Integrated Health Homes
Overview

- The Promise of Integrated Health Homes
- Enrollment Requirements
- Payment Levels
- Outcomes and Reporting
- MCO Partnership
Principles for developing care delivery model

<table>
<thead>
<tr>
<th>Status</th>
<th>Principle</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>Develop a <strong>person- and family-centered coordinated care delivery model for the whole Medicaid population, regardless of match status</strong>, that encourages member and family engagement</td>
</tr>
<tr>
<td>✓</td>
<td>Evolve toward <strong>full clinical integration of behavioral, physical, and social healthcare</strong></td>
</tr>
<tr>
<td>✓</td>
<td>Craft a flexible care delivery approach that reflects <strong>the diverse needs of members in Illinois</strong> and recognizes that member needs change over time</td>
</tr>
<tr>
<td>✓</td>
<td>Acknowledge and accommodate <strong>geographical variation in provider capabilities, readiness, and priorities</strong></td>
</tr>
<tr>
<td>✓</td>
<td>Strike an <strong>appropriate balance between provider flexibility and accountability</strong> to enable capabilities and readiness</td>
</tr>
<tr>
<td>✓</td>
<td>Prioritize <strong>economic sustainability of care delivery model</strong> at both the systemic and provider levels</td>
</tr>
</tbody>
</table>
Integrated Health Home Vision

- Fully-integrated coordinated care including **physical**, **behavioral** and **social** for members of Illinois Medicaid

- **Intensive set of services** for a small subset of members who require coordination at the highest levels

- **Comprehensive system of care coordination** for Illinois Medicaid individuals with **chronic conditions**

- **Coordinate with** and paid through MCOs

- Will have **collaborative agreements** with multiple entities / service providers to ensure service coordination

- Rewarded for outcomes
What is an Integrated Health Home?

<table>
<thead>
<tr>
<th>Integrated Health Homes in Illinois are:</th>
<th>Integrated Health Homes in Illinois are NOT:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary focus is on coordination of care…</strong></td>
<td>… and NOT on the <strong>provision of all services</strong></td>
</tr>
<tr>
<td>▪ Integrated, individualized care planning and coordination resources, spanning physical, behavioral and social care needs</td>
<td>▪ <strong>Provider of all services for members</strong></td>
</tr>
<tr>
<td>▪ An opportunity to <strong>promote quality</strong> in the core provision of physical and behavioral health care</td>
<td>▪ <strong>A gatekeeper</strong> restricting a member’s choice of providers</td>
</tr>
<tr>
<td>▪ A way to <strong>encourage team-based care</strong> delivered in a member-centric way</td>
<td>▪ <strong>A physical place</strong> where all Integrated Health Home activities occur</td>
</tr>
<tr>
<td>▪ A way of <strong>aligning financial incentives</strong> around evidence-informed practices, wellness promotion, and health outcomes</td>
<td>▪ <strong>A care coordination approach that is the same for all members</strong> regardless of individual needs</td>
</tr>
</tbody>
</table>

**For members with the highest needs:**

- A means of facilitating **high intensity, wraparound care coordination**
- An opportunity to obtain **enhanced match for care coordination needs**
- **Identifying enhanced support** to help these members and their families manage complex needs (e.g., housing, justice system)
How can we become an IHH?

Who can enroll as an IHH?
As long as the requirements are met, any provider can enroll as an IHH.

Must be able to provide coordination of care across physical, social and behavioral health and enroll with Medicaid in IMPACT as well as have agreement with MCO(s).

General Requirements

- Required Professionals – Collaborative and/or Cooperative Agreements
- Maintain Appointment Standards
- Establish relationships with hospitals, residential settings, other treatment centers, and other care providers
- Facilitate Direct Access
- Facilitate and participate in interdisciplinary team meetings
- Ability to receive notifications on member status from rendering providers
- Develop capacity for a minimum panel size of 500
Required Professionals

**Required Professionals**

- **Physician**: Must have appropriate clinical licenses and/or professional certification (and be able to refer to appropriate medical specialists)
- **Psychiatrist/Psychologist/Mental Health Specialist**: Must have one Psychiatrist/Psychologist/Mental Health Specialist with appropriate clinical license and/or professional certification.
- **Substance Use Disorder (SUD) Specialist**: Must have one SUD Specialist with an appropriate clinical license.
- **Social Worker/Social Service Specialist**: Must have one Social Worker who must possess at a minimum of a bachelor’s degree in a relevant subject.
- **Nurse Care Manager**: Must have one qualified RN
- **Clinical Care Coordinator**: Must possess a minimum of a bachelor degree with previous case management experience and appropriate clinical licenses and/or professional certification.

**Other Requirements**

- Building capacity to receive electronic records or notification.
- Panel size requirements
## Enrollment of an IHH: General Requirements

### Maintain Appointment Standards

<table>
<thead>
<tr>
<th>Type of Appointments</th>
<th>Tiers A &amp; B</th>
<th>Tier C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine/Preventative for adults</td>
<td>Within 3 weeks</td>
<td>Within 5 weeks</td>
</tr>
<tr>
<td>Routine/Preventative infants less than 6 months</td>
<td>Within 1 weeks</td>
<td>Within 2 weeks</td>
</tr>
<tr>
<td>Urgent Care Non emergencies</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Problems/Issues deemed as not being serious</td>
<td>Within 2 weeks</td>
<td>Within 3 weeks</td>
</tr>
<tr>
<td>Prenatal 1&lt;sup&gt;st&lt;/sup&gt; Trimester</td>
<td>Within 1 weeks</td>
<td>Within 2 weeks</td>
</tr>
<tr>
<td>Prenatal 2nd Trimester</td>
<td>Within 5 days</td>
<td>Within 1 week</td>
</tr>
<tr>
<td>Prenatal 3rd Trimester</td>
<td>Within 2 days</td>
<td>Within 3 days</td>
</tr>
</tbody>
</table>
General Requirements

Facilitate Direct Access for Members
• 24 hours, 7 days a week
• At a minimum, an answering service/direct notification/other preapproved arrangement, such as a secure electronic messaging system and/or video conferencing system to offer interactive clinical advice to members

Inter-Disciplinary Meetings
• Facilitate and participate / both behavioral and physical health
• Meeting the needs of the member for the coordination of care

Communication
• Bi-directional communication with members and appropriate service providers
• Develop protocols for ongoing communication and prompt notification as member’s transition from residential to community
• Ability to receive notification on members’ status from rendering providers (e.g. ADT feed, working toward EHR).
## IHH Structure

<table>
<thead>
<tr>
<th>Allowable options</th>
<th>Approach</th>
<th>Demonstration of integration</th>
<th>Proof of eligibility</th>
<th>Entities receiving payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>One, fully integrated, responsible provider</td>
<td>▪ Single, integrated behavioral health provider (e.g., CMHC), physical health provider (e.g., FQHC), and social service health provider (e.g., Lutheran SS)</td>
<td>▪ Entity is capable of providing both physical and behavioral health care coordination services</td>
<td>▪ Provider must attest to having the necessary staff and capabilities</td>
<td>▪ One (i.e., single integrated provider receives full payment)</td>
</tr>
<tr>
<td>Lead provider brings contracts/collaborative agreement</td>
<td>▪ One lead provider (type dependent on member need)</td>
<td>▪ Must submit a contract or Collaborative Agreement (CA)</td>
<td>▪ Contract or CA must contain explicit agreements in line with integration requirements laid out by State</td>
<td>▪ One lead entity, with potential disbursement of funds to partner entities left up to lead provider’s discretion</td>
</tr>
<tr>
<td></td>
<td>AND</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Contract or Collaborative agreement with the other provider types</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IHH - Illinois Health and Human Services
Enrollment and Ongoing Participation

Requirements to... Enroll as an IHH

- **Collaborative agreements** with practice(s) with complementary capabilities for both high- and low-needs members
- Specific **care coordination personnel** (IMPACT-enrolled)
- Medicaid provider **in good standing**
- Meet certain **activity requirements** prior to enrollment
- **500-member minimum panel size**, with exceptions where needed
- **Usage** of or progress towards implementing an **EHR system**
- **Ability** to perform **multi-modal outreach**

 Remain an IHH

- **Continue to meet enrollment requirements**
- **Continue to provide care coordination services** under the following five categories (HCPCS codes):
  - G9004 - Comprehensive Care Management
  - G9005 - Care Coordination and Health Promotion
  - G9007 - Transitional Care
  - G9010 - Patient and Family Support
  - G9011 - Referral to Social Services
- **Measurements**
  - 10 measures for outcomes based payments, e.g., controlling high blood pressure
  - 8 measures for reporting only, e.g., emergency department utilization per 1,000
Enrollment and Ongoing Participation

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- Measurements
  - 10 measures for outcomes based payments, e.g., controlling high blood pressure
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Client Population

4 tiers, reflecting acuity of behavioral and physical health needs:

- **Tier A**: High behavioral and high physical health needs
- **Tier B**: High behavioral and low to moderate physical health needs
- **Tier C**: High physical and low to moderate behavioral health needs
- **Tier D**: Low to moderate behavioral and low to moderate physical health needs

**Exclusions**

- Full Medicaid population except:
  - MMAI
  - Individuals with partial benefits
  - High TPL
  - Residents in a specific set of LTC facilities, e.g., SNFs (90+ days)

Clients are tiered using the CRG software and a series of behavioral health diagnosis codes or a triggering event
Overview of Tiering

Level of physical health needs

High

Low

Level of behavioral health needs

High behavioral health needs, Low physical health needs

Moderate needs members

Low needs members

Low behavioral health needs, high physical health needs

High

Highest needs

Lowest needs
What do the tiers mean?

Each IHH member will be attributed to a tier based on physical and behavioral health information in the medical history and/or a review of claims. Each tier has specific criteria. This information will be shared with the member’s health plan by HFS.

* Full Medicaid population will be included in the model, with exception of those in LTC facilities after 90 days, or with MMAI dual, partial eligible, or TPL status
### Focus: Determining member tier and provider

#### Attribution to tier

- **Determine member Tier A, B, C, or D based on:**
  - CRG status for physical conditions (high = A, C)
  - Behavioral health claims analysis for behavioral health conditions (high = A, B)

#### Assignment to / choice of provider

- **Assign member** to a provider able to meet their needs based on tiering above, based on following hierarchy:
  - Member choice
  - Claims history (if no member choice)
  - Other factors (e.g., closest provider geographically) (if no member choice or claims history)
Proposed IHH stratification approach by Behavioral Health high needs and CRG Health Category

Severity of Physical Health Needs

9. Catastrophic
8. Dominant/Metastatic malignancy
7. Dom. chronic disease in 3+ systems
6. Sign. chronic diseases in multiple systems
5. Significant chronic disease
4. Minor chronic diseases in multiple systems
3. Single minor chronic disease
2. History of significant acute disease
1. Healthy

Behavioral health needs in order of increasing severity
High behavioral health need members are identified based on diagnosis and utilization

<table>
<thead>
<tr>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single diagnosis</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Presence of the following diagnosis:</td>
</tr>
<tr>
<td>▪ Schizophrenia</td>
</tr>
<tr>
<td>▪ Bipolar disorder</td>
</tr>
<tr>
<td><strong>Or</strong></td>
</tr>
<tr>
<td><strong>Set of diagnoses</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Presence of one of the following symptoms AND one category 3 diagnosis:</td>
</tr>
<tr>
<td>▪ Attempted self-injury or suicide</td>
</tr>
<tr>
<td>▪ Homicidal ideation</td>
</tr>
<tr>
<td><strong>Or</strong></td>
</tr>
<tr>
<td><strong>3</strong> One or more behavioral health-related inpatient visit / ED / Crisis unit / residential facility / rehab facility in the past 12 months WITH a diagnosis of:</td>
</tr>
<tr>
<td>▪ Substance use</td>
</tr>
<tr>
<td>▪ Major depression</td>
</tr>
<tr>
<td>▪ Other depression</td>
</tr>
<tr>
<td>▪ Other mood disorders</td>
</tr>
<tr>
<td>▪ Conduct disorder</td>
</tr>
<tr>
<td>▪ Oppositional Defiant Disorder (ODD)</td>
</tr>
<tr>
<td>▪ Psychosis</td>
</tr>
<tr>
<td>▪ PTSD</td>
</tr>
<tr>
<td>▪ Personality disorders inc. borderline personality disorder</td>
</tr>
<tr>
<td>▪ Eating disorders</td>
</tr>
</tbody>
</table>

NOTE: Diagnoses are based on all diagnosis fields 1-18
For reference: IHH tiers

<table>
<thead>
<tr>
<th>Level of physical health needs</th>
<th>Level of behavioral health needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Low and moderate needs members</td>
</tr>
<tr>
<td>Low</td>
<td>Low and moderate needs members</td>
</tr>
<tr>
<td>Low behavior health needs, high physical health needs</td>
<td>Low and moderate needs members</td>
</tr>
<tr>
<td>Low behavior health needs, high physical health needs</td>
<td>Low and moderate needs members</td>
</tr>
<tr>
<td>Highest needs</td>
<td>Highest needs</td>
</tr>
</tbody>
</table>

- A: Highest needs
  - 59K (2.4%)

- B: High behavioral health needs, Low physical health needs
  - 100K (4.1%)

- C: Low behavioral health needs, high physical health needs
  - 117K (4.8%)

- D: Low behavioral health needs, Low physical health needs
  - 2.2M (88.7%)

SOURCE: 18 months of claims data as of 08/2018 – clients enrolled as of 08/20/2018
Tier Assignment Timing

• HFS will do tiering quarterly

• Those clients without claims data will default to tier D

• A triggering event may lead to tiering outside of the quarterly schedule
Typical IHH member journey

1. **Eligibility**
   - Member is assessed by State to meet IHH program eligibility criteria

2. **Attribution to tier**
   - Member is attributed to a tier on basis of medical history, by State or MCO

3. **Assignment to / choice of provider**
   - Member is assigned to an IHH following State-set parameters, by State or MCO

4. **Enrollment and participation**
   - Member is engaged and enrolled by IHH and begins receiving regular care coordination

<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>MCO/State and IHH deem level of need to have changed; member tier is changed (potentially involving reattribution)</td>
</tr>
<tr>
<td>B</td>
<td>Member begins receiving duplicative form of care coordination or enters LTC for 90+ days; IHH membership is suspended for duration</td>
</tr>
<tr>
<td>C</td>
<td>Member opts to change IHH and is promptly reassigned</td>
</tr>
<tr>
<td>D</td>
<td>Member is not successfully engaged by IHH for a period of time, either before or after enrollment</td>
</tr>
</tbody>
</table>
Typical IHH provider journey

1. Preparation for enrollment
   - Provider decides to enroll in Integrated Health Homes and forms agreements with collaborating providers (e.g., primary care provider and behavioral health clinic)

2. Provider enrollment
   - Provider applies for enrollment in Integrated Health Homes and specifies which tier of members it is able to address. Upon approval, provider amends contracts with MCOs

3. Receive assignment lists
   - Provider receives first list of assigned members (including member tiers) from MCOs and/or State

4. Launch and participation
   - Launch of first wave
     - Regular attribution/tiering refresh
     - Quarterly reporting (~April 2019)

5. Year-end assessment
   - Determination of bonus level based on performance outcomes
   - Determination for need of corrective action plan

6. Continue in the Model
   - Exit model by choice
   - Continue in Model

1 First report cycle would include very minimal information
2 Performance payment
3 In future years, providers may be removed from model
IHH IMPACT Enrollment

- IMPACT website: [www.illinois.gov/hfs/impact](http://www.illinois.gov/hfs/impact)

- IMPACT Enrollment Information:
  - Enrollment type = Facility, Agency or Organization (FAO)
  - Provider type = Integrated Health Home
  - Specialty = Integrated Health Home
  - Sub-specialty = IHH-Tier A, IHH-Tier B, IHH-Tier C

- Providers must have a unique Tax ID / NPI combination for this enrollment and will be assigned a new HFS provider ID

The IHH owner’s Tax ID may be used, but remember, there is only one Pay-To address per Tax ID in IMPACT

A new provider agreement/attestation outside of IMPACT for the IHH to submit the contracted/collaborative providers in the IHH
IMPACT Enrollment Checklist

- Complete and sign the IHH Provider Agreement
- Provide copies of all contracts and cooperative agreements with required partner entities
  - Should include operating policies and procedures, staffing expectations, organizational / decisional chart
  - Funding distribution agreements
- Ensure facilities, staff and services are culturally competent as required by HHS Office of Minority Health
- Maintain appropriately trained and credentialed staff required to deliver care coordination
- Use an EHR or commit to adopt / demonstrate progression
- Attest to meeting and maintaining staffing ratios
Additional Documentation for Enrollment

- IHH Provider Agreement
- Contracts/Cooperative agreements with required members of the Care Coordination Team
- Policies and procedures
- IHH Attestation of staffing ratios
IHH Agreement

• The IHH provider agreement and attachments describes the key responsibilities and standards that IHH providers are expected to meet
Agreement Attachments

• Attachment A
  – Key Responsibilities and Standards
• Attachment B
  – Care Coordination Activities
• Attachment C
  – Quality Measures
• Attachment D
  – Staffing Ratios
Contracts/Cooperative agreements with required Care Coordination Team

• IHH Providers must establish and provide copies of all contractual, cooperative and collaborative agreements with care coordination staff to meet the requirements of an IHH

• Care Coordination team must contain providers from these designated areas: physical, behavioral and social health
Care Coordination Staff Enrollment

• After HFS approval of IHH enrollment, all rendering care coordination staff will enroll and associate with IHH

• Care Coordination Staff will enroll as an individual provider with all required license
Care Coordination Team

- **Nurse Care Manager** – Must have at least one per practice who is a qualified RN. A practice may add additional nurse care managers who may be RN, RD, LPN or APN.

- **Clinical Care Coordinator** – Must possess a minimum of a bachelor’s degree, previous case management experience and appropriate clinical license and/or professional certification, if applicable.

- **Physician** – Must have appropriate clinical licenses and/or professional certification and be able to refer to appropriate medical specialists.

- **Psychiatrist/Psychologist/Mental Health Specialist** – Must possess appropriate clinical license and/or professional certification (e.g., LPHA).

- **Substance Use Disorder (SUD) Specialist** – Must have one SUD Specialist with an appropriate clinical license, if applicable.

- **Social Worker/Social Service Specialist** – Must possess a minimum of a bachelor’s degree in a relevant subject.
Policies and procedures

• IHH provider’s must establish and maintain written policies and procedures to be used by all staff in the delivery of care coordination services
• These policies and procedures will need to be submitted to the department after application submittal
IHH Attestation of staffing ratios

• IHH providers must attest to meeting the staffing ratios identified by the department and maintain them ongoing

• IHH Providers must employ or maintain contractual, collaborative or cooperative agreements with specific personnel and maintain staffing ratios as part of the care coordination team
## Integrated Health Homes

### Staffing FTEs per 500 members

<table>
<thead>
<tr>
<th>Tier</th>
<th>Under 18</th>
<th>18-20</th>
<th>21+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier A</td>
<td>Nurse Care Manager</td>
<td>1.50</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td>Clinical Care Coordinator</td>
<td>20.00</td>
<td>20.00</td>
</tr>
<tr>
<td></td>
<td>Physician</td>
<td>0.15</td>
<td>0.15</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist/Psychologist/Mental Health Specialist</td>
<td>0.20</td>
<td>0.20</td>
</tr>
<tr>
<td></td>
<td>SUD Specialist</td>
<td>0.74</td>
<td>0.74</td>
</tr>
<tr>
<td></td>
<td>Social Worker/Social Service Specialist</td>
<td>0.51</td>
<td>0.51</td>
</tr>
<tr>
<td>Tier B</td>
<td>Nurse Care Manager</td>
<td>0.51</td>
<td>0.38</td>
</tr>
<tr>
<td></td>
<td>Clinical Care Coordinator</td>
<td>6.80</td>
<td>5.10</td>
</tr>
<tr>
<td></td>
<td>Physician</td>
<td>0.05</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist/Psychologist/Mental Health Specialist</td>
<td>0.07</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td>SUD Specialist</td>
<td>0.25</td>
<td>0.19</td>
</tr>
<tr>
<td></td>
<td>Social Worker/Social Service Specialist</td>
<td>0.17</td>
<td>0.13</td>
</tr>
<tr>
<td>Tier C</td>
<td>Nurse Care Manager</td>
<td>0.31</td>
<td>0.31</td>
</tr>
<tr>
<td></td>
<td>Clinical Care Coordinator</td>
<td>4.10</td>
<td>4.10</td>
</tr>
<tr>
<td></td>
<td>Physician</td>
<td>0.07</td>
<td>0.07</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist/Psychologist/Mental Health Specialist</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>SUD Specialist</td>
<td>0.07</td>
<td>0.07</td>
</tr>
<tr>
<td></td>
<td>Social Worker/Social Service Specialist</td>
<td>0.10</td>
<td>0.10</td>
</tr>
</tbody>
</table>
# Integrated Health Homes Staffing Ratio Example

Tier A – 100 Members under 18  
Tier B – 100 Members under 18  
Tier C – 300 Members across all age ranges

<table>
<thead>
<tr>
<th></th>
<th>Nurse Care Manager</th>
<th>Clinical Care Coordinator</th>
<th>Physician</th>
<th>Psychiatrist/Psychologist/Mental Health Specialist</th>
<th>SUD Specialist</th>
<th>Social Worker/Social Service Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier A</td>
<td>0.30</td>
<td>4.00</td>
<td>0.03</td>
<td>0.04</td>
<td>0.15</td>
<td>0.10</td>
</tr>
<tr>
<td>Tier B</td>
<td>0.10</td>
<td>1.40</td>
<td>0.01</td>
<td>0.01</td>
<td>0.05</td>
<td>0.03</td>
</tr>
<tr>
<td>Tier C</td>
<td>0.19</td>
<td>2.50</td>
<td>0.04</td>
<td>0.01</td>
<td>0.04</td>
<td>0.06</td>
</tr>
<tr>
<td>Totals</td>
<td>0.59</td>
<td>7.90</td>
<td>0.08</td>
<td>0.06</td>
<td>0.24</td>
<td>0.19</td>
</tr>
</tbody>
</table>
Reimbursement

• IHHs will be paid according to the members enrolled with their entity
• Payments are PMPM, based on tiers
• Payments are made to MCOs but directed to the IHH
## PMPM rates by Tier

<table>
<thead>
<tr>
<th>Tier-based payments *</th>
<th>Child PMPM</th>
<th>19-21 PMPM</th>
<th>Adult PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier A</td>
<td>$240</td>
<td>$240</td>
<td>$120</td>
</tr>
<tr>
<td>Tier B</td>
<td>$80</td>
<td>$60</td>
<td>$48</td>
</tr>
<tr>
<td>Tier C</td>
<td>$48</td>
<td>$48</td>
<td>$48</td>
</tr>
</tbody>
</table>

* Paid once per month for each member in applicable group and when one of five (5) service codes is billed by the IHH.
## Guiding principles for measure selection

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Simple</strong></td>
<td>▪ <strong>Straightforward to operationalize</strong>, and based on readily available sources of data</td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Restricted in number</strong> to direct provider focus on what matters and what they can control</td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Reasonable in making demands on providers’ capabilities</strong></td>
</tr>
<tr>
<td><strong>Representative</strong></td>
<td>▪ <strong>Tailored to reflect members’ different needs</strong>, with particular attention given to the variation in the profiles of members with high behavioral and physical health needs, and to the needs of children</td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Attentive to transitions between different settings of care</strong></td>
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<tr>
<td></td>
<td>▪ <strong>Aligned with CMS and HFS priority measures</strong></td>
</tr>
<tr>
<td><strong>Effective</strong></td>
<td>▪ <strong>Focused on outcomes as much as process</strong></td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Complementary, rather than duplicative, with activity requirements</strong> and other performance monitoring processes</td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Reported to providers in such a way that there are clear actions or paths to improvement</strong>, potentially tied to provider education and support efforts</td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Evaluated for efficacy as they are used</strong>, with the potential to be replaced with other measures as provider performance progresses</td>
</tr>
</tbody>
</table>
Overview of outcomes metrics selected

Original consideration

~200 metrics

Focus on simple, representative, and effective quality metrics

Optimization by Working Group

Focus on relevant metrics to Illinois / HFS

18

Additional filtering

Measures used for outcomes-based payments

10

Guiding principles for metrics selection

▪ **Initial consideration** of over 200 metrics by Working Group

▪ Working Group held session to prioritize metrics based on:
  – Simplicity (e.g., straightforward to operationalize)
  – Representativeness (e.g., tailored for high / low behavioral health needs and the needs of children)
  – Effectiveness (e.g., focused on both outcomes and process)

▪ **Additional consolidation** based on consistency with CMS and MCO metrics

Metrics complement MCO metrics
List of quality measures

**Measures for reporting only**
- Plan All-Cause Readmission Rate
- Follow-up After Hospitalization for Mental Illness
- Controlling High Blood Pressure
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Prenatal and Postpartum Care
- Medication Management for People with Asthma
- Potentially preventable readmission for Behavioral Health
- Behavioral Health related ED visits per 1000

**Measures impacting outcomes-based payments**
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Screening for Clinical Depression and Follow-Up Plan
- Chronic Condition Hospital Admission Composite – PQI
- Adult BMI Assessment
- Follow-up After Hospitalization
- ED Visits per 1000
- Immunization Combo 3
- Breast Cancer Screening
- Diabetes Management (Hb1AC testing)
- Antidepressant Medication Management

- Reporting required on all 18 measures
- Outcomes-based payments impacted by the 10 selected measures

CMS health home core measures
Description of podium metrics

Minimum criteria to achieve bronze, silver, and gold status

Bronze criteria
- Average 40th percentile, with no individual measure lower than 20th percentile

Silver criteria
- Average 60th percentile, with no individual measure lower than 40th percentile

Gold criteria
- Average 80th percentile, with no individual measure lower than 50th percentile

IHHs may receive either a bronze, silver, or gold brand by surpassing the color’s level for any single measure once all 18 measures are reported on
Overview of approach to outcomes-based payment stream

Eligibility for outcomes-based payments requires reporting on all activities

Eligible practices stratified by level of performance

Payment amount based on level of performance

- **To be eligible for outcomes-based payments, IHH must report on all 18 quality measures**
- All Health Homes -- intensive and non-intensive IHHs -- are eligible for payment

- **Performance levels are:**
  - **Bronze:** Average [40th] percentile, with no individual measure lower than [20th] percentile
  - **Silver:** Average [60th] percentile, with no individual measure lower than [40th] percentile
  - **Gold:** Average [80th] percentile, with no individual measure lower than [50th] percentile

- **IHH must achieve at least a Bronze level** of performance across 10 selected performance measures to receive any outcomes-based payment

- **Bronze, Silver, and Gold levels of performance result in ascending levels of payment, respectively:**
  - **Bronze:** 10% of total amount of IHH's care coordination PMPY payment
  - **Silver:** 25% of total amount of IHH's care coordination PMPY payment
  - **Gold:** Silver-level bonus AND share of cost of care savings provider has achieved as determined via proxies for TCOC
MCO Partnership

Health plan staff designated to begin work immediately on IHH development:

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