MEDICAID ADVISORY COMMITTEE (MAC)

Feb 4th, 2022

Virtual WebEx Meeting

10AM - 12PM

AGENDA

I. Call to Order

II. Roll Call of Committee Members

III. Introduction of HFS Staff

IV. Review and Approval Meeting Minutes

V. Public Comments

VI. Healthcare & Family Services Executive Report

VII. Subcommittee Reports & Recommendations

VIII. Additional Business: Old & New

IX. Adjournment

I. Call to Order – Ann Lundy, Madam Chair

II. Roll Call of Committee Members – Melishia Bansa, Special Assistant to Director of HFS

III. Introduction of HFS Staff – Melishia Bansa

IV. Review and Approval of Meeting Minutes – Ann Lundy, Madam Chair

Facilitator: Ann Lundy, Madam Chair

V. Public Comment(s): Present motion to move public comments to end of the meeting

VI. Healthcare & Family Services Executive Report

A. Innovations

1. Nursing Home Rate Reform
2. Healthcare Transformation
3. ADT

Presenter(s): Director Theresa Eagleson & Andy Allison

Consensus Nursing Home Reforms would Improve Staffing Levels, Rescale Wages for CNAs, and Enhance Access to Quality Care

Status of recommendations to increase payment, accountability and oversight

Illinois Department of Healthcare and Family Services

NURSING HOME RATE IMPROVEMENTS

HFS spends over $2.5 billion dollars a year on care for about 45,000 people residing in nursing homes. To address some serious issues in the quality of their care, we propose directing new funding towards proper staffing levels, safety, and quality of life for residents in new, equitable, and accountable ways.

HFS proposes simplifying and raising the nursing home assessment to bring in $207 million new dollars and requests up to $60M in new state funds ($540M after federal match). We would spend this in two ways:

- $450M for direct funding to nursing homes in accountability-driven ways to pay for staffing levels, a new and higher payscale for CNAs, CNA training, and data-driven quality incentives.
- $90M in direct funding to nursing homes to accommodate rising wages for staff amidst an extended labor shortage.

The state has a moral imperative to ensure the health, safety, and quality of life for residents in nursing homes.

During the pandemic, Black and Brown Medicaid customers faced a disproportionate risk of death. They also reside disproportionately in under-staffed facilities.

ACCOUNTABILITY

The current system allows some homes to pursue profits over people.

We believe there is no better time to change the payment-driven incentives

For more information: Nursing Home Payment Update | HFS (illinois.gov)

HFS proposes a three-pronged approach to improve overall quality and equity of care for residents.

Maximize federal funds through increased assessment

- Raise assessment per occupied bed to maximum

Improve payment accuracy and integrity

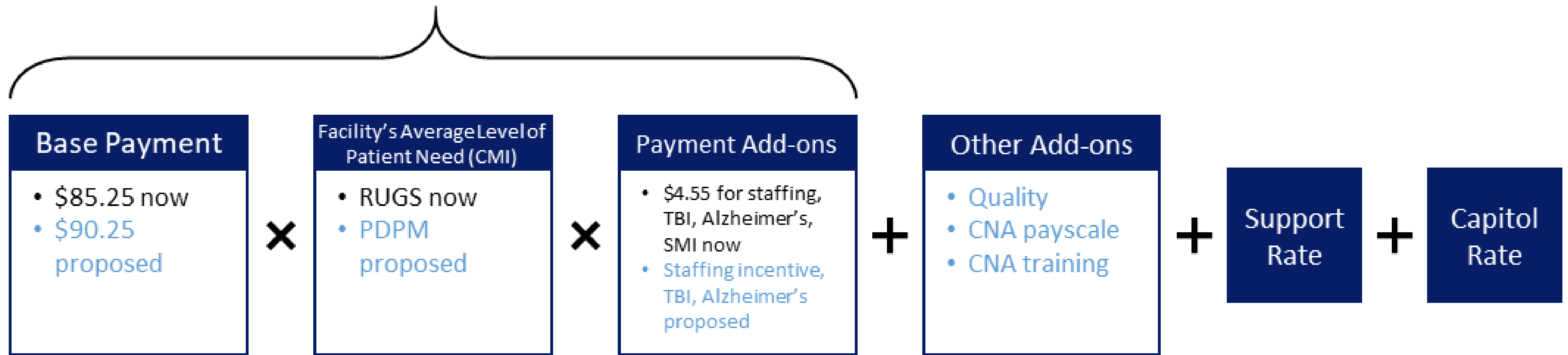
- Tie payment for staffing directly to federal standards
- Incentives for sustained quality metrics

Transition to Patient Driven Payment Model (PDPM)

- Federal payment methodology, aligns with Medicare
- Higher cost coverage for higher acuity residents

Consensus Recommendations

Payment improvements included in SB 2995



SB 2995 also includes:

- 100% ownership reporting transparency
- Pro-competitive policy for nursing agencies
- $200M+ increase in nursing home assessment
- [Implied need for as much as $60M in additional state funding]

[1]For more information see Nursing Home Payment Update | HFS (illinois.gov)

Timeline of Nursing Facility Payment Reform

Spring 2020: HFS began a comprehensive and transparent reform process with the nursing home industry, labor representatives, and other stakeholders.[1] The collaborative objective was to **promote patient-centered care, improve quality, and address understaffing**.

Spring 2021: As a result of that process, reform legislation was introduced in spring 2021. Reform was not passed, but HFS was asked to produce a report.

September 2021: HFS submitted a comprehensive review of nursing home payment and proposed reforms to the General Assembly on September 30, 2021.

November 2021: After further discussion, stakeholders coalesced around an updated set of reforms. That new agreement is reflected in SB 2995.

[1]For more information see Nursing Home Payment Update | HFS (illinois.gov)

Where things stand now

After the conceptual agreement was reached, one of three associations, HCCI, expressed concerns and identified 50 facilities (‘the 50’) that would potentially experience reduced net income under the consensus reform proposal.

In January 2022, without consulting with other stakeholders, HCCI introduced competing legislation no longer reflective of the conceptual agreement. HFS and other stakeholders are opposed to this legislation.

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To address HCCI’s concerns about the 50 facilities alleged to face hardship in the consensus proposal, the following analysis assesses the overall impact of reform on those 50 facilities.

The analysis **1) describes characteristics of HCCI-identified facilities associated with potential losses under HFS’ reform proposal 2) addresses HCCI’s concerns about the transition period into reform, and 3) identifies the effects of individual elements of reform on the list of 50 facilities.**

Defining 'The 50': HCCI's critique of consensus reforms, and their resulting alternative, centers on four facility types projected to lose net income

1. Facilities in the 3 highest proposed Medicaid tax categories (tax is stratified into 6 tiers)
   - HOWEVER, 'the 50' include disproportionately *FEW* in the first of these three tax brackets -- tier 2 (5,001-15,000 Medicaid days per year)

2. High-Medicaid facilities (at least 70% of residents funded by Medicaid)
   - HOWEVER, reform's impact generally *improves* net income at higher levels of Medicaid utilization.

3. Facilities experiencing negative financial impact from the switch to a Patient Driven Payment Model (PDPM)
   - HFS' analysis confirms this as one of reform's ***intended*** effects

4. "Subpart S" facilities (meeting specific criteria associated with residents experiencing mental illness)
   - HOWEVER, no facilities carry this classification
   - 'The 50' have *fewer* associated staffing hours than other comparable facilities (i.e., non-nurse social workers and psychiatric care workers) so adding other staff hours will not help respectively.

- 'The 50' list from HCCI almost exclusively represents homes that should be influenced by reforms to improve staffing levels and/or improve facility coding and Medicaid billing.

HFS' step-by-step analysis of the consensus reform proposal compares 'the 50' to other similar facilities:

- For-profit facilities
- In the same Medicaid tax category
- With at least 70% Medicaid utilization

Note: In additional analyses not shown below HFS (i) further narrowed the comparisons to facilities in either East St. Louis or the Chicago region and (ii) looked separately at the fourth tax bracket (results below focus on the third). Results were not materially different. Please contact HFS for more detail on these deep dives.

HFS Analysis of Reform's Impact on 'the 50'

HFS' analysis demonstrates that:

- 'The 50' were <u>significantly more profitable</u> than <u>other similar</u> facilities *prior* to reform
- 'The 50' have <u>significantly lower staffing</u> than <u>other similar</u> facilities
- ***<u>Neither</u> the proposed Medicaid tax brackets nor high Medicaid utilization separate reform's impact on 'the 50' from its impact on other similar facilities.***
    - Middle tax bracket NFs end up with modestly lower predicted net income, BUT the same is true for NFs that are NOT among 'the 50'
    - HFS' comparisons were limited to high-Medicaid facilities (and, not shown below, geographically narrowed to E STL and Chicago)
    - Ergo, the proposed tax brackets don't explain why an NF is one of 'the 50'

In other words:

- 'The 50,' as a group, are *intended* targets of reform
    - high levels of unnecessary coding for rehabilitative services
    - excessive profit-taking at the expense of staffing
- <u>Yet even 'the 50' can earn a profit with a reasonable management response to reform</u>

HFS' Consensus Proposal is Designed to Support 'Transition'

HFS already made changes to the earlier proposal to get HCCI agreement to help 'transition' into reform

- HFS' proposal heavily subsidizes step-wise increases in staffing, the principal cost of transition, through substantial staffing-related incentives tied to federal STRIVE staffing metric.
  - Through negotiations, HFS lowered the minimum qualifying percentage to 70% of STRIVE (originally 85%), providing some funding at that level as a potential interim step, but setting the incentive in the 70-79% range in a way that maintains the facility's incentive to continue increasing staffing levels.
  - Between 80 and 100% of STRIVE, **HFS' proposal would fund Medicaid's share of the expected costs of increasing nurse staffing levels.**
  - HCCI's proposed nurse staffing incentives would begin the incentive at 0% of the Federal STRIVE target but are the same as HFS's above 70% -- basically payment for doing nothing.
  - By nearly eliminating the differential between the level of incentive at 70% of STRIVE v. the level of incentive below 70%, **HCCI's proposal nearly eliminates the worst-staffed facilities' incentive to increase staffing at all.**
    - Paying more for a transition's *starting point* (i.e., current very low staffing levels) doesn't support transition.
    - Paying more for care in the lowest-staffed facilities doesn't improve the long run impact of reform for 'the 50' *unless they never hire more staff.*
    - <u>**This is unacceptable** and mitigates major principle of reform.</u>

HFS' Consensus Proposal is Designed to Support 'Transition'

Do owners and nurse coders need more time?

- **HCCI implies that the biggest remaining 'transition' issue for facilities under the new payment methodology is time to learn to accurately record the needs of their residents**
- **However, does waiting really aid in 'transition'?**
  - NFs have **already** been afforded an extended 'transition' or learning period due to the nearly 2-year discussion and debate over PDPM's adoption by Illinois Medicaid.
  - The questions associated with both PDPM, and RUGs have both been on the resident needs surveys that facility nurses have been filling out for years (on the form since 2016; required for reimbursement since 10.1.2019)
  - Medicare has been paying against the new PDPM resident needs 'grouper' for over a year.
  - Recent JAMA article (new research) shows that Medicare use of PDPM has had positive effect on quality.
  - It is unclear what remains to be 'learned' by facilities and/or their nursing staff in order to accurately record the needs of their residents.
  - HFS expects rapid adaptation by nursing staff due to the incentive for facilities to accurately record resident needs since they generally impart a lower target staffing level. (And this is reflected in HFS' estimate of 'management response,' which is significantly larger for facilities like those on the list of 50 due to their current reliance on unnecessary coding for rehab services, which are paid by Medicare).

HFS' Consensus Proposal is Designed to Support Staffing

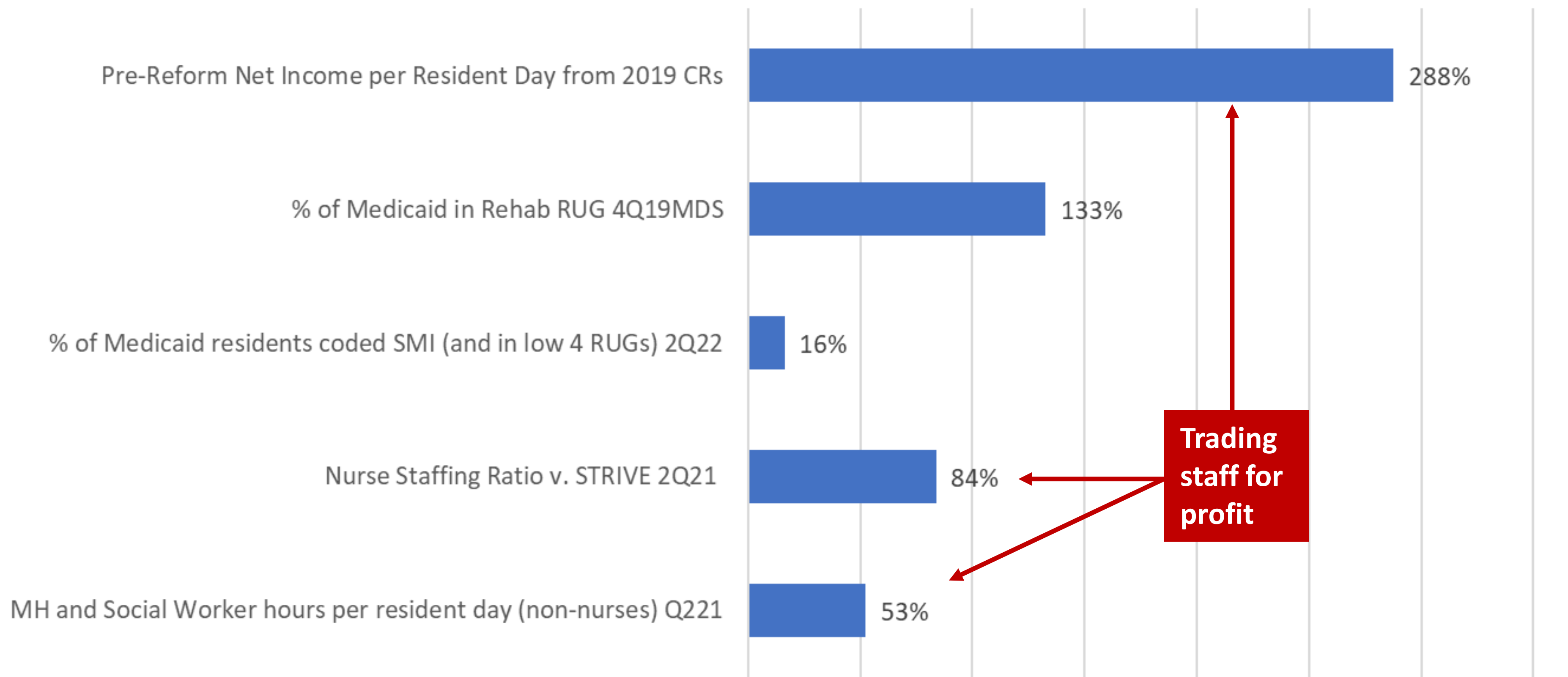
Changes to HFS' earlier proposal address a deepening crisis

- **HFS' proposal would disburse all quality incentives ($70M) beginning immediately**
  - The $70M quality improvement program in HFS' consensus proposal reflects a $50M reduction compared with HFS' earlier proposal, a concession necessary to address the rising costs of labor since the reform effort began (see enlarged staffing incentive on previous page and increased base rate below)
  - 'The 50' would, on average, be net winners based on historic quality scores
  - Quality incentives would change over time but could include language that all must pay out yearly or quarterly.

- **HFS' consensus proposal increases the base nursing rate by $5 per day vs. HFS' earlier proposal to maintain that rate at $85.25.**
  - This increase would cost $90M per year and was introduced to reflect the rising costs of nursing facility staffing across all types of labor.
  - Many of 'the 50' would benefit by *more than $5/day* since upstate facilities also receive a regional wage multiplier applied to the base rate.

- **HFS' consensus proposal would <u>disburse CNA experience pay subsidies effective immediately.</u>**
  - Higher-Medicaid facilities (like 'the 50') benefit most since Medicaid's share of the tenure bumps are subsidized.
  - Combined with the $360M nurse staffing incentive and the $90M base rate increase, the $85M package of investments in CNA pay and training represents a combined $535M increase in nursing facility payment targeted at Illinois' significant and growing staffing crisis.

HFS Analysis of ‘the 50’ vs. Comparison Group of For-Profit Facilities



Summary:

- High-Medicaid homes <u>among ‘the 50’</u> have an average nurse staffing ratio that is <u>*84% of the average ratio for other for-profit high-Medicaid homes*</u>
- …and 288% of the average profit level.

They are not doing as much as similarly-situated homes and want to be subsidized more.

HFS Analysis of 'the 50' vs. Comparison Group of For-Profit Facilities (deeper dive)

24 (of 'the 50') For-Profit High-Medicaid NFs with 15,001-35,000 Medicaid Bed Days per Year

Increase Decrease Total

Amount per (Total) Resident Day

$25.00
$20.00
$15.00
$10.00
$5.00
$-
$(5.00)
$(10.00)

$21.13
$(13.13)
$5.89
$(10.06)
$(5.16)
$2.30
$3.25
$4.85

Pre-Reform Net Income
Provider tax increase PTRD
Rate increase (net of SMI)
PDPM adoption (budget neutral)
New Staffing incentive
CNA payscale pass-through
New quality incentive payments
Management response

This page and the next further narrows the comparison of 'the 50' to other for-profits by including only those facilities with at least 70% Medicaid utilization.

…the results are essentially the same.

Note: A comparison group of high-Medicaid for-profit facilities in that same tax bracket is shown on the next page

HFS Analysis of ‘the 50’ vs. Comparison Group of For-Profit Facilities (deeper dive)

84 Comparison For-Profit High-Medicaid NFs with 15,001-35,000 Medicaid Bed Days per Year

Increase | Decrease | Total

Amount per (Total) Resident Day

$25.00
$20.00
$15.00
$10.00
$5.00
$-
$(5.00)
$(10.00)

Category	Value
Pre-Reform Net Income	$3.87
Provider tax increase PTRD	$(12.04)
Rate increase (net of SMI)	$4.55
PDPM adoption (budget neutral)	$3.03
New Staffing incentive	$9.67
CNA payscale pass-through	$2.20
New quality incentive payments	$3.51
Management response	$2.45

Compared to ‘the 50’ facilities, this comparison group of high-Medicaid facilities in the same tax bracket:

- Has *lower* pre-reform net income
- Ends up with *higher* net income (~$17/day)
- *Benefits* from both PDPM adoption and (especially) the new staffing incentive, because ‘the 50’ code more residents for rehab needs and will have to hire more staff to qualify for the incentive.

In Summary:

HCCI's list of 50 is almost exclusively a list of facilities that this reform is intended to improve: Facilities that over-code to charge Medicaid and then and under-staff.

HCCI's concerns about transition are specious and already met by the consensus proposal

The '50' could respond to reform with better staffing and other improvements to make up for the net income loss from no longer being able to over-code and under-staff.

Potential Impact of Consensus Reforms on Resident Access to Nursing Facility Services

HFS Analysis of Recent Closures and Local Alternatives to Reform-Sensitive Facilities

January 28, 2022

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A consistent refrain from those who oppose the HFS consensus proposal is that facilities might close, with the implication that those closures would put Medicaid residents at risk.

HFS does not believe closures are likely from this reform (see next slide).

However unlikely, in the event of any closures, HFS wants to ensure residents have access to the services they need. So, HFS further conducted a time and distance analysis of nursing facility access near reform-sensitive facilities.

The analysis showed that in the unlikely event of a closure, residents will not be at risk because they will still have access to the services they need at other nearby facilities.

Are Medicaid-supported residents at risk from closure?

A look at historic trends in nursing home closures

Recent trends in closure do <u>not</u> indicate that Medicaid-supported residents are at risk.

Closed facilities' Medicaid utilization tends to be *far* below average.

Closed facilities -- not surprisingly -- had below average occupancy.

To date, the pandemic has not increased closures.

In 2020 statewide occupancy fell but Medicaid utilization rose.

Number of Closed NFs, Occupancy and Medicaid utilization

(Excludes NFs that never had skilled nor intermediate beds: 2004-2020 CRs and logbooks)

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
# of NFs closed	6	14	6	5	7	1	8	11	9	5	3		2	11	7	7	9	9

Labels on the chart: 80% (statewide occupancy, 2004), 65% (statewide Medicaid utilization, 2004), 73% (statewide occupancy, 2019), 68% (statewide occupancy, 2020), 58% (statewide Medicaid utilization, 2019), 66% (statewide Medicaid utilization, 2020).

Left axis: 0–18. Right axis: 0%–90%.

- # of NFs closed (Left Axis)
- Statewide Occupancy (Right Axis)
- Medicaid Utilization (YEAR PRIOR) for Closing Facilities (Right Axis)
- Statewide Medicaid Utilization (Right Axis)
- Occupancy (YEAR PRIOR) for Closing Facilities (Right Axis)

What do nursing facility closures tell us about reform's potential impact on viability?

Results of historical analysis of nursing home closures

- Closures haven't increased markedly since the pandemic's onset.
- Closed facilities tend to have *below-average occupancy and Medicaid utilization* in the year before closure (in other words, Medicaid rates do NOT explain closures)
- Additional review of nursing facility closures indicates that:
  - Recently-closed facilities tend (strongly) to be well-staffed: *Only* 2 were below their STRIVE target.
    - **Meaning they would have been helped by the HFS consensus proposal, had it been implemented.**
  - The number of for-profit closures has been notably consistent.
  - The mixture of for-profit vs other closures has also been consistent.

Implications

- Recent closures are <u>not</u> harbingers of concern for high-Medicaid or reform-sensitive facilities.
- Closed facilities do not look like the reform-sensitive facilities identified by HCCI and HFS.
- Consensus reforms would increase marginal revenue for well-staffed homes like those that have typically closed (and those that may have permanently lost occupancy to the pandemic).

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However unlikely, in the event of any closures, HFS wants to ensure residents have access to the services they need. So, HFS further conducted a time and distance analysis of nursing facility access near reform-sensitive facilities.

The analysis showed that in the unlikely event of a closure, residents will still have access to the services they need at easily accessible nearby facilities.

Do residents of reform-sensitive facilities have alternatives? YES.

How to read this chart

The **blue line** indicates the **maximum drive time** among the four closest alternatives to the reform-sensitive facilities on this chart (not the minimum or average).

The **red bars** represent the number of **residents in a reform-sensitive facility**.

The **green bars** represent the total number of **available beds** in that facility's four alternatives.

Next to the facility's name is its Medicaid utilization and the increase or decrease in nurse staffing levels for residents in a hypothetical move to one of the four alternative facilities.

Key take away

There are **VERY few residents in reform-sensitive facilities** who would have to drive significantly farther or experience lower staffing in an alternative facility.

Daily Occupants in reform-sensitive NFs (left axis)
Sum of Unused Beds Per Day in 4 Nearest NFs v. 92% Occupancy (left axis)
Maximum drive time (in minutes) to 4 nearest alternative facilities (right axis)

Detailed Access Comparison for Reform-Sensitive Facilities

Occupancy from COMPARE in mid-2021

450
400
350
300
250
200
150
100
50
-

30
25
20
15
10
5
0

ALPINE FIRESIDE HEALTH CENTER 13% MCD, +35 PPTs
APERION CARE GLENWOOD 81% MCD, +35 PPTs
APERION CARE WEST RIDGE 92% MCD, +15 PPTs
ARCADIA CARE BLOOMINGTON 91% MCD, +43 PPTs
ARCADIA OF DANVILLE 86% MCD, +46 PPTs
BALMORAL HOME 94% MCD, +49 PPTs
BERKELEY NRSG & REHAB CENTER 82% MCD, +17 PPTs
CLARIDGE HEALTHCARE CENTER 79% MCD, +99 PPTs
ELMWOOD NURSING & REHAB CENTER 69% MCD, +42 PPTs
FOSTER HEALTH & REHAB CENTER 75% MCD, +17 PPTs
FRIENDSHIP MANOR HEALTH CARE 48% MCD, +40 PPTs
HELIA HEALTHCARE OF NEWTON 37% MCD, +7 PPTs
LANDMARK OF RICHTON PARK 87% MCD, +28 PPTs
LITTLE VILLAGE NRSG & RHB CTR 86% MCD, -2 PPTs
LOFT REHAB & NURSING OF NORMAL 68% MCD, +26 PPTs
LUTHER OAKS 4% MCD, +3 PPTs
LUTHERAN HOME FOR THE AGED 15% MCD, -1 PPTs
MADO HEALTHCARE - UPTOWN 91% MCD, N/A
MONTGOMERY PLACE 0% MCD, -111 PPTs
PALOS HEIGHTS REHABILITATION 49% MCD, +10 PPTs
PARK PLACE OF BELVIDERE 83% MCD, +28 PPTs
RIDGEVIEW CARE CENTER 36% MCD, -5 PPTs
SMITH CROSSING 2% MCD, -52 PPTs
SMITH VILLAGE 0% MCD, -121 PPTs
SPRINGS AT MONARCH LANDING 3% MCD, -43 PPTs
ST ANTHONY'S NSG & REHAB CTR 76% MCD, +52 PPTs
ST JOSEPH'S MEDICAL CENTER 0% MCD, N/A
UNION COUNTY HOSPITAL LTC 1% MCD, -170 PPTs

Facility Name, Medicaid Utilization, Avg. change in STRIVE staffing ratio for residents moving to one of the four alternative facilities

HFS

Do residents of reform-sensitive facilities have alternatives?

Red = 28 reform-sensitive facilities
Green = 4 nearest alternatives

Key Result

For 25 out of the 28 homes we find to be potentially sensitive to reforms, there is *at least* one home within 10 minutes with available beds and a history of meaningful Medicaid utilization. Only 3 have no alternatives within 10 minutes, but they have alternatives within 30 minutes. For two out of those three, staffing levels would be higher in the slightly more distant alternatives (see previous)

Again, HFS does NOT believe closures are likely. But in the *unlikely* event of a closure, this analysis raises an important access question for residents:

"Which is better, possible closure of a small number of generally under-performing facilities, and a move to a facility within 10 minutes that is likely better performing, or continued residence in the original facility?"

HFS

Very few residents are at risk of facility closure due to the impact of Consensus reforms

- On average, the nearest 4 alternative nursing facilities are within minutes (single digits) of the reform-sensitive facilities included in this analysis
  - Only 3 of 28 reform-sensitive facilities nearest alternative NFs were 20+ minutes away in Studies 1 and 2
- The nearby facilities do serve Medicaid residents. The average Medicaid utilization of nearby alternative facilities generally ranges from 50-80%
- In all but one case, the nearest 4 alternative facilities have enough unused capacity (v. 92% occupancy standard) to accommodate the current residents of reform-sensitive facilities.

HFS

IN SUM:

HFS does not believe closure is likely.

In the event of closure, residents will still have easy access to *nearby* facilities to meet their needs.

HFS

INNOVATIONS: HEALTHCARE TRANSFORMATION

Presenter: Theresa Eagleson, Director
Kimberly McCullough-Starks, Deputy Director

A. HTC Update

B. Upcoming presentations following the HFS Executive Report

   1. Chicago North Side Collaborative

   2. East St. Louis Metro Area Transformation Touchette Regional Hospital

Medicaid Advisory Committee
Healthcare Transformation Collaboratives Update

Presenter: Kimberly McCullough-Starks, Deputy Director for Community Outreach

- The application period for the second round of Healthcare Transformation funding yielded 40 applications from various communities across the state of Illinois:

  Northern Illinois – 27 Applications
  Central Illinois – 5 Applications
  Southern Illinois – 6 Applications
  Statewide – 2 Applications

- Applications were posted for public comments
- Cross segment of HFS Team members are actively reviewing the proposals for funding consideration
- Award announcements are projected to begin in Spring of 2022

Medicaid Advisory Committee
Healthcare Transformation Collaboratives Update

- **Healthcare Transformation Collaboratives Awardees - Status Update**
  - All HTC agreements have been fully executed. As of January, awardees are actively implementing their projects.
  - HFS is launching the post award monitoring process using Amplifund, an electronic grant management system to track HTC projects including monitoring of expenditures, hiring of staff including community health workers and specialists, care coordination, capital improvements, technology enhancements and overall achievement of the key milestones associated with the projects
  - HTC Project Presentation
    - ❖ Chicago North Side Collaborative
    - ❖ East St. Louis Health Transformation Partnership

Chicago North Side Collaborative

Presentation to the HFS Medicaid Advisory Committee

February 4, 2022

Swedish Hospital

Part of NorthShore

Mission

To deliver NorthShore/Swedish Hospital specialty care in the Federally Qualified Health Centers (FQHCs) that the community knows and trusts

Goals:

- Reduce healthcare disparities
- Remove barriers to specialty care
- Improve health outcomes
- Reduce Emergency Room use and hospitalization
- Provide wrap around services for social determinants of health
- Reduce overall cost of care

Chicago North Side Collaborative

Healthcare Transformation Program

Swedish/NS Specialties

- Dermatology
- Cardiology
- Endocrinology
- Orthopedic Surgery
- Gastroenterology

Collaborative Partners

- Erie Family Health Centers
- Heartland Health Centers
- Hamdard Health Alliance
- Asian Human Services Family Health Center
- Howard Brown Health
- MedEx Ambulance Service

Swedish Hospital
Part of NorthShore

Swedish Hospital Team

Anthony Guaccio
President and CEO

Bruce McNulty, M.D.
Chief Medical Officer

Shameem Abbasy, M.D.
VP Quality and Transformation

Maria Olga Cardenas, M.D.
Endocrinologist

Amrita Kushal, M.D.
Cardiologist

Kate Lawler, Senior Director
Community Health Transformation

Charles Brandon
Director, Healthcare Transformation

Swedish Hospital
Part of NorthShore

Asian Human Services Family Health Center

Mission: To provide quality and compassionate health care services to the Asian American community and all other underserved or underprivileged communities in a culturally competent and linguistically appropriate manner.

Population We Serve – (Data Source: 2020 UDS Report):
• 59% Asian, 15% Hispanic, 11% African American, 12% White, 3% more than one race.
• Approximately 33% uninsured, and 99% fall below 200% of the federal poverty level (FPL). 48% unduplicated patients have Medicaid.

Capital Build Project:
• $250,000 – will be added to the capital pool to renovate 6301 N. Western Ave clinic
• 62,000 sf building with 17,000 sq of integrated clinical space, 28 exam rooms and 130 parking slots to improve patient access in this new building
• Contract with MBE architect

How Transformation Program will Impact our Patients

Hamdard Health Alliance

<u>Mission</u>: To positively impact the health and well-being of individuals and families in our communities by delivering culturally responsive healthcare services.

HAMDARD HEALTH
ALLIANCE

<u>Population We Serve</u>: We provide culturally-tailored and multilingual services for South Asian, Middle Eastern, and Bosnian communities.

<u>Capital Build Project: $50,000</u>

- 2 additional exam rooms
- WBE/MBE contractors

<u>How Transformation Program will Impact our Patients</u>

Swedish Hospital

Heartland Health Centers

Mission: To improve the well-being of the communities we serve by providing accessible, high-quality healthcare.

Population We Serve:

- 40% Latino, 24% Black/African American,
- 8% Asian, 17% White non-Hispanic;
- 90% at or below poverty
- 31% best served in language other than English
- 46% are on Medicaid and 36% are uninsured

Capital Build Project: $250,000

- additional 1250 square feet at and existing site
- 4 additional exam rooms at existing site
- WBE/MBE contractors

How Transformation Program will Impact our Patients

Howard Brown Health

Mission: Rooted in LGBTQ+ liberation, Howard Brown Health provides affirming healthcare and mobilizes for social justice. We are agents of change for individual wellbeing and community empowerment.

Population We Serve:

- 48% White, 27% African American, 4% Asian, 18% undisclosed, 3% other
- 26% Medicaid, 24% Uninsured, 40% Commercial, 5% Medicare

How Transformation Program will Impact our Patients

Erie Family Health Centers

Mission: Motivated by the belief that healthcare is a human right, we provide high quality, affordable care to support healthier people, families and communities.

Population We Serve:

- Over 90% of Erie patients are low-income; 87% of patients are Medicaid recipients or uninsured.
- Over 70% of patients are Latino and we also serve a wide variety of other ethnic and immigrant communities.

How Transformation Program will Impact our Patients

Social Determinants of Health

Nutrition and Food Security

Pathways

Walking Beside Survivors of Domestic Violence, Human Trafficking and Sexual Assault

Housing Connections

Transportation

Swedish Hospital
Part of NorthShore

Metrics

<u>Access to specialty care</u>

- Reduced wait times for appointments
- No show rates
- Increased referral completion rate
- Increased connections to SDOH Programs
- Follow-up care after hospitalization

<u>Quality (examples)</u>

- HbA1c control
- Blood pressure control
- Skin cancer screenings
- Colorectal screenings

Oversight Quality Committee
VP Quality and Transformation, Swedish Hospital
Chief Medical Officer, Swedish Hospital
Transformation Program Team, Swedish Hospital
Quality Representative from each FQHC
Community Member
Guests: HFS and Aetna Better Health staff

Thank you

Anthony Guaccio
President and CEO
Swedish Hospital
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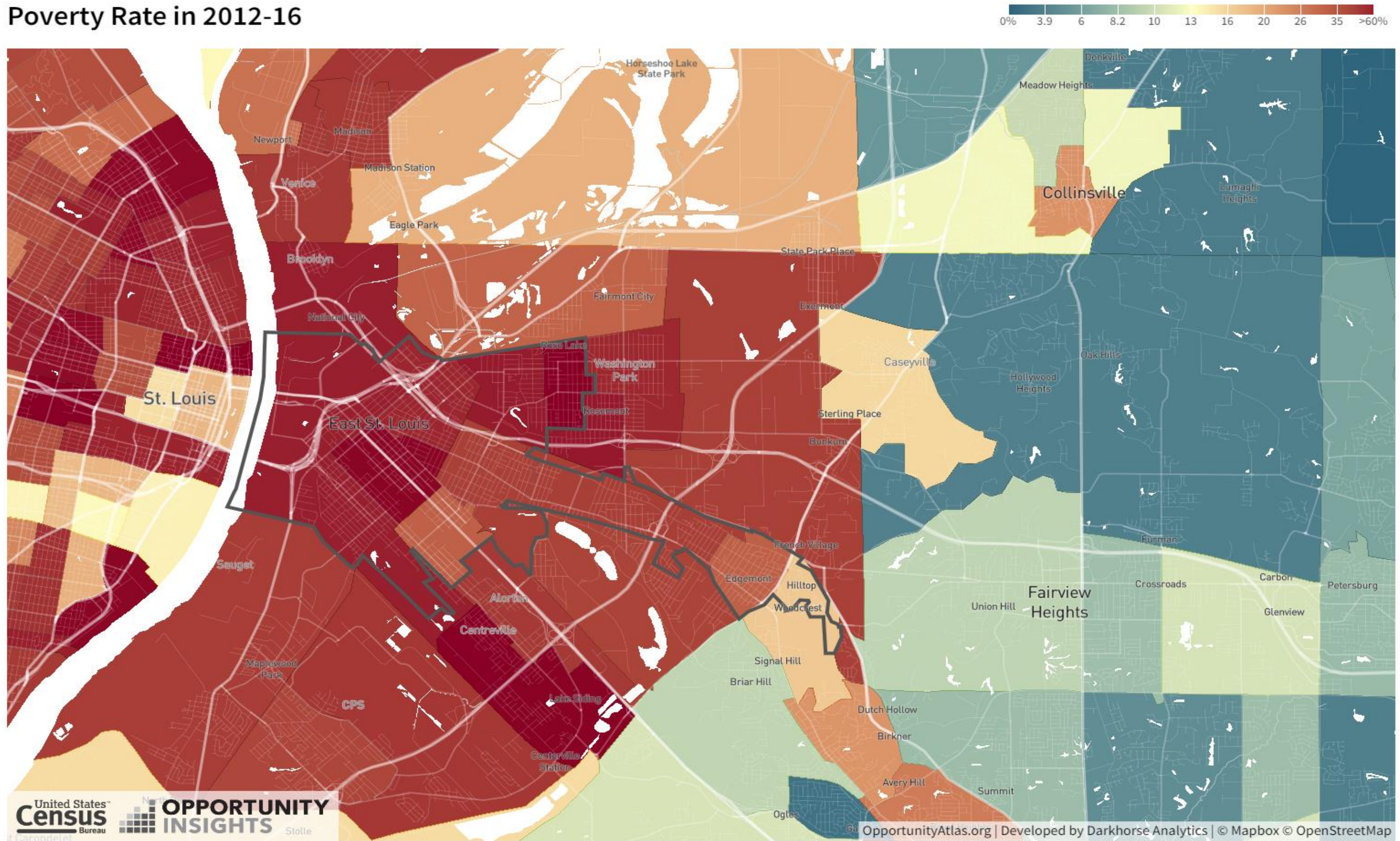
East St. Louis Metro Area Transformation
Touchette Regional Hospital

The East St. Louis Metro Area region is the most distressed region in the State of Illinois as measured by the CDC Social Vulnerability Index.

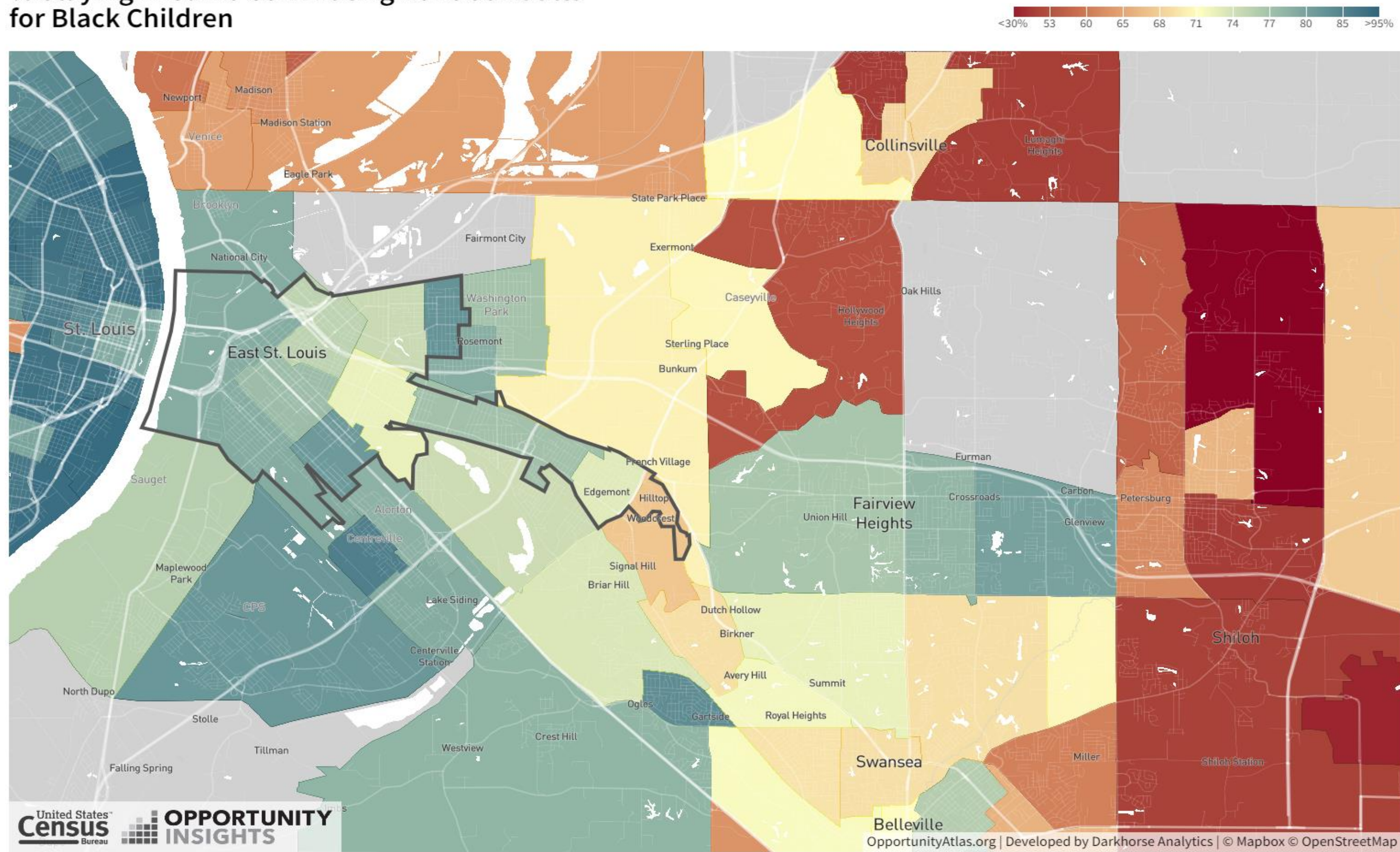
Health Data Summary

Category	Currently in the Community	Target Goal
Infant Mortality Rate per 1,000	12.9	10.0
Uncontrolled Diabetes Rate (lower is better)	37%	30%
Controlled Hypertension Rate (higher is better)	56%	65%
Breast Cancer Screening Rate	51%	60%
Cervical Cancer Screening Rate	61%	70%
Percent of Mental Illness hospitalizations with a follow-up visit within 7 days	15%	35%
Percent of Substance Use Disorder hospitalizations with a follow-up visit within 7 days	29%	50%
Unmet Specialty Referrals	50% (currently 35,561)	10%
Excess ER usage	35% of visits (9,370 of 27,832)	20% of visits
Rate of ER visits for Asthma in the community per 10,000	155	75
Percent Live Births with Prenatal Care started in first trimester	49%	80%

Health Data Summary



Health Data Summary



The status quo is not bringing the results people want or deserve

THE CURRENT LACK OF…

- Access to care (due to logistic, economic, cultural, and healthcare literacy barriers)
- Stability in the critical healthcare delivery system
- Coordinated, cross-agency focus on Social Determinants of Health

LEADS TO…

- Inconvenient, inconsistent, expense-ridden care that's often not culturally competent
- Care that does not focus on Chronic Disease management
- Care that doesn't fit people's lives

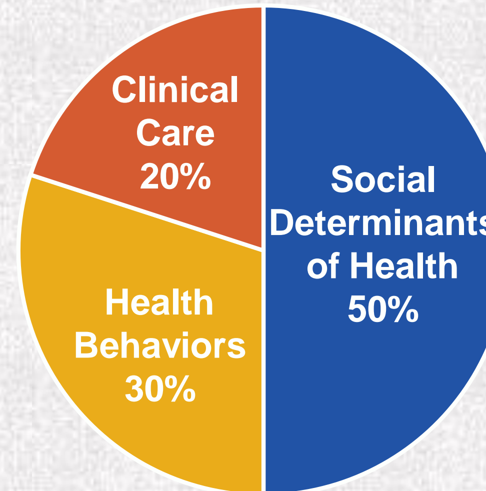
RESULTING IN…

- **Poor health outcomes.**

Social determinants account for 50% of health outcomes

Clinical care accounts for no more than 20% of a person's health and individual health behaviors, no more than 30%.

A full 50% of health can be attributed to social determinants of health, the broad term that includes social, economic, and environmental factors.



- Economic stability
- Education
- Housing
- Transportation
- Food security
- Social support networks
- Environmental quality

[1] Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. American Journal of Preventive Medicine 50(2):129-135. https://doi.org/10.1016/j.amepre.2015.08.024

WHY

"Poverty is the worst form of violence" (Mahatma Gandhi).

Development of an Urgent Care In Midtown East St. Louis

This Urgent Care will feature walk-in acute care services integrated with primary care, ancillary diagnostics for radiology, lab, pharmacy, and care management.

Community Health Workers & Health HUB

Local Community Health Workers will work closely with partners and families to connect to social and medical services to remove barriers to health.

A region wide deployment of an online software solution called "The Community Health Hub" will connect individuals and providers to improve the integration, efficiency, and coordination of care across provider types and levels of care while also providing increased access to supportive life services in order to help improve the SDOH.

New Workforce Development and Job Training Center

The Workforce Development Center will include a combine new campus in Venice, Illinois to be supported by Southwestern Illinois Community College, SIU-e, SIHF Healthcare, and local business leaders to increase job training and educational opportunities with an emphasis on trades. Additional business and housing development through private ownership includes a grocery store and affordable homes

Health & Specialist Campus

New Health Campus will feature an ambulatory care center that embeds partnerships with multi-specialty groups to address regional unmet needs for Medicaid and uninsured patients (36,800 in 2019). Primary partner on the new campus will the SIU School of Medicine who is committed to providing specialist care for the community and those with unmet access through face-to-face visits, telemedicine, and peer-to-peer consultations. The Health Campus will provide an expanded solution to the unmet need for inpatient behavioral health services for adults, adolescents, and geriatrics. The new health care campus will also serve as the primary community location for access to food and community education events.

Affordable Housing

The affordable housing initiative has commence governance through an existing Community Revitalization Contract between the Illinois Housing Development Authority (IHDA), SIHF Healthcare, and the St. Clair County Housing Authority (SCCHA). A new joint-venture will be created upon the initial approval of the first housing development that will include joint development and ownership by Zade, LLC, SIHF, SCCHA, and MHDC as a majority-controlled minority owned construction business for the development of up to 1,100 units of housing.

Diversion & Supportive Housing

The repurposing of the former hospital: 1) A diversion program in partnership with the St. Clair County Sheriff; 2) A crisis living room center for an alternative delivery model for those with an acute mental health; 3) Supportive housing for a continuum of care; and 4)the transition of additional hospital space to provide workforce development, life skills training, behavior health counseling, and high school equivalency programming.

INNOVATIONS: ADMISSIONS, DISCHARGES, AND TRANSFERS (ADT)

Presenter: Teresa Flesch

What is ADT? A technology solution that closes the communication gap across the continuum of healthcare.

ADT notifications are a keystone to improving patient care coordination

Hospital are required to share ADT information with Primary Care Physicians (PCPs), physician groups, skilled nursing facilities (SNFs), home health, hospice agencies, and other providers in their care community.

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INNOVATIONS: ADMISSIONS, DISCHARGES, AND TRANSFERS (ADT)

The ADT system holds patient demographic information such as:

- Name
- Medical record number
- Age
- Contact information

ADT notifications are sent when a patient is:

- **A**dmitted to a hospital
- **D**ischarged from the hospital
- **T**ransferred to another facility

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INNOVATIONS: ADMISSIONS, DISCHARGES, AND TRANSFERS (ADT)

Why ADT? To improve patient outcomes across the spectrum of healthcare.

Improved Outcomes for Patients

Decreases in:

- Hospital readmissions
- Length of stays for inpatient hospital admissions
- Overdoses and opioid prescriptions
- ER visits from frequent ER utilizers
- Readmissions from post-acute care provides

Increases in:

- Patient and provider satisfaction
- Efficiency in post-discharge follow-up
- Savings for the entire healthcare system

INNOVATIONS: ADMISSIONS, DISCHARGES, AND TRANSFERS (ADT)

Healthcare delivery through real-time, collaborative, coordinated care – Patient Centered

- ADT unifies a patient's entire care team through technology and data
- Offers real-time patient insights
- Provides for timely, decision – making for improved patient outcomes

INNOVATIONS: ADMISSIONS, DISCHARGES, AND TRANSFERS (ADT)

ADT is the most actionable real-time electronic information in health care today

- Patient information can be securely shared, when appropriate, with other health care facilities and systems. ADT systems can also be used as an alert system upon a patient's admission.
- ADT notifications help to identify patients who are frequent or high users of the healthcare system.
- Generates and displays gaps-in-care based on quality measures and tracks completion of activities.
- Notifications are sent to update physicians and care management teams on a patient's status, thus improving post-discharge transitions, prompting follow-up, improving communication among providers, and supporting patients with multiple or chronic conditions.

Using ADT allows providers to:

- Steer those patients toward clinical and non-clinical interventions.
- Reducing overutilization by preventing avoidable emergency department visits and hospital readmissions.

INNOVATIONS: ADMISSIONS, DISCHARGES, AND TRANSFERS (ADT)

Project Timeline

May 2021
Start of Hospital Onboarding

July 2021
Start of Long-term Care (LTC)
Provider Onboarding

Sept 2021
Hospital Onboarding Deadline

Dec 2021
LTC Provider Onboarding Deadline
&
All MCO's live on Portal

Jan 2022
1st Clinical Collaborative Group

Feb 2022
Begin Ambulatory & Community Provider Onboarding

June 2022
Steering Committee

Jun 2022
Deadline Ambulatory & Community Provider Onboarding

2022 - 2031
Increase Efficiency, Improve Patient Outcomes

Feb 2031
End of I Contract Term

*Webinars will be held each quarter for Hospitals, Managed Care Organizations (MCO) and Skilled Nursing Facilities (SNF)

VI. Healthcare & Family Services Executive Report (Contd.)

B. Program Updates

1. Budget and Legislative Updates
2. HealthChoice Illinois Metrics
3. Eligibility Metrics

PROGRAM UPDATES: BUDGET AND LEGISLATIVE UPDATES

Presenter: Director Theresa Eagleson

MISSION

Helping Families Succeed

We work together to help Illinoisans access high quality health care and fulfill child
support obligations to advance their physical, mental, and financial well-being.

KEY PROGRAMS

- Medicaid
- CHIP
- Child Support Services

About **1 in 4 Illinoisans** are served by HFS

HFS provides healthcare to more Illinoisans than any other insurer

Our Vision for the Future

WE IMPROVE LIVES.

- We address social and structural determinants of health.
- We empower customers to maximize their health and well-being.
- We provide consistent, responsive service to our colleagues and customers.
- We make equity the foundation of everything we do.

This is possible because…

…WE VALUE OUR STAFF AS OUR GREATEST ASSET. We do this by:	…WE ARE ALWAYS IMPROVING. We do this by:	…WE INSPIRE PUBLIC CONFIDENCE. We do this by:
▶ Fully staffing a diverse workforce whose skills and experiences strengthen HFS. ▶ Ensuring all staff and systems work together. ▶ Maintaining a positive workplace where strong teams contribute, grow and stay. ▶ Providing exceptional training programs that develop and support all employees.	▶ Having specific and measurable goals and using analytics to improve outcomes. ▶ Using technology and interagency collaboration to maximize efficiency and impact. ▶ Learning from successes and failures.	▶ Using research and analytics to drive policy and shape legislative initiatives. ▶ Clearly communicating the impacts of our work. ▶ Being responsible stewards of public resources. ▶ Staying focused on our goals.

COVID-19 Response Efforts

- ARPA funding distribution ($275m)
  - Support for Long Term Care ($70m)
  - Support for Hospitals *($200m)*
  - *Support for Specialized Mental Health Rehabilitation Facilities ($5m)*
- CARES Act funding distribution *($700m)*
- Surge Staffing contracts deployed 2,000 staff to over 100 hospitals *($100m+ to date)*
- Using enhanced federal match of 10 percentage points made available from ARPA to expand, enhance, and strengthen home and community-based services
- Maintaining telehealth reimbursement at face-to-face rates
- Promoting vaccination efforts by covering in-home administration of the vaccine, creating add-on payment for timely results, as well as supporting vaccine administration and counseling for children

COVID-19 Updates Page

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Meet Jordan

Challenges:

▶ Diagnosed with cancer, six-year-old Jordan was at risk for infection in his two-bedroom apartment with three siblings. But the family couldn’t afford to move.

MCO intervention:

▶ Jordan’s managed care case manager and a social determinants of health specialist helped the family get financial aid, as well as a job and caregiver training for his mom. They now live in a four-bedroom home.

A better life:

▶ Jordan was happy to have into his own bedroom, and his mom serves as his caregiver. Jordan remains stable and has not been readmitted since.

* Name changed for privacy.

Medical Programs

- Eliminated major eligibility backlogs in partnership with DHS
- Significant revamp of Hospital Assessment to meet federal requirements
- First in the nation to provide post-partum coverage for 12 months
- First in the nation to cover undocumented older adults
- Expanded telehealth parity from emergency to permanent
- New coverage for diabetes prevention and management programs
- Gender reassignment surgery coverage for transgender customers
- Developed new Quality Strategy
- Successfully launched Healthcare Transformation Collaboratives

Division of Child Support Services

- Child Support Paternity Establishment
  - Establishing paternity in 90 percent of all cases
  - Across the board increase in all key performance metrics
- Serving 378,000 families and 527,000 children
- Collected $1.33 billion for children and their families
- One of the most cost-effective government programs with $4.94 collected for every $1 dollar invested in the critical services provided

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Healthcare Equity

Commitment to healthcare equity

- Nursing home rate reform means better care in areas disproportionately impacted by COVID-19
- Healthcare Transformation Collaboratives targeted largely to underserved communities
- PACE (community-based senior care) to launch in mostly black and brown ZIP codes
- Pathways to Success to help children with behavioral and mental health needs
- Additional funding for Home and Community-Based Services (HCBS)
- Health Care and Human Services Reform Act (the Legislative Black Caucus' healthcare pillar) addressing inequities and obstacles, establishing new programming, increasing oversight and trainings
- New maternal and child health programs vital to promoting equity

Improved MCO Responsiveness

- Customers have access to more providers than under the fee-for-service system, including a 23% growth in the number of physicians providing services
- Complaint tracking closely monitors and responds to customer and provider concerns
- Claims denials are kept well within the industry standard (less than 10%)
- During the pandemic, HFS prevented potentially inappropriate profits by establishing a 'risk corridor'
  - Reinvesting $180 million from "Risk Corridor" to preserve and grow the healthcare workforce. Focusing on providers in underserved areas.
- HFS began collecting vital data on race/ethnicity, gender and Diversity, Inclusion and Access zip codes. When fully developed, these will help identify concerns and implement effective interventions.

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Meet the Nickerbocks

Challenge:

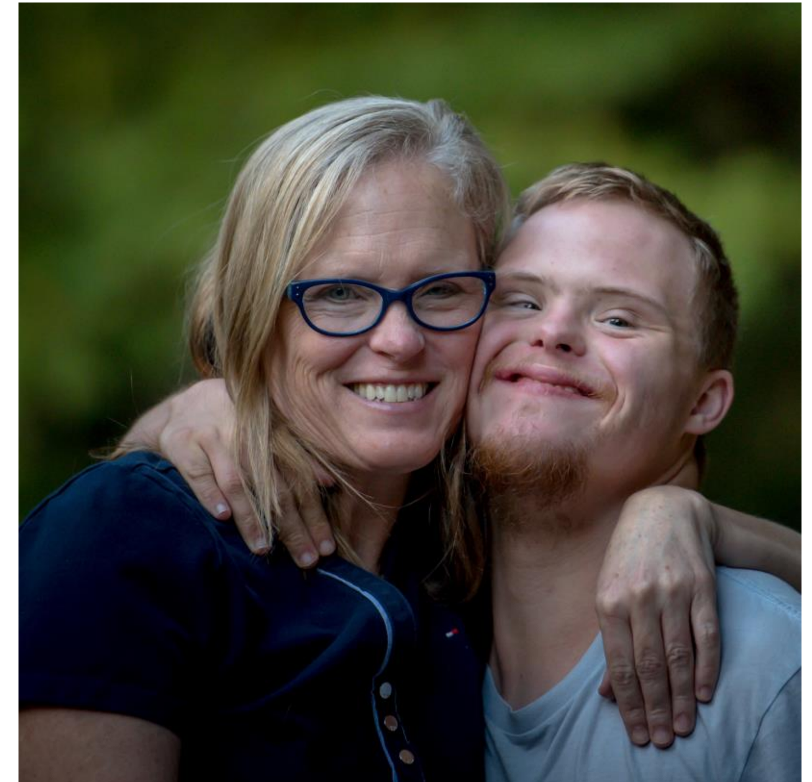
- A non-custodial parent wanted to travel internationally to be married over New Year's but owed nearly $40,000 in child support payments.

Child Support Services intervention:

- The HFS Passport Unit walked the parent through the process, and a check was sent for $32,000.

Resolution:

- The parent is sending HFS the final payment to be able to go to a February wedding. Most importantly, the mother of a 15-year-old boy is now getting the support she is owed.



* Names changed for privacy.

HFS – FY23 Goals

- Collaborate with provider and managed care (MCO) partners to ensure high quality care, address social determinants of health, reduce disparities and promote racial equity
- Provide strong child support services by establishing paternity and establishing, enforcing, and modifying obligations that will strengthen families emotionally and financially
- Prepare for a seamless unwinding of the Public Health Emergency, helping to ensure that customers understand all guidelines early and clearly
- Stand up a range of innovative programs for more targeted care, stronger data management, smoother customer and provider experiences and a more robust understanding of successful health outcomes

HFS FY23 Budget Highlights

Total budget: $33.1 billion all funds

- 7.1% change over FY23
  - More appropriation needed due to assumed expiration of enhanced federal match of 6.2 percentage points and program investments
- We are committed to people maintaining healthcare coverage, honoring our current commitments, and building for the future
- Includes funding to help customers stay enrolled in health coverage as appropriate when the public health emergency ends to prevent gaps and promote continuity of care
  - Focus on equity by targeting areas of the state that have been disproportionately impacted by pandemic

HFS FY23 Budget Highlights

ALL FUNDS ($ MILLIONS)			
TOTAL BY PROGRAM	**FY 2022 APPROPRIATION**	**FY 2023 REQUEST**	**$ Change**
Medical Assistance	$30,299.8	$32,470.4	$2,170.6
Child Support Services	$245.4	$259.4	$14.0
Administration	$269.3	$285.7	$16.3
Office of Inspector General	$28.0	$28.3	$0.3
Public Aid Recoveries	$32.5	$31.7	($0.8)
TOTAL	**$30,874.9**	**$33,075.5**	**$2,200.6**

* Numbers may not appear to add due to rounding.

HFS FY23 Budget Highlights

GENERAL FUNDS ($ MILLIONS)			
TOTAL BY PROGRAM	**FY 2022 APPROPRIATION**	**FY 2023 REQUEST**	**$ Change**
Medical Assistance	$7,533.3	$7,991.6	$458.4
Child Support Services	$35.6	$40.6	$5.0
Administration	$39.0	$42.1	$3.1
Office of Inspector General	$5.3	$5.7	$0.4
TOTAL	**$7,613.2**	**$8,080.1**	**$466.9**

* Numbers may not appear to add due to rounding.

Meet John

Challenges:

- Born with developmental delays and functional limits, John received incomplete care in the fee-for-service program. He was at risk for lifelong institutionalization.

MCO intervention:

- After an assessment, his MCO care coordinator arranged for medical teams and therapists, educated John's family about resources and coordinated homecare assistance.

Hopeful future:

- In just six months, John now prepares and eats his own meals, takes walks with his sister and enjoys time in the backyard with his family. His family has hope again.

* Name changed for privacy

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PROGRAM UPDATES: BUDGET AND LEGISLATIVE UPDATES

Presenter: Shawn McGady; Legislative Director

A. Introduction of new Staff. Patrick Hostert and Dani Mendez.

B. Legislative Initiatives

   1. Nursing Home Rate Reform

   2. Hospital Assessment Sunset Extension

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PROGRAM UPDATES: HEATLHCHOICE ILLINOIS METRICS

Presenter: Robert Mendonsa, Deputy Administrator of Care Coordination

A. **Total managed care membership as of December 2021 was 2,844,985 which is a 218,316 increase over December 2020**

B. **Membership breakdown is 2,750,636 in HealthChoice and 93,424 in MMAI**

C. **MMAI membership increased from 61,800 prior to the statewide expansion in late 2021**

PROGRAM UPDATES ELIGIBILITY METRICS

Presenter: Tracy Keen

A. <u>End of December Data</u>

- 4,545 Applications on Hand over 45 days old
- 1,762 Renewals on Hand
- 9,867 ever enrolled in Immigrant Seniors (65+), $106 million in claims
- 62,025 ex-parte renewals (25%) completed using electronic data sources without customer contact

B. End of Public Health Emergency (PHE) Planning

- The PHE end date is still uncertain, currently extended to April 16th, 2022.
- HFS continues to be actively engaged in discussions with federal CMS and other states regarding end of PHE requirements.

C. Upcoming

- Health Benefits for Immigrant Adults, age 55-64 – Spring 2022
- Family Planning implementation – Late 2022

VII. Subcommittee Reports

A. Health Equity and Quality

B. Community Integration

C. Public Education Subcommittee

D. NB Stakeholder

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HEALTH EQUITY AND QUALITY SUBCOMMITTEE

Presenter: Howard Peters

A. A meeting was held on 12/8/2021
   1. An Update on Healthcare Transformation and key dates was provided by Kimberly E. McCullough-Starks (HFS).

   2. Laura Phelan (HFS) provided in formation on HFS public comment notice released on 11/10 requesting stakeholder feedback on the implementation of Community Health Workers (CHWs), perinatal doula services, and evidence-based home visiting services within the medical assistance program under Public Act 102-0004. All comments were due by 12/31/21 and are currently under review.

   3. Aetna, BCBSIL, CountyCare, Meridan, and Molina provided presentations on how the data collected will be used to identify Social and Structure Determinants of Health (SSDOH) and to drive equity.
   4. Discussion was initiated on Community Safety Net Hospitals.

HEALTH EQUITY AND QUALITY SUBCOMMITTEE

Presenter: Howard Peters , Subcommittee Chair

Recommendation Regarding A Community Safety Net Designation:

A. The HE&Q Subcommittee convened meetings: 12/21/21, 1/5/22, 1/20/22 to begin gathering information for the development of a recommendation to the Department on the creation of a sub-category of Safety Net Hospitals in Illinois – Community Safety Net Hospital.

Presentations were provided by:

1. Ben Winick, Illinois Department of Healthcare & Family Services (HFS)
2. John Boehmer, Illinois Hospital Association (IHA)
3. Tim Egan, Community Safety-Net Association (CSNA)
4. Cristal Thomas-Gary, Safety-Net Hospitals, AMITA Health

85

Presenter: Howard Peters, Subcommittee Chair

Presentations were provided by: (Contd).

5. Amber Kirchhoff, Illinois Primary Health Care Association (IPHCA)
6. Barbara Martin, CEO, West Suburban Medical Center
7. Anne Ignore, Vice President and Director for Health Systems SEIU Healthcare IL/IN
8. Dr. Lisa Green, CEO, Family Christian Health Center
9. Dan Jenkins, Deputy Administrator of Rates and Finance, HFS

B. The HE&Q Subcommittee has requested some additional information from the Department and after its receipt will formulate a recommendation on the matter.

86

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COMMUNITY INTEGRATION SUBCOMMITTEE

Presenter: Amber Smock, Chair

A. **Current focus: Collect public input on improving service and reaching more people through the nine 1915(c) HCBS waivers**

B. **Key: Identify underserved or unserved groups, gaps in current programs/opportunities**

C. **Increased public engagement; 8 oral comments and over 20 written comments at last meeting...more please!**

D. **Presentations to date have included needs in/status of DRS-HSP, DDD PUNS, PACE (Aging), HCBS Settings Rule, etc.**

COMMUNITY INTEGRATION SUBCOMMITTEE

Presenter: Amber Smock, Chair

A. March, May, and July, meetings will continue public input and education across the HCBS waivers. Agendas in development

B. Goal: By September, begin formulation of recommendations to State for HCBS improvements, in alignment with current efforts

C. Next meeting: March 3, 3-5 pm

D. Public written and oral comment strongly encouraged!

PUBLIC EDUCATION SUBCOMMITTEE

Presenter: Kathy Chan, Subcommittee Chair

A. **Summary of December 2, 2021 subcommittee meeting**

Discussion included:

- Application processing – fewer than 3K applications over 45 days as of end of Oct 2021, representing significant reduction in backlog since January 2019.
- Redeterminations – suspended during federal Public Health Emergency (PHE) Currently, 30-40% of the clients are eligible for ex-parte rede (eligibility verified through electronic data and do not require action from enrollee.)
- "Immigrant senior 65+" expansion updates – 8,800 enrolled as of end of Oct 2021. HFS is working on programming for 55-64-year-old, which is expected before May 2022.

PUBLIC EDUCATION SUBCOMMITTEE

Presenter: Kathy Chan, Subcommittee Chair

A. Summary of December 2, 2021 subcommittee meeting Cont.

Discussion included:

- Care Coordination and DHS updates were provided.

- HFS shared a high-level overview of preliminary plans for end of PHE and asked stakeholders to provide feedback about messaging and notices that will be sent to clients. The committee requested to keep this as a standing agenda item and for HFS to provide additional details on what flexibilities could be kept permanently beyond the PHE.

- The subcommittee will meet next February 17, 2022, 10am-noon.

B. No recommendations for consideration from Subcommittee

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NB SUBCOMMITTEE

Presenter: Subcommittee Chair - Kristine Herman

A. Implementation Pathways to Success in accordance with NB Consent Decree Implementation Plan

B. HFS currently working with CMS for approval of 1915(i) application

C. Timeline for implementation will be established when approval from CMS is obtained

NB SUBCOMMITTEE

Presenter: Subcommittee Chair - Kristine Herman

D. Services include Care Coordination Services (High-Fidelity Wraparound/Intensive Care Coordination); Intensive Home-Based; Family Peer Support; Respite; Therapeutic Mentoring; Individual Support Services and Therapeutic Support Services

E. Currently focusing on public messaging for Intensive Home-Based Services to elicit provider interest and to support family engagement when service is implemented

F. Will explore public messaging for additional Pathways services in future meetings.

V. Public Comment(s):

A. Luis E. Rueda
B. Valerie Bollini

VIII. Additional Business: Old & New

A. Items for future discussion

IX. Adjournment

THANK YOU!