Illinois Department of Healthcare and Family Services
Integrated Health Home Provider Terms and Conditions

The provider applying for enrollment as an Integrated Health Home (IHH)) in the Illinois Medical Assistance Program ("Program") administered by the Illinois Department of Healthcare and Family Services (Department) represents, agrees, and certifies to the following terms and conditions, including Attachments A, B, C and D. These terms and conditions do not affect any other relationship or agreement, including the general Provider Agreement, between the Department and the Provider.

Participation Requirements

IHH agrees to provide a fully-integrated form of care coordination of physical, behavioral, and social healthcare for enrollees of the IHH program and adhere to the following requirements:

- Employ or maintain contractual, collaborative or cooperative agreements with the following personnel as part of the IHH and maintain staffing ratios as required in Attachment D to these terms and conditions:
  - **Nurse Care Manager** – Must have a qualified RN. A practice may add additional nurse care managers who may be RN, RD, LPN or APN. Must have a valid clinical license in the state of practice and is legally authorized under state law or rule and/or professional certification.
  - **Clinical Care Coordinator** – Must have a clinical care coordinator who possesses a minimum of a bachelor's degree and previous case management experience. Must have a valid clinical license in the state of practice and is legally authorized under state law or rule and/or professional certification, if applicable.
  - **Physician** – Must have a physician with a valid clinical license in the state of practice and is legally authorized under state law or rule and/or professional certification and be able to refer to appropriate medical specialists.
  - **Psychiatrist/Psychologist/Mental Health Specialist** – Must have a Psychiatrist or Psychologist or Mental Health Specialist with a valid clinical license in the state of practice and is legally authorized under state law or rule and/or professional certification.
  - **Substance Use Disorder (SUD) Specialist** – Must have a SUD Specialist that holds a clinical certification as a Certified Alcohol and Drug Counselor from the Illinois Alcoholism and Other Drug Abuse Professional Certification Association (IAODAPCA), or holds assessor certification as a Certified Assessment and Referral Specialist (CARS) from IAODAPCA.
  - **Social Worker/Social Service Specialist** – Must have a social worker with a valid clinical license in the state of practice and is legally authorized under state law or rule or a social service specialist who possess at a minimum of a bachelor's degree in a relevant subject.
- Maintain:
  - An IHH with physical and behavioral health (including SUD) and social capabilities housed under a single roof must attest to having necessary staff and capabilities. or
  - An IHH not possessing the full set of physical and behavioral health (including SUD) and social capabilities housed under a single roof, but having contractual, collaborative, or cooperative 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 Department in Attachment A.
- Identify in an Excel Spreadsheet all individual practitioners and providers or organizations in the IHH.
  - Include all providers that are part of the Integrated Health Home.
  - IMPACT application ID, if application is still in process or IMPACT provider ID, if application is approved.
  - Licensure type – specify the field in which the practitioner is licensed.
  - Certification Type – specify any special designation a provider or clinic has. For practitioners, indicate specialty (if any) or any special professional designation or qualification provider has earned: internal medicine, psychiatry, etc.
  - Practitioner's NPI, if applicable.
  - IHH coverage counties.
- Provide a copy of all IHH related contractual, collaborative, or cooperative agreements to the Department's

IMPACT system with this Agreement. After enrollment provide notice to the Department's IMPACT system of any change in network provider within three (3) days, and provide a copy of the new agreement within ten (10) days of the change.

- Comply with the terms and conditions of the Illinois Medical Assistance Program's general provider enrollment agreement, which can be found in Appendix M of the IMPACT system.

Provider may terminate participation as an IHH upon 45 days written notice sent by certified mail to the Bureau of Hospital and Provider Services. If the Department finds that the IHH has failed to comply with these terms and conditions or any applicable Federal or State laws or regulations, the IHH's participation in the Medical Assistance program may be terminated, subject to applicable notice and hearing requirements.

By signing below, I certify that I have read and that I agree and accept all the enrollment terms and conditions of the contained herein. I also agree that facsimiles of signatures shall constitute acceptable, binding signatures for purposes of agreement to these terms and conditions. I certify that I am an authorized representative of the IHH and that all information provided in the IHH Application is correct.

I am an Authorized Representative of _____ Integrated Health Home

Printed Name of Authorized Representative: _____

Signature of Authorized Representative: _____

Integrated Health Home's NPI: _____

Date: _____

Attachment A to the Integrated Health Home Provider Terms and Conditions

The following list provides the key responsibilities and standards that IHH Providers are expected to meet. The Department recognizes that lack of patient compliance can prevent IHHs from meeting some of these standards, despite the IHH's best efforts to work with the patient. These integration requirements, as applicable to care coordination team members through a collaborative agreement, must be part of the collaborative agreement.

1) Develop a comprehensive; culturally-competent, person-centered, goal-oriented written care plan (Plan) developed from a comprehensive assessment of the member's physical and behavioral health needs within thirty (30) days of member's enrollment.
2) Demonstrate ability to meet the following activity requirements:
   a) Maintain the following appointment standards for members

Type of Appointments	Tiers A & B	Tier C
Routine/Preventative for adults	Within 3 weeks	Within 5 weeks
Routine/Preventative infants less than 6 months	Within 1 weeks	Within 2 week
Urgent Care Non-emergencies	Within 24 hours	Within 24 hours
Problems/Issues deemed as not being serious	Within 2 weeks	Within 3 weeks
Prenatal 1st Trimester	Within 1 weeks	Within 2 weeks
Prenatal 2nd Trimester	Within 5 days	Within 1 week
Prenatal 3rd Trimester	Within 2 days	Within 3 days

   b) Facilitate 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
   c) Facilitate and participate in regular interdisciplinary care team meetings, including clinicians from the members' primary behavioral and physical care providers when possible
   d) Establish relationships with hospitals, residential settings, rehabilitation settings, other treatment settings, long term care supports and services (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
   e) Have ability to receive notifications on member status from rendering providers (e.g., via ADT feeds)
3) Maintain a minimum panel size of 500, as determined by the Department attribution algorithm (this may be relaxed for specific provider types, e.g., acute specialists, and in rural areas with Department approval).
4) Be able to conduct bi-directional, multimodal outreach and engagement (e.g., via telephone, secure messaging).
5) Use an EHR or commit to adopt or demonstrate progression towards adoption of EHR by Department-set adoption timetable
6) Commit to ensure staff receives appropriate training to support highest need members
7) Commit to participate in and contribute to the IHH learning collaborative
8) Commit to supply all relevant data to Department/MCOs as needed for reporting purposes, e.g., for annual program evaluations and required transmittal of data to CMS.
9) 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)
10) 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. The consent must authorize sharing of medical information among the IHH partners and comply with all applicable state and federal laws for such sharing.
11) Provide care coordination services contained in these terms and conditions and 89 Illinois Administrative Code,

Section 140 to each IHH member.

12) Report on quality measures identified in Attachment C. Ten of these measures will be used for outcomes based payments. To be eligible for payment, an IHH provider must report on all 18 measures. For any measure with sub-metrics, reporting must be performed on each sub-metric.
13) Develop procedures to prevent the duplication of care coordination efforts by the health home and targeted case management services.

Attachment B to the Integrated Health Home Provider Terms and Conditions
Care Coordination Activities – Refer to 89 Illinois Administrative Code, Section 140

Comprehensive Care Management	Comprehensive Care Management consists of the following activities: • Complete a comprehensive health assessment/reassessment inclusive of medical/behavioral/rehabilitative and long term care and social service needs. • Complete/revise an individualized patient-centered plan of care with the member to identify member's needs/goals and include family members and other social supports as appropriate. • Consult with multidisciplinary team on client care plan/needs/goals. • Consult with primary care physician and/or any specialists involved in the treatment plan. • Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improve health outcomes. • Prepare client crisis intervention plan.
Care Coordination and Health Promotion	Care Coordination and Health Promotion consists of the following activities: • Coordinate with service providers and health plans as appropriate to secure necessary care, share crisis intervention (provider) and emergency info. • Link/refer client to needed services to support care services to support care plan/treatment goals, including medical/behavioral health care; patient education and self- help/recovery and self- management. • Conduct case reviews with interdisciplinary team to monitor/evaluate client status/service needs. • Advocate for services and assist with scheduling of needed services. • Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed. • Monitor/support/accompany the client to scheduled medical appointments. • Crisis intervention, revise care plan/goals required.
Transitional Care	Transitional Care consists of the following activities: • Follow up with hospitals/ER upon notification of a client's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting. • Facilitate discharge planning from an ER, hospital/residential/rehabilitative setting to a safe transition/discharge where care needs are in place. • Notify/consult with treating clinicians, schedule follow up appointments and assist with medication reconciliation. • Link client with community supports to assure that needed services are provided. • Follow up post discharge with client/family to assist client care plan needs/goals.
Patient and Family Support	Patient and Family Support consists of the following activities: • Develop/review/revise the individual's plan of care with the client/family to ensure that the plan reflects individual's preferences, education and support for self-management. • Consult with client/family/caretaker on advanced directives and educate on client rights and health care issues, as needed. • Meet with client and family, inviting any other providers to facilitate needed interpretation services. • Refer client/family to peer supports, support groups, social services, entitlement programs as needed. • Collaborate/coordinate with community based providers to support effective utilization of services based on client/family need.
Referral to Social Services	Referral to Social Services consists of the following activities • Identify resources and link client with community supports as needed. • Collaborate/coordinate with community base providers to support utilization of services based on client/family need.

Attachment C to the Integrated Health Home Provider Terms and Conditions

Quality Measures

Reporting Only

1. Plan All-Cause Readmission Rate – NQF #1768
2. Follow-up After Hospitalization for Mental Illness - NQF #0576
3. Controlling High Blood Pressure - NQF #0018
4. Metabolic Monitoring for Children and Adolescents on Antipsychotics - NCQA/HEDIS – Acronym APM
5. Prenatal and Postpartum Care - NCQA/HEDIS – Acronym PPC
6. Medication Management for People with Asthma – NCQA/HEDIS – Acronym MMA
7. Potentially Preventable Readmission for Behavioral Health – NQF N/A
8. Behavioral Health related ED visits per 1000 – NQF N/A

Impacting Outcomes-Based Payments

1. Initiation and Engagement of Alcohol and other Drug Dependence Treatment – NQF #0004
2. Screening for Clinical Depression and Follow-Up Plan – NQF #0418
3. Chronic Condition Hospital Admission Composite – AHRQ - PQI 92
4. Adult BMI Assessment – NCQA/HEDIS – Acronym ABA -HH
5. Follow-Up after Hospitalization
6. ED Visits per 1000 – NCQA/HEDIS – Acronym AMB
7. Immunization Combo 3 – NCQA/HEDIS – Acronym CIS
8. Breast Cancer Screening - NQF #2372
9. Diabetes Management (Hb1AC testing) – NCQA/HEDIS – Acronym CDC
10. Antidepressant Medication Management – NQF #0105

Attachment D to Integrated Health Homes Terms and Conditions
Staffing FTEs per 500 members

		Nurse Care Manager	Clinical Care Coordinator	Physician	Psychiatrist/ Psychologist	SUD Specialist	Social Worker/Social Service Specialist
Tier A	Under 18	1.5	20	0.15	0.20	0.74	0.51
	18-20	1.5	20	0.15	0.20	0.74	0.51
	21+	0.80	10.3	0.07	0.10	0.37	0.25
Tier B	Under 18	0.51	6.80	0.05	0.07	0.25	0.17
	18-20	0.38	5.10	0.03	0.05	0.19	0.13
	21+	0.31	4.10	0.03	0.04	0.15	0.10
Tier C	Under 18	0.31	4.10	0.07	0.02	0.07	0.10
	18-20	0.31	4.10	0.07	0.02	0.07	0.10
	21+	0.31	4.10	0.07	0.02	0.07	0.10