DRAFT Health Home Concept Paper

1. How are health home services provided?

Illinois Medicaid has been primarily a fee-for-service system, involving thousands of healthcare providers who have provided invaluable healthcare services and social supports to low-income individuals and families for many years. Aligned with national healthcare reform, the State of Illinois has embraced the vision of the Triple Aims: improving the experience of care, improving the health of populations, and reducing the growth in health care costs.

To accomplish the Triple Aims, Illinois Medicaid is in the process of implementing a redesign of the Medicaid healthcare delivery system. This ambitious redesign will move Illinois from a fundamentally fee-for- service system to a system that aggressively promotes care coordination, payment reform and health outcomes. The new system incentivizes providers, community-based organizations, and traditional managed care organizations to work together to coordinate care and improve the experience and quality of care received by Illinois Medicaid clients. Illinois is unique in the nation with the development of innovative Managed Care Entity (MCE) models:

- **Care Coordination Entities (CCE):** CCEs are a collaboration of providers and community agencies, governed by a lead entity that receives a care coordination payment in order to provide care coordination services for its enrollees (medical services are still fee-for-service). A CCE may serve Seniors and Persons with Disabilities or Children with Special Needs. A CCE must have a network of providers and community partners who shall deliver coordinated quality care across provider and community settings to Enrollees. The Enrollee shall be at the center of the CCE's coordinated care network and delivery system. The CCE shall coordinate care across the spectrum of the healthcare system with emphasis on managing transitions between levels of care and coordination with community and social services. CCEs are eligible to share in Medicaid savings pursuant to the State Plan (state plan amendment currently under CMS review) provided that it meets quality measure targets.
- **Managed Care Community Networks (MCCN):** A MCCN is an entity, other than a Health Maintenance Organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides primary, secondary and tertiary managed health care services under a risk-based capitation arrangement. MCCNs are subject to aggressive care coordination contract standards that require assignment of an interdisciplinary care team of health professionals to Enrollees. The interdisciplinary care team must coordinate care across the continuum of the healthcare system and with community and social service organizations to

ensure the Enrollee is at the center of the delivery system. MCCNs are monitored and eligible for incentive payments for meeting quality measures. MCCNs may serve individuals enrolled in all eligibility categories (SPD, FHP, ACA Expansion, etc.).

- **Managed Care Organizations (MCO):** MCOs operating in Illinois provide the full range of Medicaid services under a capitated payment arrangement. MCOs must be recognized by the Illinois Department of Insurance. MCOs are subject to aggressive care coordination contract standards that require assignment of an interdisciplinary care team of health professionals to Enrollees. The interdisciplinary care team must coordinate care across the continuum of the healthcare system and with community and social service organizations to ensure the Enrollee is at the center of the delivery system. MCOs are monitored and paid according quality measures. MCOs serve individuals enrolled in all eligibility categories.
- **Accountable Care Entities:** An ACE is an organization comprised of and governed by its participating providers, with a legally responsible lead entity, that receives a care coordination payment to coordinate the care of its Enrollees (medical services are still fee-for-service for the first 18 months, and take on financial risk thereafter), and is accountable for the quality, cost, and overall care of its Enrollees. An ACE cannot be an insurance plan. The ACE demonstrates an integrated delivery system, shares clinical information in a timely manner, and designs and implements a model of care and financial management structure that promotes provider accountability, quality improvement, and improved health outcomes. ACEs are eligible to share in Medicaid savings pursuant to the State Plan (state plan amendment currently under CMS review) provided that it meets quality measure targets. ACEs generally serve children, families, pregnant women, and newly eligible ACA Adults.

The Illinois Health Home program builds on its redesigned delivery system and leverages the infrastructure and the strong care coordination models already in place within the Managed Care Entities' (CCE, MCCN, MCO, and ACE) networks.

Individuals eligible for Health Homes will be defined by the State. Eligible individuals will be provided Health Home services by the Managed Care Entity (Health Home), which they are enrolled for the provision of Medicaid services and/or care coordination services under the redesigned Medicaid delivery system in Illinois. In the five mandatory managed care regions, eligible individuals will have the option to refuse health home services at any time. In addition, Enrollees have the option to switch Health Homes within 90 days of enrollment into the Health Home and the opportunity to switch Health Homes at their annual open enrollment. In a voluntary managed care county, Enrollees may opt out of the Health Home or switch Health Homes on a month-to-month basis.

2. Geography

Health Homes will operate in the following service areas:

- **a.** Greater Chicago (including Cook and 5 collar counties)
- **b.** Rockford (tier of 3 northern Illinois counties)
- **c.** Quad Cities (3 counties in the Rock Island-Moline area)
- **d.** Central Illinois (15 county region including cities of Springfield, Bloomington, Campaign, and Peoria)
- **e.** Metro East (3 Illinois counties in St. Louis area)
- **f.** Specified Voluntary Counties

3. Population Criteria

The State will provide health home services to individuals with:

- Two Chronic Conditions
- One chronic condition and at risk for developing another
- Chronic conditions include:
    - Mental Health condition
    - Substance Abuse
    - Asthma
    - Diabetes
    - Heart Disease
    - BMI over 25, at which time data is available
    - Other chronic conditions:

Illinois will provide health home services to individuals in the major categories described above, as identified through the 3M Clinical Risk Grouping software. The State will identify Medicaid clients enrolled in a MCE and who have a specific CRG score or higher as Health Home enrollees. Individuals will receive health home services for a period of eight quarters at which time the State will reassess their CRG score. The State will further identify higher risk individuals using CRGs who will require enhanced health home services.

Health Home services will be provided to all categorically eligible Medicaid recipients including children, dual eligible, and waiver participants. The State plans to implement health homes on July 1, 2015.

4. Provider Infrastructure

Health Homes will be a designated provider as defined in Section 1945(h)(5) of the Act. The designated provider will work with a multi-disciplinary team of health care professionals including representation from the medical, behavioral health, social and community service, and, as applicable, long-term care sectors to provide health home

services. The team of health care professionals will include physicians and other professionals such as a nurse practitioner, nutritionist, social worker, behavioral health professional, peer support specialist, outreach worker, pharmacist, or a HCBS waiver case manager. The designated provider will be the Managed Care Entity.

Entities eligible to become health homes in Illinois are the Managed Care Entities and include MCOs, MCCNs, CCEs, and ACEs. The designated provider will assign a team of health care professionals to work together under a formal agreement and agreed upon care coordination protocols to offer health home services as defined by the State. The delivery of health home services will be lead by a designated care manager who will assure that enrollees receive medical, behavioral health, and social services under a single care plan, agreed upon among the team of health professionals. The care manager will be responsible for monitoring the care plan and ensuring goals are updated, as necessary. The State will provide initial and ongoing to training and technical assistance to the MCEs (Health Homes).

5. Service Definitions

a. Comprehensive Care Management must include:

i. Individualized Care Plan. For all Health Home Enrollees, Health Homes must provide an individualized, person-centered care plan developed based upon a comprehensive health risk and, if necessary, behavioral health risk assessment. The care plan must integrate an Enrollee's medical, behavioral health, long-term care, rehabilitative and social service needs, as appropriate. The care plan must clearly identify the primary care physician and any other providers involved in delivering care to the Enrollee as well as community networks and social supports. The care plan must include goals, timeframes, and action steps towards improving the Enrollee's overall health. The Enrollee must be an active participant in the development of the care plan. The care team will be required to play an integral role in the creation, monitoring, and updating of the care plan. The care team is the patient advocate and primary resource for both medical and social multidisciplinary communication.

ii. Integration of physical and behavioral health. Health Homes will provide integrated physical and behavioral health services as appropriate to the Enrollees needs. Screenings for intimate partner violence, depression, and substance abuse should be part of the initial assessment. Enrollees should be screened using validated tools with appropriate and timely follow up and referrals. Inpatient and outpatient behavioral health treatment plans should be incorporated in the overall care plan.

iii. **Family involvement.** Health Homes must provide the opportunity for family and/or caregiver involvement based on the Enrollee's preference. This includes the development, monitoring and updating of the care plan, according to the Enrollee's needs and wishes.

iv. **Tracking care plan goals.** The care manager will be responsible for monitoring and tracking care plan goals, and working with the team of health professionals to update goals and interventions as necessary.

v. **Mental health and substance abuse screenings.** The Health Home must complete an initial screen for behavioral health issues within a specified period of time after enrollment, and complete a further comprehensive assessment, if indicated in the initial screen.

vi. **Periodic reassessment.** Health Homes must periodically reassess an Enrollee's needs and update care plans as dictated in the MCE contracts or as needed based on changes in health status.

vii. **Care Manager to Enrollee Ratios.** Health Homes must have Care Manager to Enrollee Ratios appropriate to need.

viii. **Integration of Housing Services.** The Health Home must work with community organizations that provide supportive housing or other services related to homelessness or tenancy service.

ix. For health home eligible individuals the State identifies as high-risk, the Health Homes will be required to have smaller care manager to enrollee ratios.

b. **Care Coordination** must include:

i. **Adherence to treatment / medication monitoring.** The care manager is responsible for coordinating all necessary care and monitoring Enrollee adherence to the care plan, which includes medication monitoring. The Health Home must assure defined responsibilities among each health home team member and foster communication between the care manager and the members of the health home such as the treating clinicians to discuss the enrollee's needs. The health home must have defined accountabilities in place to assure effective collaboration among the health home members.

ii. **Referral tracking.** The Health Home must develop and/or utilize a system to share regularly updated clinical information and track referrals and care needs across providers, preferably using Certified Electronic Health Record Technology (CEHRT), meeting ONC Meaningful Use criteria and PCMH standards.

iii. **Emphasis on face-to-face contacts.** The Health Home must have policies and procedures in place to ensure care managers engage in regular face-to-face contact with enrollees.

iv. **Use of case conferences.** The Health Home must have policies and procedures in place to ensure regular case reviews with all members of the care team.

v. **Tracking test results**. The Health Home must have systems in place to track test results and ensure those results are accessible to all members of the care team.

vi. **Requiring discharge or transition of care summaries.** The Health Home will require use of discharge summaries that are incorporated into the care plan and accessible to all members of the care team, preferably using CEHRT and HIE.

vii. **Automated notification of admission.** The Health Home will develop a system to notify care team members when an Enrollee is discharged from the ED or is admitted to a hospital.

viii. **Housing coordination.** Health homes will provide housing coordination assistance as necessary.

ix. For high-risk enrollees identified as needing enhanced Health Home services, the Health Home must ensure regular face-to-face contact between the care manager and enrollee as appropriate to coordinate the enrollee's care. The State also encourages health homes to perform a home visit from someone from the care team during the development of the care plan, and periodic home visits in order to monitor and update care plans.

c. **Health Promotion** must include:

i. Development of self-management plans through the individualized care plan and the referral to needed resources such

as smoking cessation, self-help recovery, or management of chronic diseases.

ii. Evidence-based wellness and promotion through enrollee health education via methods such as one on one teaching, group therapy, and peer support.

iii. Culturally, linguistically and age appropriate educational resources to encourage patient engagement, family/caregiver involvement, and self-health improvement or maintenance.

d. **Comprehensive Transitional Care** will be provided to prevent readmission and to ensure appropriate and timely follow up after discharge. Health homes must ensure:

i. **Notification of admissions/discharge.** The Health Home must have policies, procedures, and relationships in place with hospitals and residential and rehabilitation facilities to ensure prompt notification to the care manager of admission or planned discharge of an Enrollee.

ii. **Receipt of summary care record.** The Health Home will develop and utilize a follow-up protocol to assure timely access to follow-up care post-discharge that includes at a minimum, medication reconciliation, pharmacist coordination, home health nursing, if applicable, and a plan for timely scheduled appointment at outpatient providers preferably transmitted using CCDA (Consolidated Clinical Document Architecture) compliant protocols.

iii. **Specialized transitions (age- related, corrections).** The Health Home must have policies and procedures in place with local practitioners including emergency departments, hospitals, and community-based providers to ensure safe transportation for enrollees who require it especially those who require transfer between sites of care.

iv. For high-risk enrollees identified as needing enhanced Health Home services, the State encourages Health Homes to require the care manager to be present at discharge from any level of care and make a timely home visit upon an inpatient or ED discharge.

e. **Individual and Family Support Services.** The Health Home must ensure:

i. Use of support groups and self-care programs to facilitate improved self-management of conditions and improved adherence to treatment.
ii. Reflection of the Enrollee and family or caregiver preferences in the care plan.
iii. Communication is culturally and linguistically appropriate.
iv. Enrollees, families, and caregivers are provided information on the use of advance directives and end of life wishes are discussed and documented if applicable.
v. Family/caregivers are involved with patient centered plans including peer supports if applicable.
vi. Assistance with attaining highest level of functioning in the community.
vii. Encouraging home and community based service integration by maximizing social supports with Enrollee's preferred networks.

f. Referral to Community and Social Support Services. The Health Home will actively identify community-based resources and manage appropriate referrals to community-based resources including follow-up. The Health Home will place an emphasis on identifying resources closest to home and least restrictive. The Health Home may also consider developing a resource manual. The Health Home must have policies, procedures, and accountabilities with community-based organizations to ensure effective collaborations and coordination of care.

g. The Way HIT will link services.

Health Homes will be required to utilize CEHRT and HIE as feasible to improve service delivery and coordinate care across the continuum. Health Homes must have policies and procedures in place that allow members of a care team to securely share clinical information, track referrals and to access to a single care plan. Health Homes are encouraged to use CCDA compliant HIT to provide notification to care team members of ED and inpatient hospital admissions. The State understands that some providers in a Health Home network may not utilize HIT. As such, the State encourages MCOs, MCCNs, CCEs (and requires ACEs) to utilize the Illinois Health Information Exchange (ILHIE). Utilization of the ILHIE will allow care team members to securely share clinical information.

6. Provider Standards.

In Illinois, a Health Home provider is the central point in coordinating an Enrollee's care including medical, behavioral, and social need. A Health Home provider is responsible for reducing preventable inpatient admission/readmissions; preventing

avoidable ED visits; improving quality outcomes while reducing overall per capita cost. A Health Home provider must:

- Be enrolled in the Illinois Medicaid program and comply with all program requirements.
- Be capable of providing or contracting for the provision of all Health Home services required in its contract. The Health Home is ultimately responsible for all subcontracted activities.
- Include hospitals in its network and have policies and procedures in place to refer any Health Home Enrollee who seeks or needs treatment in a hospital ED to the appropriate outpatient provider and to include the care manager in the referral process.
- Have policies and procedures in place that passes a readiness review by the State's EQRO to provide all required Health Home services described in *Section 5, Service Definitions*.

7. **Payment.** The State, in its redesigned delivery system, has created Health Homes in each type of Managed Care Entity (MCEs). All MCEs are essentially responsible for the overall quality and cost of care delivered and must implement similar health home service requirements. Taking into consideration that all MCEs are Health Homes, the State proposes the following payment methodologies.

    a. **MCOs/MCCNs:** The MCOs and MCCNs operate under a risk-based payment arrangement. A portion of the capitation payment (care coordination component) is designed to cover the provision of the contractual health home services. Because not all Enrollees in a MCO or MCCN will be identified as health home eligible, the State proposes to cost allocate the care coordination component included in the capitation rates for all beneficiaries and attribute more of the care coordination fees to the health home populations. The State is requesting 90 percent match on the cost allocated amounts to health home beneficiaries. This proposal is based on the fact that MCOs and MCCNs will spend more of the care coordination component of the capitation rate on providing health home services to health home populations. The State's actuary will be engaged to complete this analysis. All MCEs will be monitored by the State and its EQRO to assure Health Home eligible enrollees receive the robust level of care coordination they need and the Plan is contractually required to provide. The MCO and MCCN contracts include a per member per month withhold from the capitation payment that MCOs and MCCNs can earn for meeting quality measure targets. This withhold is an incentive for Health Homes to provide the robust level of care coordination required to improve quality outcomes.

        For the high-risk Health Home populations, MCOs and MCCNs will be required to provide additional services beyond what is currently assumed in

the capitation rates. As such, the State proposes to pay an additional fee to the MCOs and MCCNs for the provision of high-risk health home services. The State will request 90 percent match on this additional fee. The additional fees will be allocated across all beneficiaries enrolled in the MCE. The State will withhold a percentage of the additional fees that the MCEs can earn back for performing required care coordination activities that the State will monitor through quarterly reporting and encounter data (e.g. meeting care plan completion targets). Furthermore, the State will include a separate MLR requirement for the additional fee. To provide MCOs and MCCNs with an incentive to offer the additional health home services, MCOs and MCCNs will have the opportunity to share in the difference between the actual and contractual MLR and to reinvest savings in areas to improve overall health. The retained amount would be capped (i.e. 3 percent) and tiered.

b. ACEs. ACEs currently receive a flat care coordination fee for all Enrollees regardless of whether the individual is Health Home eligible. Similar to the proposal above, because the majority of care coordination activity will be provided to Health Home eligible individuals, the State proposes to cost allocate the care coordination fees for all beneficiaries and attribute more of the care coordination fees to the health home populations. The State will request 90 percent match on the cost allocated amounts attributed to health home beneficiaries. ACEs are eligible to receive shared savings payments for meeting certain quality measure targets. Shared savings is an incentive for the ACEs to implement the robust level of required Health Home services.

For high-risk Health Home populations, the State proposes to provide an additional fee to the ACEs for the enhanced health home services not assumed in the original care coordination fee. The State will request 90 percent match on this additional fee. The additional fees will be allocated across all beneficiaries enrolled in the ACE. The State will withhold a percentage of the additional fees that the ACEs can earn back for performing required care coordination activities that the State will monitor through quarterly reporting and encounter data (e.g. meeting care plan completion targets).

c. CCEs. The CCEs generally serve Seniors and Persons with Disabilities with greater care needs or Children with Special Needs and have smaller enrollments. CCEs currently receive a flat care coordination fee for all Enrollees. The CCE care coordination fees assume all levels of health home services including those high-touch services required for the high-risk Health Home individuals. Because the majority of care coordination activity will be provided to Health Home eligible individuals, the State proposes to cost allocate the care coordination fees for all beneficiaries and attribute more of the care coordination fees to the Health Home populations. The State will

request 90 percent match on the cost allocated amounts attributed to Health Home beneficiaries. CCEs are eligible to receive shared savings payments for meeting certain quality measure targets. Shared savings is an incentive for the CCEs to implement the robust level of required Health Home services.

8. **Monitoring.** Below are the methodologies the State will use to monitor avoidable hospital readmissions and for calculating cost savings. Please note that because Health Homes are integral to the MCE structure, the State cannot identify Health Home outcomes and savings separately.

    a. **Tracking avoidable hospital readmissions.** To be provided at a later date.
    b. **Method for calculating cost savings.** To be provided at a later date.

9. **Evaluations.**

    a. **Hospital Admission Rates.** The State will collect encounter data to monitor hospital admission rates.

    b. **Chronic Disease Management.** The State will monitor chronic disease management through contractually defined quality measures.

    c. **Coordination of Care for Individuals with Chronic Conditions.** The State will monitor coordination of care for individuals with chronic conditions through quality measures, encounter data, and regular reporting of care coordination activities.

    d. **Assessment of Program Implementation.** The State will monitor program implementation through regular meetings with the MCEs, and quarterly and annual reporting.

    e. **Processes and Lessons Learned.** The State will monitor program implementation and identify processes and lessons learned through regular meetings with the MCEs, quarterly and annual reporting, and regular stakeholder meetings.

    f. **Assessments of Quality Improvements and Clinical Outcomes.** The State will monitor assessments of quality improvements and clinical outcomes through its Bureau of Quality Managements and contractually defined quality measures.

    g. **Estimates of Cost Savings.** To be provided at a later date.

10. Quality Measures. The table below depicts the quality measures the State will use to monitor Health Homes.

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Program Measures
N/A	1. Adult Body Mass Index (BMI) Assessment	Percentage of members 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.	**Numerator Description:** Body mass index documented during the measurement year or the year prior to the measurement year. **Denominator Description:** Member 18-74 years of age who had an outpatient visit.	Medicaid Adult Core Set, HEDIS
N/A	2. Ambulatory Care-Sensitive Condition Admission	Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years.	**Numerator Description:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under the age of 75 years. **Denominator Description:** Total mid-year population under 75 years.	
648	3. Care Transition – Transition Record Transmitted to Health Care Professional	Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary care physician or other health care professional designated for follow-up care within 24 hours of discharge.	**Numerator Description:** Patient for whom a transition record was transmitted to the facility or primary care physician or other health care professional designated for follow-up care within 24 hours of discharge. **Denominator Description:** All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or	Medicaid Adult Core Set.

			rehabilitation facility) to home/self-care or any other site of care.	
0576	4. Follow-up After Hospitalization for Mental Illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	**Numerator Description:** An outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. **Denominator Description:** Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 31 of the measurement year.	Children's Core Set, Medicaid Adult Core Set, HEDIS
1768	5. Plan- All Cause Readmission	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	**Numerator Description:** County the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination. **Denominator Description:** Count the number of Index Hospital Stays for each age, gender, and total combination.	Medicaid Adult Core Set, HEDIS
0418	6. Screening for Clinical depression and Follow-up Plan	Percentage of patients aged 18 years and older screened for clinical depression using a standardized toll AND follow-up documented.	**Numerator Description:** Total number of patients from the denominator who have follow-up documentation. **Denominator Description:** All patients 18 years and older screened for clinical depression using a standardized tool.	PQRS, CMS QIP, Medicare Shared Savings Program, Medicaid Adult Core Set, Meaningful Use Stage 2
0004	7. Initiation	Percentage of adolescent and	**Numerator Description:**	Meaningful Use Stages

	and Engagement of Alcohol and Other drug Dependence Treatment	adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD treatment. • Engagement of AOD treatment	Initiation of AOD Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. **Denominator Description:** Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18+ years) and the total rate. The total rate is the sum of the two numerators divided by the sum of the twp denominators.	1 and 2, Medicaid Adult Core Set, HEDIS.
0018	8. Controlling High Blood Pressure	The percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	**Numerator Description:** The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be < 140/90mm Hg. **Denominator Description:** Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN	Million Hearts, Medicaid Adult Core Set, Meaningful Use Stage 2, ACO Measure.

			during the first six months of the measurement year.	
		Percent of members in the Plan who had a Health Risk Assessment completed within __ days of auto-assignment or enrollment; percentage of members determined Health Home eligible via HRA who had a person-centered care plan developed and in place within ___ days of Health Home eligibility determination.		
		Percent of Health Home Eligible persons identified by HFS through 3M-CRG stratification who have a person-centered care plan developed and in place within ___ days of Health Home eligibility notification of the Plan.		