
# Integrated Health Homes

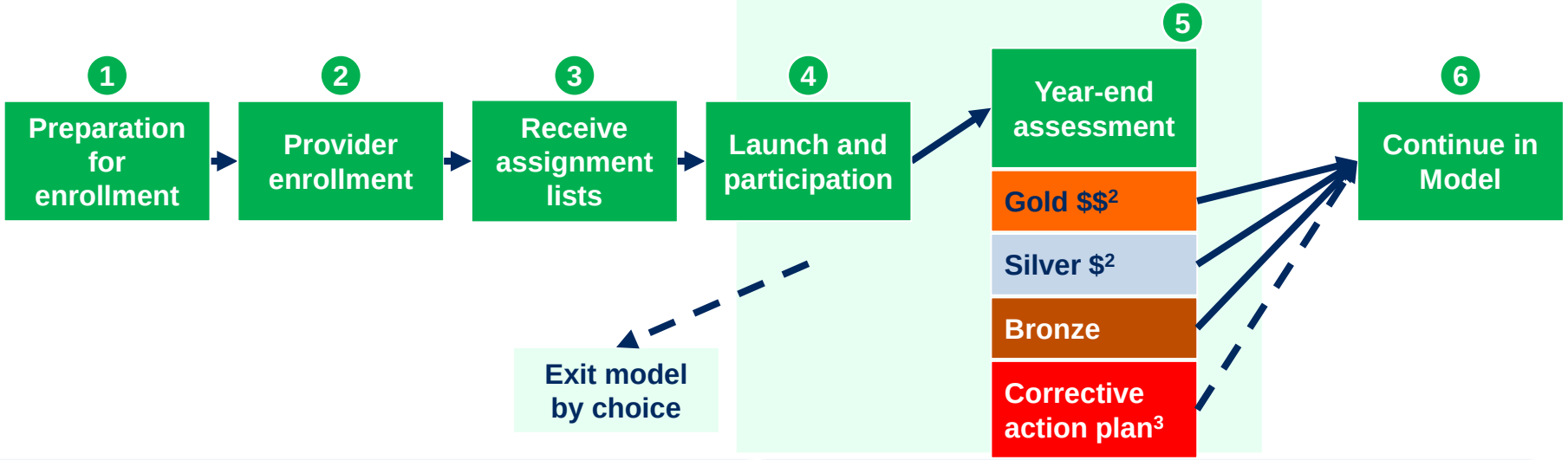
Quality Indicators, Incentive Payments and Reporting

# Housekeeping Items

- Phone lines are in listen only mode
- Questions can be submitted through the "chat" function **on the right hand side of the screen.**
- Answers to questions will be posted on HFS' website as a Integrated Health Home Frequently Asked Questions document

# Typical IHH provider journey

***Formal launch of Integrated Health Homes***
*January 2019 for first wave (Tier A,B and C)*




**1** 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 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** Provider receives first list of assigned members (including member tiers) from MCOs and/or State

**4** Launch of first wave
- Regular attribution/tiering refresh
- Quarterly reporting *(~April 2019)*[1]

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

**6** Continue in the Model

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

# 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

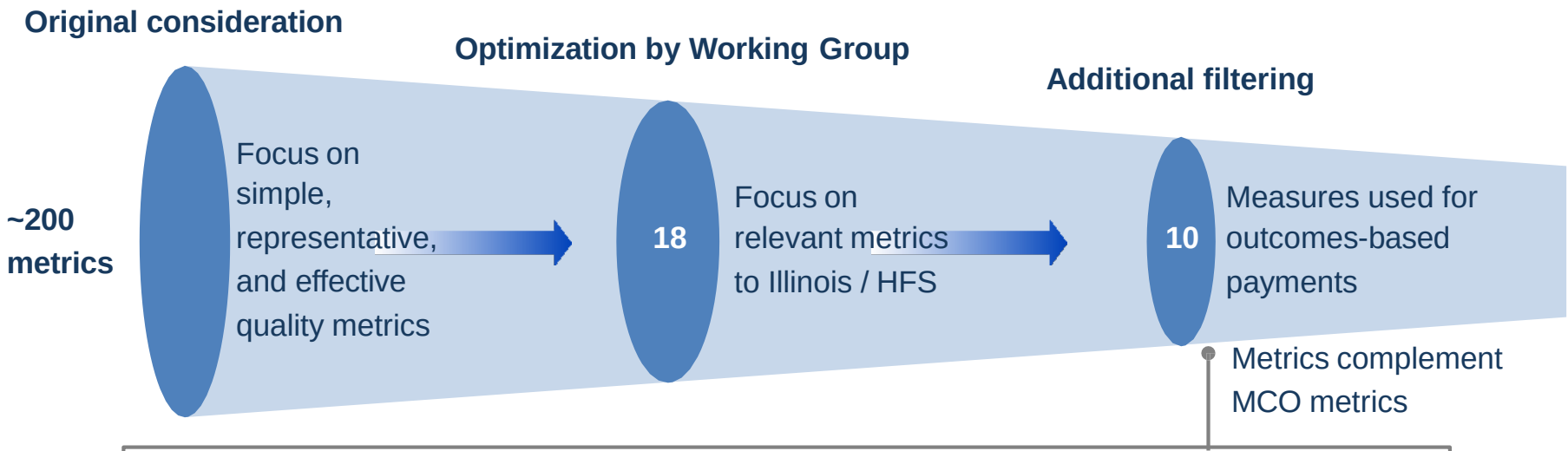
| Tier-based payments | Child PMPM | 19-21 PMPM | Adult PMPM |
|---|---|---|---|
| Tier A | $240 | $240 | $120 |
| Tier B | $80 | $60 | $48 |
| Tier C | $48 | $48 | $48 |

ILLINOIS DEPARTMENT OF Healthcare and Family Services

# Guiding principles for measure selection

| | Description |
|---|---|
| **Simple** | ▪ **Straightforward to operationalize,** and based on readily available sources of data<br>▪ **Restricted in number** to direct provider focus on what matters and what they can control<br>▪ **Reasonable in making demands on providers' capabilities** |
| **Represen-tative** | ▪ **Tailored to reflect members' different needs,** 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<br>▪ **Attentive to transitions between different settings of care**<br>▪ **Aligned with CMS and HFS priority measures** |
| **Effective** | ▪ **Focused on outcomes as much as process**<br>▪ **Complementary, rather than duplicative, with activity requirements** and other performance monitoring processes<br>▪ **Reported to providers in such a way that there are clear actions or paths to improvement,** potentially tied to provider education and support efforts<br>▪ **Evaluated for efficacy as they are used,** with the potential to be replaced with other measures as provider performance progresses |

# Overview of outcomes metrics selected




**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

# 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

CMS health home core measures

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

# Measures impacting outcomes-based payments

| | Reporting Guidance | Measure steward | Collection method |
|---|---|---|---|
| **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment** | ▪ Two rates are reported: initiation of AOD treatment and engagement of AOD treatment<br>▪ This measure applies to Health Home enrollees age 13 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable) and a total rate: ages 13 to 17, and ages 18 and older | ▪ NCQA/ HEDIS | ▪ Admini-strative/ EHR |
| **Screening for Clinical Depression and Follow-Up Plan** | ▪ This measure applies to Health Home enrollees age 12 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 12 to 17, ages 18 to 64, and age 65 and older<br>▪ This measure uses administrative data and medical record review to calculate the denominator exclusions for the measure. States may also choose to use medical record review to identify numerator cases. States should indicate deviations from the measure specifications if they choose to use the hybrid method to identify numerator cases<br>▪ This measure may be calculated using sampling, but measure-specific guidelines on sampling are not available from CMS. States should describe their sampling methodology in the "Additional Notes/Comments" field<br>▪ The measure steward does not provide diagnosis codes for the depression and bipolar disorder exclusions; medical record review is required to determine the exclusions<br>▪ The original specification for this measure included six G codes intended to capture whether individual providers reported on this measure. For the purpose of Health Home Core Set reporting, there are two G codes included in the numerator to capture whether clinical depression screening was done and if the screen was positive, whether a follow-up plan was documented | ▪ CMS | ▪ Administrat ive/Hybrid/ EHR |

# Measures impacting outcomes-based payments

| | Reporting Guidance | Measure steward | Collection method |
|---|---|---|---|
| **Screening for Clinical Depression and Follow-Up Plan (contd.)** | ▪ The date of encounter and screening must occur on the same date of service; if a patient has more than one encounter during the measurement year, the patient should be counted in the numerator and denominator only once based on the most recent encounter<br>▪ The screening tools listed in the measure specifications are examples of standardized tools. However, states may use any assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record<br>▪ The denominator for this measure includes Health Home enrollees age 18 and older with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups<br>– Those enrollees with a positive screen for clinical depression during an outpatient visit using a standardized tool with a follow-up plan documented.<br>– Those enrollees with a negative screen for clinical depression during an outpatient visit using a standardized tool | | |
| **Chronic Condition Hospital Admission Composite – PQI 92** | ▪ This measure applies to Health Home enrollees ages 18 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable) and a total rate: ages 18 to 64 and age 65 and older<br>▪ States should report this measure as a rate per 100,000 enrollee months as opposed to per 100,000 Health Home enrollees | ▪ AHRQ | ▪ Admini-strative |

# Measures impacting outcomes-based payments

| | Reporting Guidance | Measure steward | Collection method |
|---|---|---|---|
| **Chronic Condition Hospital Admission Composite – PQI 92 (cont'd)** | ▪ A two-step process should be used to determine whether enrollees should be counted in the measure: For each enrollee month considered for the denominator, assess the enrollee's age at either the 15th or 30th of the month (or the 28th of the month in February). If the enrollee was age 18 or older by that date, the enrollee month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a member is over age 18 on the 30th but only has eligibility through the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator<br>▪ For each hospital admission representing a qualifying numerator event, assess the enrollee's age on the date of admission. Only admissions for enrollees age 18 or older should be included in the numerator<br>▪ This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers shown in Table PQI92-B, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations<br>▪ Free software is available from the AHRQ Web site for calculation of this measure: http://www.qualityindicators.ahrq.gov/Archive/Software.aspx. These specifications are based on version 6.0 of the software. Version 7.0 is now available. Use of the AHRQ software is optional for calculating the PQI measures. Because the software is optional, states that do not use it should not document this as a deviation from specifications in the "Deviations from Measurement Specifications" section | | |

# Measures impacting outcomes-based payments

| | Reporting Guidance | Measure steward | Collection method |
|---|---|---|---|
| **Adult BMI Assessment** | ▪ This measure applies to Health Home enrollees ages 18 to 74. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable) and a total rate: ages 18 to 64 and ages 65 to 74<br>▪ The height, weight, and BMI should be from the same data source<br>▪ The height and weight measurement should be taken during the measurement year or the year prior to the measurement year<br>▪ If using hybrid specifications, documentation in the medical record should indicate the weight and BMI value, dated during the measurement year or the year prior to the measurement year | ▪ NCQA/ HEDIS | ▪ Admini-strative/ Hybrid |
| **Follow-up After Hospitaliza-tion for Mental Illness** | ▪ This measure applies to Health Home enrollees age 6 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 6 to 17, ages 18 to 64, and age 65 and older<br>▪ Follow the detailed specifications to (1) include the appropriate discharge when the patient was transferred directly or readmitted to an acute or nonacute care facility for a mental health diagnosis, and (2) exclude discharges in which the patient was transferred directly or readmitted to an acute or nonacute care facility for a non-mental health diagnosis<br>▪ The denominator for this measure should be the same for the 30-day rate and the 7-day rate<br>▪ The 30-day follow up rate should be greater than (or equal to) the 7-day follow-up rate | ▪ NCQA/ HEDIS | ▪ Admini-strative |

# Measures impacting outcomes-based payments

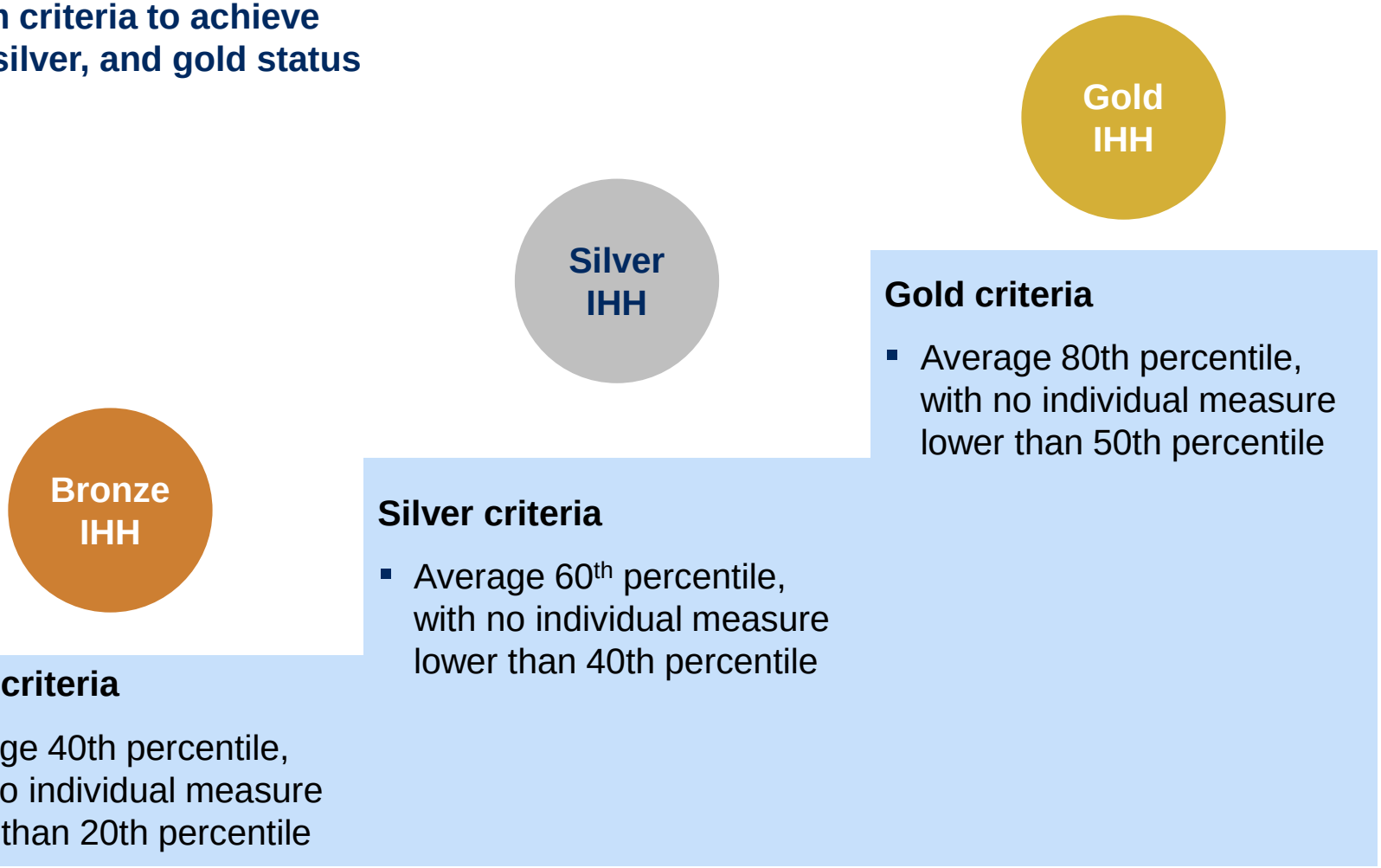
| | Reporting Guidance | Measure steward | Collection method |
|---|---|---|---|
| **ED Visits per 1000 member months** | ▪ The measure applies to Health Home enrollees of all ages. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 0 to 17, ages 18 to 64, and age 65 and older<br>▪ Report all services the state paid for or expects to pay for (i.e., claims incurred but not paid). Do not include services and days denied for any reason<br>▪ Consider all inpatient stays, regardless of payment status (paid, suspended, pending, denied), when confirming that an ED visit did not result in an inpatient stay. For example, if an ED visit is paid but an inpatient stay is denied, the ED visit resulted in an inpatient stay and should not be included in the measure numerator | ▪ NCQA/ HEDIS | ▪ Admini-strative |
| **Immunization Combo 3** | ▪ The denominator for this measure is comprised of all members who turn two years of age during the measurement year<br>▪ The numerator is comprise of children who had four diphtheria, tetanus, and acellular pertussis (DTaP) vaccinations; three polio (IPV) vaccinations; one measles, mumps, and rubella (MMR) vaccination; three haemophilus influenza type B (HiB) vaccinations; three hepatitis B (HepB) vaccinations; one chicken pox (VZV) vaccination; four pneumococcal conjugate (PCV) vaccinations; one hepatitis A (HepA) vaccination; two or three rotavirus (RV) vaccinations; and two influenza vaccinations by their second birthday | ▪ NCQA/ HEDIS | ▪ Admini-strative |

# Measures impacting outcomes-based payments

| | Reporting Guidance | Measure steward | Collection method |
|---|---|---|---|
| **Breast Cancer Screening** | ▪ Measures the percentage of women age 50 to 74 who had a mammogram to screen for breast cancer (the denominator for this measure is comprised of age 52 to 74 years as of December 31 of the measurement year).<br>▪ The numerator for this measure is comprised of members who received one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year | ▪ NCQA/ HEDIS | ▪ Admini-strative |
| **Diabetes Management (Hb1AC testing)** | ▪ The denominator for this measure is comprised of members ages 18-75 with diabetes (type 1 and type 2)<br>▪ The numerator for this measure is comprised of members who had each of the following a) HbA1c testing b) HbA1c poor control c) HbA1c control d) eye exam e) medical attention for nephropathy f) BP control g) HbA1c control for a selected population | ▪ NCQA/ HEDIS | ▪ Admini-strative/ Hybrid |
| **Anti-depressant Medication Management (Continuation Phase)** | ▪ The denominator for this measure is comprised of Patients age 18 years and older as of April 30 of the measurement year, with a Negative Medication History, with a diagnosis of major depression, and who were treated with antidepressant medication nduring the Intake Period<br>▪ The numerator for this measure is comprised of those members who received at least 180 days (6 months) of continuous treatment with antidepressant medication during the 231-day period following the Index Prescription Start Date (IPSD) | ▪ NCQA/ HEDIS | ▪ Admini-strative/ Hybrid |

# Description of podium metrics

**Minimum criteria to achieve bronze, silver, and gold status**




- **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

- 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

## Eligible practices stratified by level of performance

- **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[1] of performance across 10 selected performance measures to receive any outcomes-based payment

## Payment amount based on level of performance

- **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

# Providers will receive 3 types of reports from the State in the

| Report | Description | Frequency | Methodology |
|---|---|---|---|
| 1 Baseline report | ▪ IHH results along performance measures in year that serves as reference for IHH<br>▪ Helps IHH identify where to focus<br>▪ Serves as reference point for improvement | ▪ Once at program launch | ▪ Based on paid claims |
| 2 Quarterly performance report | ▪ Provides information-only reporting on performance measures and activities | ▪ Quarterly | ▪ Based on paid claims<br>▪ Updating quarterly |
| 3 End of year annual report | ▪ Assigns IHH metal tier based on year-end performance measures<br>▪ Calculates IHH outcomes-based payments | ▪ Annually | ▪ Calculated using claims for service dates of that year paid within 6 months of year-end. |

# Upcoming Webinars

**Provider Requirements, Expectations and Staffing Ratios**
- Friday, August 24, 2018 - 9:00 am – 10:30 am
- Monday, August 27, 2018 - 9:00 am – 10:30 am

**Quality Indicators, Incentive Payments and Reporting**
- Friday, August 24, 2018 - 1:00 pm – 2:00 pm
- Monday, August 27, 2018 - 1:00 pm – 2:00 pm

**Attribution,Tiering and Assignment**
- Thursday, August 30, 2018 - 9:00 am – 10:00 am
- Friday, August 31, 2018 - 9:00 am – 10:00 am
- Tuesday, September 4, 2018 - 9:00 am – 10:00 am

**Enrollment in the IMPACT System**
- Wednesday, August 29, 2018 - 1:00 pm – 2:00 pm
- Thursday, August 30, 2018 - 1:00 pm – 2:00 pm
- Tuesday, September 4, 2018 - 1:00 pm – 2:00 pm

A schedule of the following subject matter webinars will be held at a later date.
- Billing, Claiming and Payment