DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SECOND NOTICE OF PROPOSED RULEMAKING

1) Agency Name: Department of Healthcare and Family Services

2) Subject of Proposed Rulemaking: Integrated Health Home

Heading of the Part: Medical Payment

Code Citation: 89 Ill. Adm. Code 140.990 – 140.997

3) Date of Proposed Rulemaking: October 12, 2018

Illinois Register Citation: 42 Ill. Reg. 18242

Summary of Proposed Rulemaking: This proposed amendment creates the Integrated Health Home (IHH) program.

4) Text and Location of Changes Made to the Proposed Rulemaking During the Public Comment Period: See Attachment 1

5) Response to Recommendations Made by the Administrative Code Division: No recommendations made.

6) Incorporation by Reference: This proposed rulemaking does not include any incorporation by reference.

7) Final Regulatory Flexibility Analysis:

A) The Department did not receive any comments from small businesses or local governmental units regarding this proposed rulemaking.

B) No alternatives to the proposed rulemaking were suggested by small businesses or local governmental units.

8) Compliance with Small Business Flexibility Requirements: This rulemaking has no effect on small businesses or units of local government. No action is required with respect to Section 5-30 of the Illinois Administrative Procedure Act.

9) Agency's Evaluation of Submissions by Interested Persons During the Public Comment Period:

A) List of individuals and groups submitting comments: See Attachment Four

B) Specific criticisms, suggestions, and comments raised: See Attachment Four

C) Changes made as a result of public comments: See Attachment Four and Attachment One

D) Public hearings: Not requested.

10) Justification and Rationale for the Proposed Rulemaking:

A) Changes in Illinois laws that require the rulemaking: None

B) Changes in agency policies and procedures that require the rulemaking: On July 18, 2018 the Centers for Medicare & Medicaid Services (CMS) approved Illinois' State Plan Amendment (SPA) implementing Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act. This rulemaking is proposed to implement Health Homes SPA.

C) Federal laws, rules or funding requirements which require the rulemaking: None

D) Court orders or decisions which require the rulemaking: None

E) Any other reasons for the rulemaking: None

11) Agency Personnel Who Will Respond to Joint Committee Questions Regarding the Proposed Rulemaking: Please address any questions to:

Christopher Gange
Acting General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

12) State Mandates Act Questionnaire: See Attachment Two.

13) Analysis of Economic and Budgetary Effects of the Proposed Rulemaking: See Attachment Three.

14) Impact Statement from Department of Commerce and Economic Opportunity: Not requested.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SECOND NOTICE OF PROPOSED RULEMAKING

ATTACHMENT ONE

CHANGES IN THE TEXT OF THE PROPOSED AMENDMENTS
DURING THE FIRST NOTICE PERIOD

Agency: Department of Healthcare and Family Services

Heading of the Part: Medical Payment (89 Ill. Adm. Code 140)

Illinois Register Citation: 42 Ill. Reg. 18242

Changes:

Section 140.4991 is being changed as follows:

- Lines 813 add "/collaborative" after "contractual"
- Lines 818 and 822 add "contractual/" before "collaborative"
- Line 832 remove "~~three~~" and replace with "ten"
- Line 834 remove "~~ten~~" and replace with "sixty"

Section 140.992 is being changed as follows:

- Line 932 add "for noncitizens" after "emergency medical conditions"
- Line 940 after Subsection (a)(9) add: "; or"
  10) Individuals enrolled in a Medicaid Home and Community-Based Services (HCBS) Waiver Program authorized under Section 1915(c) of the Social Security Act.
- Line 968 remove "~~of schizophrenia~~" and replace with "from the schizophrenia spectrum"
- Line 985 remove "~~major depression~~" and replace with "depression disorders"
- Line 987 remove "~~other mood disorders~~" and replace with "disruptive impulse control and conduct disorders"
- Line 988 remove "~~conduct disorder~~"
- Line 989 remove "~~oppositional defiant disorder~~"
- Line 990 remove "~~psychosis~~" and replace with "diagnosis with psychotic features"

Section 140.993 is being changed as follows:

- Line 1121 after subsection (i) add:
  "k) Provides assurances that there will be no duplication of services and payment for similar services provided under other Medicaid authorities including but not limited to services identified in Section 140.453(e)(1)."

Section 140.994 is being changed as follows:

- Line 1171 after "assessment" add: "based on a health history, physical examination, risk profile and/or screening completed by a physician, as defined in the Medical Practice Act of 1987 (225 ILCS 60/2), physician assistant, as defined in the Physician Assistant Practice Act of 1987 (225 ILCS 95/4), or advanced practice nurse, as defined in the Nurse Practice Act (225 ILCS 65/50-10), and assessment and treatment planning as defined by Section 140.453 (d) (1)"
- Line 1250 change "~~consultating~~" to "consulting"
- Line 1277 change "~~calendar~~" to "outcomes-based payment"
- Line 1281 through 1283 replace "~~Outcomes-based payment years will be calendar years. The first outcomes-based payment year will begin January 1, 2019 and end December 31, 2019~~." with " Outcomes-based payment years will be calendar years, except the first outcomes-based payment year will be from the first day of the first month after these rules are adopted through December 31, 2019."
- Line 1319 change "~~continuous~~" to "consecutive six month"

Section 140.994 is being changed as follows:

- Lines 1163 – 1167 (subsection b) replace with:

  Beginning the first day of the first month after these rules are adopted, an IHH shall be paid for only one qualifying care coordination service per member per month (PMPM) for each member who receives at least one qualifying care coordination service per month based on telephonic or face-to-face contact. If an IHH fails to have at least one face-to-face qualifying care coordination service per month in at least six (6) months of an outcome-based payment year (as defined in subsection (d)(1)) and fails to qualify for an outcomes-based payment per subsection (d), then during the following outcomes-based payment year, after a total of six (6) months of PMPM payments based on telephonic contact, the IHH will only receive a PMPM payment for a member's qualifying care coordination service based on face-to-face contact. A face-to-face qualifying care coordination service may occur through telehealth, in compliance with Section 140.403. Qualifying care coordination services are:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SECOND NOTICE OF PROPOSED RULEMAKING

ATTACHMENT TWO

STATE MANDATES ACT QUESTIONNAIRE

Agency: Department of Healthcare and Family Services

Heading of the Part: Medical Payment (89 Ill. Adm. Code 140)

Illinois Register Citation: 42 Ill. Reg. 18242

1. Does this rulemaking affect a municipality, county, township, other unit of local government, school district or community college district?

   Yes ☐ No ☒

   If yes, please check the type of entity or entities that are affected.

   Municipality ☐
   County ☐
   Township ☐
   Other Unit of Local Government ☐
   School District ☐
   Community College District ☐

2. Does this rule require a unit of local government, a school district, or a community college district to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues?

   Yes ☐ No ☒

   Total number of units affected: _____

   If yes, please estimate the amount of additional expenditures necessitated by this rulemaking per unit of government: $____

   NOTE: If the dollar amount, or total number of units affected is unknown, please outline and attach to this form a specific and detailed explanation of the steps taken by the

agency to determine the approximate expense of the rulemaking, and the number of units affected.

If no, please explain why the rule does not necessitate such additional expenditures.

These proposed amendments do not require additional expenditures by any units of local government because they do not regulate or impose any responsibilities on units of local government.

3. Were any alternatives to the rule, which did not necessitate additional expenditures considered?

Yes ☐ No ☒

If yes, please list these alternatives and explain why these alternatives were rejected.

4. What is the policy objective(s) of the rulemaking? (Please be specific)

The policy objectives of these proposed amendments are fully explained in the Notice of Proposed Amendments.

5. Please explain, in detail, why the policy objective(s) of this rule cannot be achieved in the absence of the rule.

In general, the Department implements new service and payment standards contained in approved State Plan Amendments through administrative rule.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SECOND NOTICE OF PROPOSED RULEMAKING

ATTACHMENT THREE

AGENCY ANALYSIS OF ECONOMIC AND BUDGETARY EFFECTS
OF PROPOSED RULEMAKING

Agency: Department of Healthcare and Family Services

Heading of the Part: Medical Payment (89 Ill. Adm. Code 140)

Illinois Register Citation: 42 Ill. Reg. 18242

Please attempt to provide as dollar-specific responses as possible and feel free to add any relevant narrative explanation.

1. Anticipated effect on State expenditures and revenues.

   (a) Current cost to the agency for this program/activity.
   Approximately $0 as this rulemaking implements a new service.

   (b) If this rulemaking will result in an increase or decrease in cost, specify the fiscal year in which this change will first occur and the dollar amount of the effect.

   Approximately: $309 million annually

   (c) Indicate the funding source, including Fund and appropriation lines for this program/activity.
   Healthcare Provider Relief Fund (0793)
   General Revenue Fund (0001)

   (d) If an increase or decrease in the costs of another State agency is anticipated, specify the fiscal year in which this change will first occur and the estimated dollar amount of the effect.

   There is no anticipation of an increase or decrease in costs associated with another State agency.

   (e) Will this rulemaking have any effect on State revenues or expenditures not already indicated above? Specify effects and amounts.

This rulemaking will not have an effect on State revenues or expenditures not already mentioned.

2. Economic effect on entities regulated by the rulemaking.

(a) Indicate the economic effect and specify the entities affected:

Positive ☒ Negative ☐ No effect ☐

Entities Affected: Integrated Health Home Providers
Dollar amount per entity: Differs by provider based on the services provided.

(b) If an economic effect is predicted, please briefly describe how the effect will occur. (Example: Additional continuing education courses will require expenditures for course fees.) N/A

(c) Will the rulemaking have an indirect effect that may result in increased administrative costs? Will there be any change in requirements such as filing, documentation, reporting or completion of forms? Compare to current requirements.

This rulemaking will have no indirect effect that may cause an increase in administrative costs.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SECOND NOTICE OF PROPOSED RULEMAKING

ATTACHMENT FOUR

Proposed Rule Section	**Commenter**	**Summary of Comments on 1st Notice Proposed Rule**	**HFS Response to Comments**	**Revisions for 2nd Notice**
140.991.a	CBHA	The term "any entity" is very open-ended, and it would seem there might be exceptions. Needs additional definition.	The Department is not proposing any changes to this section at this time.	No changes required.
140.991 b. 2	Thresholds IARF	IHHs serving enrollees in highest need tier should not coordinate care for family members in lowest tier.	Under this rulemaking, Tier A must also serve Tier B and C. Tier B providers only serve Tier B and Tier C providers only serve Tier C. IHHs must be able to serve all members of a family regardless of the family member's tiers. This arrangement will allow families to all be enrolled in the same IHH, if they choose to be. However, if one family member wants to choose another IHH, that is also acceptable. The Department is not proposing any changes to this section at this time. No rules have been promulgated for Tier D.	No changes required.
140.991 b. 2	Lurie	Request that IHHs be allowed to define the age groups that they will serve or that the auto-assignment does not assign adults to IHHs that are more appropriate for children	The Integrated Health Home (IHH) model must include capacity for all eligible populations. However, IHH's may decide to employ different strategies for different populations in their design. HFS encourages providers to partner with specialized entities and build on their strengths. (HFS FAQ) The Department is not proposing any changes to this section at this time.	No changes required.
140.991 b. 2. A. and B.	IHA IHPA	IHHs serving tier A, B and C can operate under contractual agreements, but IHHs serving Tiers B or C individually can operate with collaborative agreements.	Thank you for your comments. This section has been updated	Section updated.
140.991.b. 4	CBHA	The 3 day and 10 day requirement	Thank you for your comments. This section has been	Section updated.

Proposed Rule Section	Commenter	Summary of Comments on 1st Notice Proposed Rule	HFS Response to Comments	Revisions for 2nd Notice
	Thresholds IHA IARF	for notifying HFS of changes in IHH professional staff is too short recommend allowing for a longer time period.	updated	
140.991 b. 5	CBHA Lurie	Please explain the state's guidance on how IHHs will address 42 CFR Part 2 and the exchange of substance use information.	The sample consent forms provided by the Department will comply with federal and state laws. The Department is not proposing any changes to this section at this time.	No changes required.
140.991 b. 5	Thresholds IARF	Clarification is needed on what happens when a client refuses to consent to IHH services. Recommend the IHH be paid for this encounter where consent is not given, and that the enrollee is then taken off the IHH's roster.	IHHs can only receive reimbursement for care coordination services. The Department is not proposing any changes to this section at this time.	No changes required.
140.992 a.	IARF	Are I/DD Medicaid waiver participants excluded?	Persons enrolled in Home and Community Based Services (HCBS) Waiver Programs authorized under Section 1915(c) of the Social Security Act are not eligible to participate in IHH	Section updated.
140.992 a. 2	CBHA	Does the exclusion of individuals residing for more than 90 days in a residential facility include those in a "supervised" or "support" residential program funded by DMH?	Yes, these facilities meet the definition of 140.992(a)(2).	No changes required.
140.992 c. 2. A.	Thresholds IARF	This section needs to be clear that all schizophrenia spectrum disorders.	Thank you for your comments. This section has been updated	Section updated.
140.992 c. 2. A.	Lurie	Suggests that behavioral health criteria include developmental delay NOS/NEC/Mixed, disruptive and impulse control disorders, ADHD	The criteria recommended would fall within one of the categories that are listed in 140.992(c)(2)(C)(i).	Section updated

Proposed Rule Section	Commenter	Summary of Comments on 1st Notice Proposed Rule	HFS Response to Comments	Revisions for 2nd Notice
		and trauma and stressor related disorders.		
140.992 d. 2	CBHA	How does a provider submit a referral to request a tier change?	This transaction related information will be provided in the IHH provider manual. The Department is not proposing any changes to this section at this time.	No changes required.
140.992 e.	CBHA	Please explain the state's guidance on how IHHs will address 42 CFR Part 2 and the exchange of substance use information.	The sample consent forms provided by the Department will comply with federal and state laws. The Department is not proposing any changes to this section at this time.	No changes required.
140.993	CBHA IHA	This section outlines the responsibilities of the Department. Are these items delegated to the MCOs for individuals in Medicaid Managed Care plans?	These are the Department's responsibilities. As appropriate the responsibilities will be delegated to the Department's agents or contractors with Department oversight.	No changes required.
140.993 b.	Lurie	Allow 60 days for an individual to select an IHH before auto-assignment.	30 days is the same period as MCO enrollment choice period.	No changes required.
140.993 e.	CBHA Thresholds IARF	Recommend that IHHs are provided membership rosters every 30 days, a periodic basis is not enough.	Your concern is noted and the Department will review the time frames for providing member rosters.	No changes required.
140.993 h.	CBHA	Recommend quarterly be added.	The Department is not proposing any changes to this section at this time.	No changes required.
140.994	CBHA	Will IHH providers be responsible for these activities?	Yes. These activities were required in the approved state plan.	No changes required.
140.994 b.	DCHD Lurie	Face-to-face interactions with each member every month is excessive. Some activities can be accomplished over the phone. Places a burden on members to attend additional monthly appointments. Payment via telehealth cannot be made when the	Thank you for your comment. The face-to-face requirements have been changed.	Section updated.

Proposed Rule Section	Commenter	Summary of Comments on 1st Notice Proposed Rule	HFS Response to Comments	Revisions for 2nd Notice
		member is at home. Recommend payment for subsequent care coordination. Relax the telehealth parameters.		
140.994 b. 1. A.	CBHA	Is there a standardized assessment?	No, the Department is not providing a standardized assessment. This section has been updated to add the items needed to compile the assessment.	Section updated.
140.994 b. 1. B.	CBHA IHA	Is there a standardized patient-centered plan?	No. The IHH program was designed to allow providers the flexibility to be creative in assessing each individual's specific needs.	No changes required.
140.994 b. 1.C-F	CBHA	Is there specific criteria regarding how often or when each of these activities should occur?	No. The IHH program was designed to allow providers the flexibility to be creative in assessing each individual's specific needs.	No changes required.
140.994 c.	CBHA Thresholds DCHD IPHCA IARF Lurie IHPA	The fees developed for this project do not meet even the most minimal staffing costs for organizations. The reimbursement rates under the current PMPM model are not sustainable. Small providers are disadvantaged by the 500 member panel size requirement. If at any time the panel falls below 500, the IHH will be disqualified from receiving a bonus payment. The IHH payment model is not a PMPM, it's a capped monthly FFS payment with no flexibility to achieve good health outcomes that does not meet the costs of providing services even if bonus payments are	The reimbursement rates are published on the Department's web site and were set in the approved state plan.	No changes required.

Proposed Rule Section	Commenter	Summary of Comments on 1st Notice Proposed Rule	HFS Response to Comments	Revisions for 2nd Notice
		factored in. • Recommend a PMPM with flexibility on staffing and care coordination as long as specific quality and outcomes metrics are met. If this is not possible recommend an encounter based model where costs are covered. • Recommend the model take into account the difficulty of conducting face-to-face encounters. If a face-to-face encounter is required to payment, providers are not incentivized to contact the hard to reach population…the very population		

Proposed Rule Section	Commenter	Summary of Comments on 1st Notice Proposed Rule	HFS Response to Comments	Revisions for 2nd Notice
		this program targets. Payment rates for IHHs are not sustainable and significantly below rates paid by other states.		
140.994 d.	CBHA	Suggest the basis for the outcomes payments for year 1 be revised to July –December.	The first outcomes-based year will be from the first day of the first month after the rules are adopted through December 31, 2019.	Section 140.994 d. 1. updated.
140.994 d.	IHA	More clarity is needed on the outcomes-based payment eligibility such as what is the minimum number of members required to meet the thresholds of the outcomes-based payments? What happens if there are enrollment issues? Do IHHs that serve a panel of fewer than 500 members become ineligible for outcomes-based payments?	To qualify for the outcomes-based payments, IHH providers must maintain the minimum panel size (500) for six (6) consecutive months. IHHs that serve a panel of fewer than 500 members for six (6) consecutive months become ineligible for outcomes-based payments	Section 140.994 d. 4. B updated.
140.994 d. 1	Lurie	Recommends that the Department provide additional details about the measures, benchmarks and thresholds well in advance of the start of the measurement period to give IHHs time to develop necessary workflows and reporting processes.	The 30-day timeframe was approved in the state plan amendment. The Department will work with the IHHs to develop a cost effective and efficient manner for reporting the data. (HFS FAQ)	No changes required.
General Comment	Alexian Brothers Center for Mental	Case management must be reserved as a Medicaid service for enrollees that are enrolled in an IHH. Case management is a very different	A member who is already receiving case management through Medicaid and does not want to switch to care coordination through an IHH can opt out of participation. There will be no duplication of	Section 140.993 updated.

Proposed Rule Section	Commenter	Summary of Comments on 1st Notice Proposed Rule	HFS Response to Comments	Revisions for 2nd Notice
	Health Centerstone CBHA Thresholds IARF	service than care coordination. • Under this proposed rule, if an enrollee is receiving care coordination through an IHH, the service/treatment provider cannot bill for targeted case management services. Targeted case management should be preserved as a service and billed by the service provider even if the enrollee is also receiving IHH services. The current handbook and fee schedule have several targeted case management services including Client Centered Consultation, Mental health and Transition Linkage and Aftercare case management services. Will IHH's cover all of these services in the future or only some of them?	services and payment for similar services provided under other Medicaid authorities including but not limited to services identified in Section 140.453(e)(1). Refer to SSA, Section 1945 (42 USC 1396w-4).	

Proposed Rule Section	Commenter	Summary of Comments on 1st Notice Proposed Rule	HFS Response to Comments	Revisions for 2nd Notice
General Comment	The Joint Commission	Recommend amending the rule to recognize The Joint Commission behavioral health home certification as part of the eligibility to be classified as an Integrated Health Home in Illinois.	Thank you for your comment. The Department is not proposing any changes at this time.	No changes required.
General Comment	IHA	Will PCCM program be completely phased out or will MCOs use this program in a separate but option capacity?	The PCCM program ended January 1, 2018. Please refer to the November 8, 2017, Provider notice titled Illinois Health Connect Plan Closure.	No changes required.
General Comment	IHA	Must a provider serving Tier B also serve Tier C?	No. See HFS response to 140.991(b)(2).	No changes required.
General Comment	IHA	Approximately 89% of Medicaid beneficiaries will be enrolled in Tier D, the rules should address this so providers may adequately plan for this volume.	Tier D is not part of the initial rollout of the IHH program. The proposed rulemaking for Tier D will be separate from this rulemaking.	No changes required.
General Comment	Thresholds	IHHs are not the treating provider and should not perform the IM-CANS assessment (3-4 hrs to complete). Recommend IHHs perform a shorted assessment like the comprehensive health risk assessment that MCOs perform. Assessments should be given their own billing code as an assessment is a separate service from care coordination.	See HFS response to 140.994 b. 1. A. and B.	Section updated.

Proposed Rule Section	Commenter	Summary of Comments on 1st Notice Proposed Rule	HFS Response to Comments	Revisions for 2nd Notice
General Comment	Thresholds	The IHH program and financial models are seriously flawed and need to be restructured. • The State should focus on enabling CMHCs to become IHHs and need specific state investments to be able to compete with larger healthcare providers. Specifically start up dollars for infrastructure investment • CMHCs that become IHHS should receive "Deemed Status" so that all MCOS in that service area contract with CMHC IHHs rather than letting MCOS determine which IHHS they will contract with. • CMHCs should be the IHH for tiers A and B. As	The reimbursement rates are published on the Department's web site and were set in the approved state plan.	No changes required.

Proposed Rule Section	Commenter	Summary of Comments on 1st Notice Proposed Rule	HFS Response to Comments	Revisions for 2nd Notice
		currently structured and reimbursed the vast majority of CMHCs will not become IHHS		
General Comment	DCHD IARF IPHCA	Providers lack comprehensive and updated information regarding this new delivery model including the current number or tiering of existing clients. Providers would be able to develop IHHs and staff accordingly if they knew how many clients were in each tier	The webinar on Attribution, Tiering and Assignment contains a statewide map with the aggregate regional data of individuals stratified by tier, effective August 2018. Tiering depicted in the map is preliminary and will be updated prior to final assignment. (HFS FAQ)	No changes required.
General Comment	DCHD IARF IHPA	Consumers and families are not educated on this new model. Confusion related to enrollment could be disruptive to vulnerable individuals.	Individuals will receive letters advising them of their need to choose an IHH and will also receive a list of IHHs with contact information. The process will be similar to the current MCO/PCP selection process and the former PCCM Program.(HFS FAQ)	No changes required.
General Comment	DCHD Lurie	MCOs cannot describe how the IHH care coordination functions will work with MCO care coordination functions.	HFS is establishing the baseline requirements for IHHs. The Department continues to work with MCOs to ensure a successful rollout of the IHH Program.	No changes required.
General Comment	DCHD IARF IPHCA	Program should be reviewed to facilitate strong connections between a patient's PCP and/or behavioral health provider.	PCPs will continue to contract with MCO(s) and will be able to offer primary care services to clients regardless with which IHH the client is enrolled. The IHH will want to establish a relationship with the PCP to ensure that the IHH is able to effectively communicate with the PCP for the purposes of care coordination. However, a PCP is encouraged to also	No changes required.

Proposed Rule Section	Commenter	Summary of Comments on 1st Notice Proposed Rule	HFS Response to Comments	Revisions for 2nd Notice
			contract with and/or collaborate with one or more IHHs to assist in meeting the needs of their members. (HFS FAQ)	
General Comment	DCHD IARF IPHCA IHPA	Provider education has been minimal and there is no access to technical assistance. The program calls for ADT feeds to have immediate connectivity with hospitals. This would require significant provider investment.	The Department began provider education in August 2018, through townhall meetings, webinars and FAQs. This information has been published on the Department's website. The Department's immediate goal is to implement a state-wide Admission, Discharge and Transfer (ADT) alerting notification system to advance its care coordination objectives. The Department is currently in the procurement process for an ADT system. (HFS FAQ)	No changes required.
General Comment	DCHD IHPA	Details have not been provided on the auto-assignment algorithm. Auto-assignments require testing and refinement. Untested assignments disrupt care.	The algorithm for initial roll out will first look at other family members on the same case who are also tiered. If a client can be appropriately served by a health home to which another tiered family member belongs, the algorithm will assign the client to that IHH. Otherwise, the algorithm will look at the last six months of claims data from the core provider types. The core provider will the highest number of claims will be used as the key. The algorithm will find an IHH in the client's MCO with whom that core provider is associated and assign the client to that IHH. If the client is fee-for-service, the algorithm will assign to an IHH with whom the core provider is associated as a plan network will not be applicable. (HFS FAQ)	No changes required.
General Comment	DCHD Lurie IHPA	Staffing ratios and staff qualifications are too high and clarity should be provided in writing if these ratios change.	Clinical Care Coordinator qualifications have been adjusted in the Provider Terms and Conditions.	No changes required.

Proposed Rule Section	Commenter	Summary of Comments on 1st Notice Proposed Rule	HFS Response to Comments	Revisions for 2nd Notice
General Comment	TASC	Patients should be allowed to select an IHH at the beginning of the year and switch only once during the plan year	Members may choose a different IHH if they relocate. Regardless of the situation, members may change IHHs as frequently as once per month. Members are also free to opt of the IHH program at any time. (HFS FAQ)	No changes required.
General Comment	TASC	Enrolling member in an IHH by default and requiring they opt-out is detrimental to patient care and provider success.	Thank you for your comment. The approved state plan requires the opt-out option.	No changes required.
General Comment	TASC	Who notifies individuals transitioning from institutions of IHH eligibility? (Correctional facilities/residential treatment concern)	Medicaid eligible individuals transitioning from an institution will not receive notification unless they meet the requirements of 140.992. A provider or MCO can send the Department a referral to request that an individual be tiered for IHH eligibility.	No changes required.

List of Commenters:

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