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State/Territory Name: IL

State Plan Amendment (SPA) #: 18-0017

This file contains the following documents in the order listed:

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

January 11, 2019

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

Attn: Kelly Cunningham

Dear Ms. Bellock:

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

Transmittal #18-0017 – Modifies Provider Qualifications for Health Homes Clinical Care Coordinators Modifies Mental Health Professional Provider Qualifications
– Effective Date: October 1, 2018
– Approval Date: January 11, 2019

If you have any questions, 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: Sara Barger, HFS
Kimberley Cox, HFS
Mary Doran, HFS

CMS-10434 OMB 0938-1188

Package Information

Package ID	IL2018MS0004O	**Submission Type**	Official
Program Name	Integrated Health Homes	**State**	IL
SPA ID	IL-18-0017	**Region**	Chicago, IL
Version Number	1	**Package Status**	Approved
Submitted By	Mary Doran	**Submission Date**	11/2/2018
Package Disposition		**Approval Date**	1/11/2019 2:19 PM EST
Priority Code	P2		

Name		

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | IL2018MS0004O | IL-18-0017 | Integrated Health Homes

Package Header

Package ID IL2018MS0004O

Submission Type Official

Approval Date 1/11/2019

Superseded SPA ID IL-17-0014

System-Derived

SPA ID IL-18-0017

Initial Submission Date 11/2/2018

Effective Date 10/1/2018

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

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 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

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.

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 strati cation and analysis of member-level data to support assignment to tiers
- Providing reports showing provider performance on key quality and e ciency 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 reprocurement 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.)

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):
  - 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.
  - Clinical care coordinator. The clinical care coordinator staff meeting the appropriate staffing ratios for the IHH panel must be comprised of 50% staff possessing a bachelor's degree in a relevant subject and demonstrated experience of care coordination/case management and 50% staff meeting the requirements of a Rehabilitative Services Associate (RSA) defined in Appendix to Attachment 3.1-A, 13d.
  - Physician, possessing appropriate clinical licenses and/or professional certifications
  - Psychiatrist or other behavioral health specialist, possessing appropriate clinical licenses and/or professional certifications
  - SUD specialist, possessing appropriate clinical licenses and/or professional certifications
  - Psychologist, possessing appropriate clinical licenses and/or professional certifications
  - Social worker, possessing at minimum a bachelor's degree in a relevant subject
  - 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:
  - 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]
  - 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
  - Facilitate and participate in regular interdisciplinary care team meetings, including clinicians from the members' primary behavioral and physical care providers when possible
  - 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
  - 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	

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 O cer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.