently not folded into the IHH PMPM rates:

- Administration of a functional assessment to a member (e.g., IM-CANS)
- MCO care management
- Other Waiver services and transition support

Beyond the submission of care coordination claims for activities provided to the member, the IHH must also document these services within the members' medical records, in compliance with the State's broader

requirements with service documentation.

In addition to the PMPM payment, IHHs may potentially be eligible for separate outcomes-based payments (paid out in annual lump sums). Outcomes-based payments will be issued according to performance against state benchmarks. These benchmarks will be used to set thresholds based on the previous calendar year's measurement period. For the bonus payment period from 10/1/2019 through 9/30/2020, the measurement year (MY) will be 10/1/2018 through 9/30/2019. The measures, performance level thresholds and benchmarks will be posted on the agency's website at www.illinois.gov/hfs by the first day of the month preceding the start of the performance year which begins October 1, 2018.

From the first year of operation, each IHH will be able to earn a bonus payment, i.e., outcomes-based payment, equal to the value of either 10% or 25% of the amount of their total annual care coordination reimbursement. The percentages were developed by the Department based on the withhold and the allocation thereof.

The Department will create a pool of funds dedicated to outcomes-based payments. Outcomes-based payments are determined for an individual IHH in three stages:

- Determination of eligibility for outcomes-based payment
- Level of performance on selected measures
- Determination of payment

There are 18 quality measures in year 1 of the program. Providers will report on all 18 measures. Ten of these measures will be used for outcomes-based payments.

Determine IHH's eligibility for outcomes-based payment

To be eligible for any outcomes-based payment, an IHH must report on all 18 measures. For any measures with sub-metrics, reporting must be performed on each sub-metric. All Integrated Health Homes – intensive and non-intensive – can be eligible for payment.

Determine IHH's level of performance for outcomes-based payment

Each IHH eligible to receive outcomes-based payments will be split into a performance level. Performance levels are determined based on two factors equally weighed: average percentile performance across all 10 selected measures and lowest performance on any given measure, in comparison with all other IHHs throughout the state.

An IHH must achieve a minimum of a Bronze level of performance across 10 selected measures to receive any outcomes-based payment.

The average percentile performance will only be calculated across those measures with 30 or more observations in the measure's denominator, i.e., a practice will only be assessed on any given measure if it has seen at least 30 members eligible for that measure. Similarly, the thresholds for lowest performance on any given measure do not apply for those measures that do not have the minimum of 30 or more observations.

Calculate amount of outcomes-based payment due to each IHH

IHHs eligible for payment will receive ascending payment amounts based on performance across 10 selected measures:

Bronze: 10% of total amount equal to the IHH's care coordination Per Member, Per Year (PMPY) payment

Silver: 25% of total amount equal to the IHH's care coordination PMPY payment

Gold: Silver-level bonus plus additional bonus including all funding remaining in outcomes-based payment pool

If there are no remaining funds in the outcomes-based pool, the additional gold bonus is \$0.

The State will disburse payment within one year of the end of the performance year. For instance, for an outcomes-based payment period from 10/1/2019 through 6/30/2020, the measurement year (MY) would be 10/1/2018 through 9/30/2019.

Total pool of funding for outcomes-based payment across all providers

The total pool of funding for outcomes-based payment across all providers will consist of funds allocated from the total funds available for the Integrated Health Homes program. The PMPYs distributed to IHHs will be 80% of the previously determined rate. The 20% excluded will be pooled to create the funding for the outcomes based payments.

The State reserves the right to review and rebase PMPM rates at least annually, in order to ensure that these rates enable providers to coordinate care for their members to the degree that their needs require. For purposes of this review, the State will consider both the quality and efficiency of care delivered to members, as determined by consideration in aggregate of IHH program members' medical data for the given year against state-selected performance measures, in addition to an assessment of program cost savings as data quality permits. The State will align the review process, as far as is possible, with existing rate review processes, incorporating as appropriate feedback from MCOs and providers. The care coordination per-member-per-month reimbursement rate is posted at

<https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/defaultnew.aspx> and is effective for dates of services provided on or after October 1, 2018.

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Assurances

The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved Health Homes are responsible for coordinating all care and therefore providers may not claim for both integrated health home services and TCM services for Medicaid beneficiaries at the same time.

The State has determined that:

- dually eligible individuals participating in the Medicare-Medicaid Alignment initiative
- individuals with third-party liabilities
- partially-eligible individuals

will not, for the duration of this statuses, be eligible for IHH membership, due to the elevated potential for duplication in care coordination services associated with said individuals. In addition, members entering LTC facilities will, after 90 days within these facilities, have their membership of their IHH suspended for the duration of their stay, in order to avoid duplication and to ensure that IHHs are reimbursed for care coordination only when they can affect delivery of care for their members.

The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.

The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

The State defines comprehensive care management as comprising the following activities. Providers will need to deliver from the set of following activities as reflects member needs (i.e. with greater scope and provision for members in higher needs tiers):

- Co-ordinate screenings and assessment as necessary of members by functional assessments by relevant professionals to understand members' strengths and levels of functional need, thus identifying members with high needs which may not have previously manifested themselves in claims data
- Initiate, complete, update, and monitor the progress of a comprehensive, culturally-competent, person-centered, goal-oriented care plan, following a comprehensive assessment of the member's behavioral and physical health needs within 30 days of member enrollment. Plan should be updated at least twice a year and address the member's overall health treatment and care coordination needs, including protocols for treatment adherence and crisis management. Input should be incorporated from:
 - o The member, the member's caregiver, and the member's social supports (if applicable)
 - o The member's MCO (if applicable). The IHH should give particular attention in engaging with the MCO on care planning particularly to achieving the requisite prior authorizations for treatment, and, if necessary, making appeals on the member's behalf
 - o The member's primary behavioral and physical health providers as well as specialty care providers (within 90 days of enrollment with the Integrated Health Home)
- Carry out the member's comprehensive integrated care plan, through collaboration with a behavioral health provider if the Integrated Health Home is a physical health provider or through collaboration with a physical health provider if the lead entity is a behavioral health provider
- Track and make improvements based on quality outcomes
- Identify highest risk members on a continuous basis, supported by appropriate stratification tools, aligning within the organization (and, where necessary, with MCOs) to focus resources and interventions

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

- Providers will be supplied by MCOs/State of attributed panel list electronically and will use the list to identify their members
- Providers will use analysis and insights from stratification and population health management tools to focus resources and interventions in the care planning process
- Providers will have electronic access to – and help coordinate access/usage of – screening and functional assessment data as appropriate to inform the care planning process
- Providers will be able to use online/electronic means to refer their members and set up appointments, in order to carry out the members' integrated care plan
- Where appropriate, providers will be able to use members' EHRs to undertake care planning
- Provider focus on this service may be informed by supply by MCOs/State of reports on panel outlining performance on key indicators of care delivery quality and efficiency, with indicators for how to improve performance
- Training on relevant topics may be provided via webinars to providers (in addition to via Learning collaboratives)
- Transition assistance funding (as applied for through the current 1115 Waiver package) for relevant HIT infrastructure support for delivery of this service may be available for selected providers

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Description

Same as defined in the Medicaid state plan.

Nurse Practitioner

Description

Same as defined in the Medicaid state plan.

Nurse Care Coordinators

Nurses

Description

Same as defined in the Medicaid state plan.

Medical Specialists

Physicians

Physician's Assistants

Pharmacists

Social Workers

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Other (specify)

Description

Same as defined in the Medicaid state plan.

Description

As defined by the Illinois Physician Assistant Practice Act (225 ILCS 95).

Description

Same as defined in the Medicaid state plan.

Provider Type	Description
Clinical Care Coordinator	Clinical care coordinators (further information on qualifications included in provider standards section) will be responsible for the majority of the day-to-day interaction with members and the provision of support to them as needed, particularly with regard to enacting smooth transitions from settings of care, ensuring completion of necessary follow-up, ensuring scheduling and attendance at appointments, engaging in outreach, and coordinating member/family education and support etc.. In this they will consult as necessary with the nurse care manager and specialists (as detailed in the provider standards section).
Nurse Care Manager	Nurse care managers (further information on qualifications included in the provider standards section) will be responsible in particular for establishing and maintaining linkages and with specialists (e.g., convening interdisciplinary care team meetings), ensuring that specialist input is reconciled and reflected within the care planning process, providing supervisory support for clinical care coordinators (including ensuring that best practices are followed with regards to population health management and the promotion of wellness across the practice) etc. Key specialists with whom the nurse care manager will interact for planning and consultation purposes are detailed in the provider standards section).

Care Coordination

Definition

The State defines care coordination as comprising the following activities. Providers will need to deliver from the set of following activities as reflects member needs (i.e. with greater scope and provision for members in higher needs tiers):

- Proactively outreach to partner entities regarding specific gaps in care
- Facilitate and participate in regular interdisciplinary care team meetings, including clinicians from the members' primary behavioral and physical care providers when possible
- Communicate with partner entities and other providers (including MCOs) to understand significant changes in members' medical status, and translate into care plan
- Follow up with other providers or clinical staff, including specialists, as needed to understand additional behavioral and physical health needs, incorporating these in the care plan
- Maintain following appointment standards for members (stricter requirements for high behavioral health tier members in brackets):
 - o Routine, preventive care available within 5 [3] weeks from request, but within 2 [1] weeks for infants less than 6 months, from the date of request for such care
 - o Urgent care appointments not deemed emergency medical conditions triaged and, if deemed necessary, provided within 24 hours
 - o Appointments for member problems or complaints not deemed serious available within 3 [2] weeks from the date of request for such care
 - o Initial prenatal appointments without expressed problems: 1st trimester within 2 [1] weeks, 2nd trimester within 1 week [5 days], 3rd trimester within 3 days [2 days]
- Provide direct access to members for coverage 24 hours a day, seven days a week, at the very least through an answering service/direct

notification mechanism or other approved arrangement , e.g., secure electronic messaging system and/or video conferencing system to offer interactive clinical advice to members. In addition, providers must develop emergency contact protocols for members to establish contact with clinical personnel directly during crisis situations, and protocols for timely sharing of information with other providers relevant to members' care

- Support scheduling and reduce barriers to adherence for medical and behavioral health appointments, including in-person accompaniment to some appointments
- Engage in outreach to establish and renew relationship with member

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

- Providers will be required to be able to receive notifications on members status (e.g., via ADT feeds)
- Providers will be able to use online/electronic means to schedule appointments and make referrals for members
- Providers will be required to make available direct access to members on a 24/7 basis, potentially through use of a secure electronic messaging system and/or video conferencing system to offer interactive clinical advice to members
- Provider focus on this service may be informed by supply by MCOs/State of reports on panel outlining performance on key indicators of care delivery quality and efficiency, with indicators for how to improve performance
- Training on relevant topics may be provided via webinars to providers (in addition to via Learning collaboratives)
- Transition assistance funding (as applied for through the current 1115 Waiver package) for relevant HIT infrastructure support for delivery of this service may be available for selected providers

Scope of service

The service can be provided by the following provider types

- | | |
|--|--|
| <input checked="" type="checkbox"/> Behavioral Health Professionals or Specialists | Description
Same as defined in the Medicaid state plan. |
| <input checked="" type="checkbox"/> Nurse Practitioner | Description
Same as defined in the Medicaid state plan. |
| <input type="checkbox"/> Nurse Care Coordinators | |
| <input checked="" type="checkbox"/> Nurses | Description
Same as defined in the Medicaid state plan. |
| <input type="checkbox"/> Medical Specialists | |
| <input checked="" type="checkbox"/> Physicians | Description
Same as defined in the Medicaid state plan. |
| <input checked="" type="checkbox"/> Physician's Assistants | Description
As defined by the Illinois Physician Assistant Practice Act (225 ILCS 95). |
| <input type="checkbox"/> Pharmacists | |
| <input checked="" type="checkbox"/> Social Workers | Description
Same as defined in the Medicaid state plan. |
| <input type="checkbox"/> Doctors of Chiropractic | |
| <input type="checkbox"/> Licensed Complementary and alternative Medicine Practitioners | |
| <input type="checkbox"/> Dieticians | |
| <input type="checkbox"/> Nutritionists | |
| <input checked="" type="checkbox"/> Other (specify) | |

Provider Type	Description
Nurse Care Manager	Nurse care managers (further information on qualifications included in the provider standards section) will be responsible in particular for establishing and maintaining linkages and with specialists (e.g., convening interdisciplinary care team meetings), ensuring that specialist input is reconciled and reflected within the care planning process, providing supervisory support for clinical care coordinators (including ensuring that best practices are followed with regards to population health management and the promotion of wellness across the practice) etc. Key specialists with whom the nurse care manager will interact for planning and consultation purposes are detailed in the provider standards section).

Provider Type	Description
Clinical Care Coordinator	Clinical care coordinators (further information on qualifications included in provider standards section) will be responsible for the majority of the day-to-day interaction with members and the provision of support to them as needed, particularly with regard to enacting smooth transitions from settings of care, ensuring completion of necessary follow-up, ensuring scheduling and attendance at appointments, engaging in outreach, and coordinating member/family education and support etc.. In this they will consult as necessary with the nurse care manager and specialists (as detailed in the provider standards section).

Health Promotion

Definition

The State defines health promotion as comprising the following activities. Providers will need to deliver from the set of following activities as reflects member needs (i.e. with greater scope and provision for members in higher needs tiers):

- Coordinate access for members and families to independent living skill and wellness/prevention education, respite care, and peer support
- Give information, where relevant, to members and caregivers on pathway to becoming a Recovery Support Specialist
- Participate in transition assistance training and learning collaboratives at which best practice on a variety of topics, including health promotion, will be disseminated
- Make available settings of care and methods of interaction outside of physical clinics (e.g., telehealth) to accommodate the needs of those members who would prefer a non-clinical setting

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

- Providers may be able to record or plan as appropriate any wellness or education initiatives for the member in their EHR
- Providers may be able to use electronic means to refer members or set up appointments for them with specialists on wellness topics
- Providers will be encouraged to make settings of care and methods of interaction available that most fit members' preferences, including via telemedicine and electronic communication

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Description

Same as defined in the Medicaid state plan.

Nurse Practitioner

Description

Same as defined in the Medicaid state plan.

Nurse Care Coordinators

Nurses

Description

Same as defined in the Medicaid state plan.

Medical Specialists

Physicians

Description

Same as defined in the Medicaid state plan.

Physician's Assistants

Description

As defined by the Illinois Physician Assistant Practice Act (225 ILCS 95).

Pharmacists

Social Workers

Description

Same as defined in the Medicaid state plan.

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Other (specify)

Provider Type	Description
Clinical Care Coordinator	Clinical care coordinators (further information on qualifications included in provider standards section) will be responsible for the majority of the day-to-day interaction with members and the provision of support to them as needed, particularly with regard to enacting smooth transitions from settings of care, ensuring completion of necessary follow-up, ensuring scheduling and attendance at appointments, engaging in outreach, and coordinating member/family education and support etc.. In this they will consult as necessary with the nurse care manager and specialists (as detailed in the provider standards section).
Nurse Care Manager	Nurse care managers (further information on qualifications included in the provider standards section) will be responsible in particular for establishing and maintaining linkages and with specialists (e.g., convening interdisciplinary care team meetings), ensuring that specialist input is reconciled and reflected within the care planning process, providing supervisory support for clinical care coordinators (including ensuring that best practices are followed with regards to population health management and the promotion of wellness across the practice) etc. Key specialists with whom the nurse care manager will interact for planning and consultation purposes are detailed in the provider standards section).

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

The State defines comprehensive transitional care as comprising the following activities. Providers will need to deliver from the set of following activities as reflects member needs (i.e. with greater scope and provision for members in higher needs tiers):

- Have ability to receive notifications on member status from rendering providers (e.g., via ADT feeds)
- Develop a systemic protocol to assure timely access to follow-up care post discharge, reflecting all relevant agency protocols that includes at a minimum all of the following:
 - o Receipt of a summary of care record from the discharging entity
 - o Medication reconciliation
 - o Reevaluation of the care plan to include and provide access to needed community support services
 - o A plan to ensure timely scheduled appointments
- Establish relationships with hospitals, residential settings, rehabilitation settings, other treatment settings, LTSS, and support providers to facilitate transitions as member moves between levels of care or back into community. This includes developing protocols for prompt notification and ongoing communication
- Communicate and provide education to the member, the member’s supports, the providers located at the setting from which the member is transitioning, and those at the setting to which the member is transitioning
- Participate in implementation of discharge plan for each hospitalization to support member’s transition, particularly to ensure all relevant follow-up after discharge takes place (including with partner agencies and member’s MCO). This includes discharges from ERs, inpatient residential, rehabilitative, and other treatment settings.
- Coordinate access to additional high touch support in crisis situations when other resources unavailable, or as alternative to ED/CSU (including developing with member crisis self-support plan in advance)

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

- Providers will be required to be able to receive notifications on members status (e.g., via ADT feeds)
- Providers will be able to use online/electronic means to supply new settings of care with information as needed in order to plan member care for duration and to prepare for discharge (EHR data may also be used to support providers offering crisis support)
- Provider focus on this service may be informed by supply by MCOs/State of reports on panel outlining performance on key indicators of care delivery quality and efficiency, with indicators for how to improve performance
- Training on relevant topics may be provided via webinars to providers (in addition to via Learning collaboratives)
- Transition assistance funding (as applied for through the current 1115 Waiver package) for relevant HIT infrastructure support for delivery of this service may be available for selected providers

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Description

Same as defined in the Medicaid state plan.

Nurse Practitioner

Description

Same as defined in the Medicaid state plan.

Nurse Care Coordinators

Nurses

Description

Same as defined in the Medicaid state plan.

Medical Specialists

Physicians

Description

Same as defined in the Medicaid state plan.

Physician's Assistants

Description

As defined by the Illinois Physician Assistant Practice Act (225 ILCS 95).

Pharmacists

Social Workers

Description

Same as defined in the Medicaid state plan.

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Other (specify)

Provider Type	Description
Nurse Care Manager	Nurse care managers (further information on qualifications included in the provider standards section) will be responsible in particular for establishing and maintaining linkages and with specialists (e.g., convening interdisciplinary care team meetings), ensuring that specialist input is reconciled and reflected within the care planning process, providing supervisory support for clinical care coordinators (including ensuring that best practices are followed with regards to population health management and the promotion of wellness across the practice) etc. Key specialists with whom the nurse care manager will interact for planning and consultation purposes are detailed in the provider standards section).
Clinical Care Coordinator	Clinical care coordinators (further information on qualifications included in provider standards section) will be responsible for the majority of the day-to-day interaction with members and the provision of support to them as needed, particularly with regard to enacting smooth transitions from settings of care, ensuring completion of necessary follow-up, ensuring scheduling and attendance at appointments, engaging in outreach, and coordinating member/family education and support etc.. In this they will consult as necessary with the nurse care manager and specialists (as detailed in the provider standards section).

Individual and Family Support (which includes authorized representatives)

Definition

The State defines individual support as comprising the following activities. Providers will need to deliver from the set of following activities as reflects member needs (i.e. with greater scope and provision for members in higher needs tiers):

- Coordinate access to high-touch in-person support to ensure treatment and medication adherence (including medication reconciliation, medication management for specialty medications, medication drop-off, and help arranging transportation to appointments)
- Check-in with member to support treatment adherence
- Identify and communicate resources to assist individuals and family supporters in acquiring and improving self-help/advocacy, socialization, and adaptive skills
- Coordinate access (via MCO if applicable) to caregiver counseling or training including skill development to help members improve function, understand information on their condition, and navigate service system
- Seek out and integrate member feedback on all relevant elements of their experience

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

- Providers will be supplied by MCOs/State of attributed panel list electronically and will use the list to identify their members
- Providers will be able to use online/electronic means to engage their members as appropriate, and as reflects member preferences (this will also include telemedicine)
- Where appropriate, providers will be able to use members' EHR records to record further specifications, by their members, of their preferred means of engagement and of any ad-hoc feedback on care delivery
- Providers may use online surveys to elicit, where appropriate, members' feedback on a regular basis
- Providers will be able to use online/electronic means to refer their members to other providers or supply these providers with information as needed in order to deliver this service (e.g., providing members' EHR data to pharmacist)
- Provider focus on this service may be informed by supply by MCOs/State of reports on panel outlining performance on key indicators of care delivery quality and efficiency, with indicators for how to improve performance
- Training on relevant topics may be provided via webinars to providers (in addition to via Learning collaboratives)
- Transition assistance funding (as applied for through the current 1115 Waiver package) for relevant HIT infrastructure support for delivery of this service may be available for selected providers

Scope of service

The service can be provided by the following provider types

- | | |
|--|--|
| <input checked="" type="checkbox"/> Behavioral Health Professionals or Specialists | Description
Same as defined in the Medicaid state plan. |
| <input checked="" type="checkbox"/> Nurse Practitioner | Description
Same as defined in the Medicaid state plan. |
| <input type="checkbox"/> Nurse Care Coordinators | |
| <input checked="" type="checkbox"/> Nurses | Description
Same as defined in the Medicaid state plan. |
| <input type="checkbox"/> Medical Specialists | |
| <input checked="" type="checkbox"/> Physicians | Description
Same as defined in the Medicaid state plan. |
| <input checked="" type="checkbox"/> Physician's Assistants | Description
As defined by the Illinois Physician Assistant Practice Act (225 ILCS 95). |
| <input type="checkbox"/> Pharmacists | |
| <input checked="" type="checkbox"/> Social Workers | Description
Same as defined in the Medicaid state plan. |
| <input type="checkbox"/> Doctors of Chiropractic | |
| <input type="checkbox"/> Licensed Complementary and alternative Medicine Practitioners | |
| <input type="checkbox"/> Dieticians | |
| <input type="checkbox"/> Nutritionists | |
| <input checked="" type="checkbox"/> Other (specify) | |

Provider Type	Description
Clinical Care Coordinator	Clinical care coordinators (further information on qualifications included in provider standards section) will be responsible for the majority of the day-to-day interaction with members and the provision of support to them as needed, particularly with regard to enacting smooth transitions from settings of care, ensuring completion of necessary follow-up, ensuring scheduling and attendance at appointments, engaging in outreach, and coordinating member/family education and support etc.. In this they will consult as necessary with the nurse care manager and specialists (as detailed in the provider standards section).
Nurse Care Manager	Nurse care managers (further information on qualifications included in the provider standards section) will be responsible in particular for establishing and maintaining linkages and with specialists (e.g., convening interdisciplinary care team meetings), ensuring that

Provider Type	Description
	specialist input is reconciled and reflected within the care planning process, providing supervisory support for clinical care coordinators (including ensuring that best practices are followed with regards to population health management and the promotion of wellness across the practice) etc. Key specialists with whom the nurse care manager will interact for planning and consultation purposes are detailed in the provider standards section).

Referral to Community and Social Support Services

Definition

The State defines referral to community and social support services as comprising the following activities. Providers will need to deliver from the set of following activities as reflects member needs (i.e. with greater scope and provision for members in higher needs tiers):

- Identify community supports where applicable that would facilitate members in achieving their highest level of function, social skill development, independence, and wellness/self-management
- Provide information, assistance, and referrals where applicable to members and their caregivers to enhance access to social support services, and undertake follow-up
- Attend Integrated Regional Meetings to alert agency partners of gaps in supportive service provision in locality
- Engage community partners to support the member outreach process (e.g., to ascertain location, optimal means of communication and approach)
- Communicate member needs to community partners and incorporate information from community partners into care planning process, ensuring social determinants of health are addressed within this (e.g., housing situation)
- Communicate via MCOs (if applicable) with partner agencies (e.g., DCFS) to involve social supports (e.g., caseworkers) and incorporate appropriate legal guidance
- Coordinate consolidation of information on member held by social supports and community partners, with member's consent, in order to improve care planning and delivery process

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

- Providers will be able to use online/electronic means to refer their members to community and social supports where possible
- Where appropriate, providers will be able to use members' EHR data to provide community and social supports with relevant information on the members' needs
- Where appropriate, providers (and the State/member's MCO) will be able to share analysis and insights derived from the members' medical history (including any risk scoring or tier status) and screening/assessment data to give evidence of social functioning and needs
- Providers will be expected to engage community and social support services, as applicable, during their attempts to locate and engage members, which may involve usage of secure electronic communications
- Provider focus on this service may be informed by supply by MCOs/State of reports on panel outlining performance on key indicators of care delivery quality and efficiency, with indicators for how to improve performance
- Training on relevant topics may be provided via webinars to providers (in addition to via Learning collaboratives)
- Transition assistance funding (as applied for through the current 1115 Waiver package) for relevant HIT infrastructure support for delivery of this service may be available for selected providers

Scope of service

The service can be provided by the following provider types

<input checked="" type="checkbox"/> Behavioral Health Professionals or Specialists	Description Same as defined in the Medicaid state plan.
<input checked="" type="checkbox"/> Nurse Practitioner	Description Same as defined in the Medicaid state plan.
<input type="checkbox"/> Nurse Care Coordinators	
<input checked="" type="checkbox"/> Nurses	Description Same as defined in the Medicaid state plan.
<input type="checkbox"/> Medical Specialists	
<input checked="" type="checkbox"/> Physicians	Description Same as defined in the Medicaid state plan.
<input checked="" type="checkbox"/> Physician's Assistants	Description As defined by the Illinois Physician Assistant Practice Act (225 ILCS 95).
<input type="checkbox"/> Pharmacists	
<input checked="" type="checkbox"/> Social Workers	Description

Same as defined in the Medicaid state plan.

- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Nurse Care Manager	Nurse care managers (further information on qualifications included in the provider standards section) will be responsible in particular for establishing and maintaining linkages and with specialists (e.g., convening interdisciplinary care team meetings), ensuring that specialist input is reconciled and reflected within the care planning process, providing supervisory support for clinical care coordinators (including ensuring that best practices are followed with regards to population health management and the promotion of wellness across the practice) etc. Key specialists with whom the nurse care manager will interact for planning and consultation purposes are detailed in the provider standards section).
Clinical Care Coordinator	Clinical care coordinators (further information on qualifications included in provider standards section) will be responsible for the majority of the day-to-day interaction with members and the provision of support to them as needed, particularly with regard to enacting smooth transitions from settings of care, ensuring completion of necessary follow-up, ensuring scheduling and attendance at appointments, engaging in outreach, and coordinating member/family education and support etc.. In this they will consult as necessary with the nurse care manager and specialists (as detailed in the provider standards section).

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

Package ID	IL2016MH00010	SPA ID	IL-17-0014
Submission Type	Official	Initial Submission Date	12/5/2017
Approval Date	7/18/2018	Effective Date	10/1/2018
Superseded SPA ID	N/A		

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Slide showing flow in order:

- How eligibility assessed (claims, referrals + claims),
- Attribution determination according to pre-set hierarchy
- Notification of member/IHH
- Conditions for service suspension/end (member switch, opt out, entry into LTC/duplicative care coordination arrangement, decrease in level of need to tier D, i.e. out of population covered by Health Home SPA)

Name	Date Created	
20170426 2000 Member flow vF	4/27/2017 5:04 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

Package ID	IL2016MH00010	SPA ID	IL-17-0014
Submission Type	Official	Initial Submission Date	12/5/2017
Approval Date	7/18/2018	Effective Date	10/1/2018
Superseded SPA ID	N/A		

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

The state will annually perform analyses of total cost of care per member per month (TCOC PMPM) figures for the IHH target population belonging to each practice, for each member tier. Historic Medicaid claims data using a three-year base period will be employed to determine the average TCOC PMPM for each member tier before program launch. A growth rate will be trended forward on this baseline figure to permit comparison between projected PMPM costs in absence of the program and the actual PMPM costs following program launch. The growth rate will be specific to each tier .

The TCOC PMPM will be calculated based on the total Medicaid membership net of the following members to ensure data completeness, consistent service coverage, comparability of pricing, as well as to avoid excessive influence of outliers:

- Dual eligible members
- Members with third party liabilities
- Partially eligible members
- Members with fewer than 6 months of attribution period with the attributed practice
- Members with extended stay in long-term care facilities (>90 days)
- Members whose spend are outliers given their health profile, based on 3M CRG tool

In addition, the TCOC PMPM will be calculated making the following spend exclusion:

- Spend for vision, dental, and transportation services
- NICU spend
- Spend for care coordination, including IHH or legacy programs such as targeted case management

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

Health information technology will be used in the following ways to support the provision of health home service delivery and coordination across the care continuum.

State

- Requiring providers seeking to become IHHs either to already possess an EHR at the time of application, or committing to adopt or make measurable progress towards adopting an EHR following the state's adoption timetable
- Reserving the right to select and roll out an ADT system, use of which would be required of all IHH providers
- Requiring providers to be capable of engaging in multimodal outreach and engagement with members (including via secure electronic communication)
- Supporting IHH providers with potential grants from waiver development funds
- (For providers supporting FFS members) Supporting provider population health management through supplying providers with information from applicable risk stratification and member tiering tools
- Organizing learning collaborative and training to share best practice for e.g., selection and use of EHR and use of wireless patient technology

MCO

- (For members in managed care) Supporting provider population health management through supplying providers with information from applicable risk stratification and member tiering tools

State/MCO

- Providing reports on an ongoing basis to IHHs indicating their performance against key quality and efficiency measures and potential actions that could be taken to improve performance further
- Generating and updating member lists/rosters with appropriate privacy safeguards for use by members' IHHs

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | IL2016MH00010 | IL-17-0014 | Integrated Health Homes

Package Header

Package ID	IL2016MH00010	SPA ID	IL-17-0014
Submission Type	Official	Initial Submission Date	12/5/2017
Approval Date	7/18/2018	Effective Date	10/1/2018
Superseded SPA ID	N/A		

Quality Measurement and Evaluation

- The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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