THE INFORMATION IN THIS BOX IS NOT A PART OF THE CONTRACT AND IS FOR COUNTY USE ONLY

SAN BERNARDINO COUNTY

Contract Number
18-78 A-5

SAP Number
N/A

Behavioral Health

Department Contract Representative	Tammi Phillips
Telephone Number	(909) 388-0860
Contractor	Inland Empire Health Plan and IEHP Access
Contractor Representative	Mathew Wray
Telephone Number	(909) 890-2932
Contract Term	February 13, 2018 through December 31, 2022
Original Contract Amount	
Amendment Amount	
Total Contract Amount	$2,798,013
Cost Center	9209191000

Briefly describe the general nature of the contract: Amendment No. 5, effective January 1, 2021, to Memorandum of Understanding No. 18-78 with Inland Empire Health Plan is hereby amending the contract language to the Health Home Program.

FOR COUNTY USE ONLY

Approved as to Legal Form	Reviewed for Contract Compliance	Reviewed/Approved by Department
DocuSigned by: Dawn Martin	DocuSigned by: Natalie Kessee	DocuSigned by: Veronica Kelley
Dawn Martin, County Counsel	Natalie Kessee, Contracts Manager	Veronica Kelley, Director
Date 5/27/2021	Date 5/27/2021	Date 5/27/2021

AMENDMENT NO. 5

MEMORANDUM OF UNDERSTANDING
Between the

Inland Empire Health Plan (IEHP)
and
San Bernardino County Department of Behavioral Health (SBDBH)
for
Medi-Cal Managed Care

February 13, 2018 through December 31, 2022

THE MEMORANDUM OF UNDERSTANDING entered into **February 13, 2018**, by and between **Inland Empire Health Plan, a Joint Powers Agency,** hereinafter referred to as **IEHP** and the San Bernardino County **DEPARTMENT OF BEHAVIORAL HEALTH**, hereinafter referred to as **SBDBH,** for the provision of Medi-Cal Managed Care, is hereby amended, effective January 1, 2021 in the following manner:

I. ADDENDUM I – The following paragraph is hereby added:

WHEREAS, pursuant to DHCS's All Plan Letter 18-015 ("APL"), as more specifically described in Attachment 2 of the APL, IEHP and SBDBH are required to ensure timely sharing of Protected Health Information ("PHI") for the purposes of medical and behavioral health care coordination pursuant to Title 9, CCR, Section 1810.370(a)(3) and in compliance with HIPAA as well as other state and federal privacy laws;

II. ADDENDUM I - SECTION V – **GENERAL PROVISIONS,** is hereby amended to read as follows:

A. The SBDBH agrees to participate in the Health Homes Program and be bound to all outlined requirements. Failure to achieve outlined requirements will impact payment.

B. Any future changes or modifications to the program after the effective date of this Addendum shall be by mutual written consent of the parties. Thirty (30) days' notice will be provided of any changes or modifications.

C. These revisions to the Health Homes Program shall be effective January 1, 2021 and shall terminate December 31, 2021. Upon termination of the program, this Amendment will expire. Any continuation of the Health Homes Program would require a new Amendment with Board approval.

D. It is mutually agreed and understood that the obligations of IEHP are contingent upon the availability of state and federal funds. In the event that such funds are not forthcoming for any reason, this Addendum is rendered null and void, and IEHP shall immediately notify PROVIDER in writing. This Amendment shall be deemed terminated and of no further force and effect immediately on IEHP's notification to PROVIDER. In the event of such termination, PROVIDER shall be entitled to reimbursement of costs for services rendered in accordance with this agreement.

E. Payment to SBDBH will be made pursuant to the attached compensation schedule.

i. In the event that SBDBH has failed to meet the metrics, goals, or objectives as outlined in the Health Homes Guidelines as attached hereto, IEHP, in its sole discretion, may withhold payment, if payment has not been remitted or recoup any and all funds related to SBDBH's failure to meet such metrics, goals, or objectives. Recoupment may be effectuated by withholding future payments or a demand for reimbursement of the funds to be paid within ten (10) days.

F. The Health Homes program is subject to and is governed by the terms of the MOU, provided, however, that the provisions of this Addendum, shall govern, control, and supersede any contrary or conflicting term or provision of the Agreement.

G. All other terms and conditions of the MOU, as amended, are to remain in full force and effect.

H. SBDBH certifies that the individual signing herein has authority to execute this Amendment on behalf of SBDBH and may legally bind SBDBH to the term and conditions of this Amendment, and any attachments hereto.

I. To the extent reasonably possible, each party agrees to maintain this Agreement as a confidential document and not to disclose the Agreement or any of its terms or reports without the approval of the other party, subject to the limitation of the Public Records Act and the Brown Act

II. ATTACHMENT A of ADDENDUM I, is hereby replaced.

III. ATTACHMENT B of ADDENDUM I, is hereby replaced.

IV. ATTACHMENT C of ADDENDUM I, is hereby added.

V. All other terms and conditions of the MOU remain the same.

This Agreement may be executed in any number of counterparts, each of which so executed shall be deemed to be an original, and such counterparts shall together constitute one and the same Agreement. The parties shall be entitled to sign and transmit an electronic signature of this Agreement (whether by facsimile, PDF or other email transmission), which signature shall be binding on the party whose name is contained therein. Each party providing an electronic signature agrees to promptly execute and deliver to the other party an original signed Agreement upon request.

IN WITNESS WHEREOF, the parties hereto have signed this FIFTH AMENDMENT as set forth below.

Approved as to Form and Consent:

By: DocuSigned by: Dawn Martin
Dawn Martin

Deputy County Counsel
San Bernardino County

Date: 5/27/2021

Approved as to Form and Consent:

By: DocuSigned by: DS MP
Anna W. Wang

General Counsel
Inland Empire Health Plan

Date: 7/15/2021

CONTRACTOR:

By: DocuSigned by: Veronica Kelley
Veronica Kelley, LCSW

Director

Date: 5/27/2021

By:
Curt Hagman, Chairman

San Bernardino County

Board of Supervisors

Date: JUN 22 2021

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD
LYNNA MONELL
Clerk of the Board of Supervisors
of the County of San Bernardino
By _____ Deputy

INLAND EMPIRE HEALTH PLAN

By: DocuSigned by: Keenan Freeman
Keenan Freeman, CFO for
Jarrod McNaughton

Chief Executive Officer

Date: 7/15/2021

By: DocuSigned by: Karen S. Spiegel
Chair, IEHP Governing Board

Print Name: Karen S. Spiegel

Date: 7/15/2021

Attest: DocuSigned by:
Annette Taylor, Secretary
IEHP Governing Board

Date: 7/15/2021

ATTACHMENT A

HEALTH HOMES

SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

I. HEALTH HOMES PROGRAM COMPENSATION

On or before the fifth (5th) day of each month following the month of service, IEHP Health Plan shall pay PROVIDER the following reimbursement rate for each Member assigned to the PROVIDER who meets the eligibility criteria definition at the time of consent or the engagement definition thereafter. Retro eligibility additions and deletions are limited to three-hundred sixty-five (365) days for all Members. Retro Medicare Status changes are limited to sixty (60) days.

Effective JANUARY 1, 2021 through DECEMBER 31, 2021

STATE PROGRAMS (IEHP MEDI-CAL BENEFICIARIES THAT DO NOT HAVE MEDICARE COVERAGE OR HAVE MEDICARE PART A ONLY)

IEHP shall reimburse PROVIDER $250.00 per engaged member per month (PEMPM) for Members who meet the eligibility criteria for the HHP at the time of consent and who are engaged with the CB-CME/PROVIDER as of the effective date of this Agreement. The $250.00 PEMPM rate will remain in effect through March 31st, 2021. Beginning April 1st, 2021, IEHP shall reimburse Provider $200.00 PEMPM for Members who meet the eligibility criteria for the HHP at the time of consent and who are engaged with the CB-CME/PROVIDER.

a) Eligibility criteria definition:
1. Member is an active Medi-Cal Member;
2. Member is eligible for HHP (meets eligibility criteria per HHP Program Guide);
3. Member is assigned to a Primary Care Provider (PCP) at a CB-CME;
4. Member has consented to participate and is enrolled in HHP; and

b) Engagement definition:
1. Member has received an HHP service where the first HHP service is received within 90 days of enrollment and all ongoing HHP service are received within at least 90 days of the last HHP service received; and
2. IEHP has received an HHP service encounter (G-code) for the Member following the timeline requirements as noted in b) 1.

MEDI-MEDI (IEHP MEDI-CAL BENEFICIARIES WITH FULL FEE FOR SERVICE (FFS) MEDICARE COVERAGE OR MEDICARE PART B ONLY)

IEHP shall reimburse PROVIDER $60.00 per engaged member per month (PEMPM) for Members who meet the eligibility criteria for the HHP and who are engaged with the CB-CME/PROVIDER as of the effective date of this Agreement:

a) Eligibility criteria definition:
1. Member is an active Medi-Cal Member;
2. Member is eligible for HHP (meets eligibility criteria listed on Page 14 of HHP Program Guide);

3. Member is assigned to a Primary Care Provider (PCP) at a CB-CME;
4. Member has consented to participate and is enrolled in HHP; and

b) Engagement definition:

1. Member has received an HHP service where the first HHP service is received within 90 days of enrollment and all ongoing HHP service are received within at least 90 days of the last HHP service received; and

2. IEHP has received an HHP service encounter (G-code) for the Member following the timeline requirements as noted in b) 1.

CAL MEDICONNECT BENEFICIARIES (DUAL CHOICE)

PROVIDER will not be reimbursed for Cal MediConnect Members as they are excluded from HHP.

Supplemental Payment Details

1. Payment will be provided for up to 250 IEHP enrolled Members per month per care team who meet eligibility criteria and meet the engagement definition.
2. Evidence of HHP services rendered is with the HHP code scheme as follows. All codes and definitions are subject to DHCS changes:

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 minutes equals 1 UOS; Multiple UOS allowed

Encounter Data – Providers contracted to provide HHP services shall send Encounters to IEHP on a CMS1500 claim form, or through the Provider Portal. Claims will be adjudicated as Encounters and Pay at $0. Claims submitted for services not listed above will be denied.

IEHP reimburses PROVIDER on a per engaged member per month (PEMPM) rate for Members who meet the eligibility criteria for the HHP at the time of consent and who are engaged with the CB-CME/PROVIDER.

ATTACHMENT B

HEALTH HOMES
SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

II. HEALTH HOMES PROGRAM - VALUED BASED PAYMENT MEASURES

Effective JANUARY 1, 2021 through DECEMBER 31, 2021

SECTION 1: PROGRAM OVERVIEW

I. Introduction

This program guide provides an overview of the 2021 Health Homes Program (HHP) Payment Methodology for Community Based Care Management Entities (CB-CMEs) and is designed as an easy reference. In the first two years, IEHP's approach to HHP payment was to incentivize HHP enrollment alone. In the third year of the HHP, IEHP is moving towards value-based payment to continually improve quality outcomes for our most vulnerable population. The IEHP HHP value-based payment is designed to reward contracted CB-CMEs who meet performance standards in key quality performance areas. Although certain processes and outcomes are financially incentivized, the expectation is that each CB-CME will comply with all the requirements of the HHP program as outlined in the scope of their agreement.

If you would like more information about IEHP HHP payment methodology, email the Practice Transformation department at healthhomes@iehp.org.

II. What's New?

HHP payment is made up of two components. First, IEHP will continue to pay a base rate for enrollment so long as encounter submissions requirements are met. Second, and new to the HHP is a valued-based payment for HHP services. Payments will be based on the performance of the following metrics: Care Plan, Blood Pressure, and Depression.

III. Minimum Data Submission Requirements

1. Encounter Data
    i. Encounter data is foundational to performance scoring and is essential to success in the base rate payment for HHP. Complete, timely, and accurate encounter data should be submitted through normal reporting channels for all HHP services rendered to IEHP HHP enrolled Members. Please use the appropriate HHP encounter codes (G-codes) listed in the table found in Attachment B to meet measure requirements. For more information regarding HHP encounter submission instructions, please refer to the HHP Encounter Submission Guide.

2. Care Director Data
    i. Care Director is the platform CB-CMEs are required to use to document HHP services (enrollment, assessment, and care planning). Accurate

documentation therein will be foundational to performance scoring and is essential to success in the value-based payment for the HHP.

IV. Measurement Period Definition

Measurement periods are defined as rolling quarters per Table 1 below:

Table 1: Measurement Period Schedule

Measurement Period	Months Covered	Expected VBP Payment Date
1	January, February, March 2021	On or around last business day of April 2021
2	February, March, April 2021	On or around last business day of May 2021
3	March, April, May 2021	On or around last business day of June 2021
4	April, May, June 2021	On or around last business day of July 2021
5	May, June, July 2021	On or around last business day of August 2021
6	June, July, August 2021	On or around last business day of September 2021
7	July, August, September 2021	On or around last business day of October 2021
8	August, September, October 2021	On or around last business day of November 2021
9	September, October, November 2021	On or around last business day of December 2021
10	October, November, December 2021	On or around last business day of January 2022

SECTION 2: ENROLLMENT

I. Enrollment

Enrollment continues to be the foundation for the HHP and serves as the primary mechanism by which CB-CMEs are paid. As stated in Section 1, II above, IEHP will continue to pay a base rate for enrollment. IEHP will pay a base rate per member per month (PMPM) for Members who meet the eligibility criteria for the HHP at the time of consent, which includes the following:

Eligibility criteria definition:

1. Member is an active Medi-Cal Member;
2. Member is eligible for HHP (meets eligibility criteria per HHP Program Guide);
3. Member is assigned to a Primary Care Provider (PCP) at a CB-CME (Primary Care sites only);
4. Member has consented to participate and is enrolled in HHP; and

In addition to the eligibility criteria above, Members must meet the following engagement requirements in order to receive the HHP PMPM base rate payment:

1. Member has received an HHP service where the first HHP service is received within 90 days of enrollment, and all ongoing HHP services are received within at least 90 days of the last HHP service received; and
2. IEHP has received an HHP service encounter (G-code) for the Member following the timeline requirements.

SECTION 3: THE MEASURES

II. VPB HHP Payment Measures

IEHP is aligning contracting with the intended goals of the program to advance high value processes and improve health outcomes. In this first year of value-based payments, we will be focusing on the following measures:

- Care Plan
- Blood Pressure
- Depression

These quality measures were chosen because, done well, they are the foundational components of a successful Health Homes Program. The Care Plan is the heart of the HHP work as it is the place to memorialize patient-identified and whole-person health and wellness goals and demonstrates ongoing services to Members via connection to a critical relationship with the care team. Overall, the care plan is the representation of an ongoing conversation between the care team and Member to move them along the continuum towards health and self-management.

Hypertension is the most common diagnosis among all HHP enrollees and is an underlying factor of morbidity and mortality for this vulnerable population. Blood pressure was selected as a quality measure because even small improvements in blood pressure have a significant impact on reducing morbidity and mortality. Finally, the HHP population has a disproportionate level of behavioral health diagnoses. Depression monitoring in this population moves the needle towards integrated and whole person care.

Value-based payment measures will change over the course of the program. As CB-CMEs demonstrate success in these early measures, IEHP will look to strengthen other measures over time.

III. Care Plan

Measure Description: The percentage of HHP enrolled Members who had a Care Plan initiated or updated during each month of the measurement period.

Source Data: Care Director Data

Measure Denominator:

1. Members continuously enrolled during the entire measurement period at attribution plans within the same Healthcare Organization (e.g. patients continuously enrolled at ARMC locations within the measurement period should be included, but a patient enrolled with ARMC and then St. Mary's should not).

Measure Numerator:

1. Members in the denominator who had at least one intervention created/customized or updated *each month* of the measurement period.
    a. Created / customized:
        i. The intervention "date modified" does *not* equal the intervention "date created," **AND**
        ii. The intervention name does *not* equal "patient stated intervention:" **AND**
        iii. Associated with the intervention is one activity note with a contact date within the measurement period **AND**
        iv. A note outcome of "Successful" or "Housing Services Provided" **OR**
    b. Updated:
        i. Associated with the intervention is a subsequent activity note with a contact date within the measurement period **AND**
        ii. A note outcome of "Successful" or "Housing Services Provided."

IV. Blood Pressure

The Blood Pressure measure will consider two components: documentation of the blood pressure into Care Director and the actual controlling of blood pressure into normal range. Therefore, two measures will be described.

Measure 1 – Blood Pressure Documentation

Measure Description: The percentage of HHP enrolled Members who have a blood pressure documented in CD.

Source Data: Care Director Data

Measure Denominator:

1. Members continuously enrolled during the entire measurement period at attribution plans within the same Healthcare Organization (e.g. patients continuously enrolled at ARMC locations within the measurement period should be included, but a patient enrolled with ARMC and then St. Mary's should not), **AND**
2. 18 years of age and older on the first date of the measurement period

Measure Numerator:

1. Members in the denominator who have at least one Physical Health Measures assessment with a status = complete, where the SBP and DBP fields are populated, with a contact date in the measurement period, **AND**

2. Where the SBP *and* DBP field values are within the valid ranges.
    a. SBP: > 40 and < 300 (greater than 40 and less than 300)
    b. DBP: > 40 and < 150 (greater than 40 and less than 150)

Measure 2 – Blood Pressure Control

Measure Description: The percentage of HHP enrolled Members who have a diagnosis of hypertension or who have a documented elevated blood pressure in Care Director by the first day of the measurement period whose blood pressure (BP) was controlled (<150/90 mm Hg) by the end of the measurement period.

Source Data: Care Director Data

Measure Denominator:

1. Members continuously enrolled during the entire measurement period at attribution plans within the same Healthcare Organization (e.g. patients continuously enrolled at ARMC locations within the measurement period should be included, but a patient enrolled with ARMC and then St. Mary's should not), **AND**
2. 18 years of age and older on the first date of the measurement period, **AND**
3. Where the SBP *and* DBP field values are within the valid ranges
    a. SBP: > 40 and < 300 (greater than 40 and less than 300)
    b. DBP: > 40 and < 150 (greater than 40 and less than 150), **AND**
4. Who meet at least one of the following criteria on the first day of the measurement period:
    a. Members who have a diagnosis of hypertension within the last two years **OR**
    b. Members who have at least two Physical Health Measures assessments with a status = complete, where the SBP was greater than or equal to 150 **OR** DBP was greater than or equal to 90 prior to the start of the measurement period.

Measure Numerator:

1. Members in the denominator who have at least one Physical Health Measures assessment with a status = complete with a contact date in the measurement period where the SBP field is less than 150 but greater than 40 AND the DBP field is less than 90 but greater than 40.

V. Depression

The Depression measure will consider two components: documentation of a PHQ-9 in Care Director and ongoing monitoring for Members with elevated PHQ-9s. Therefore, two measures will be described.

Definition: For the purposes of the following measure, the term "enrollment" and

"enrollment date" refer to the first enrollment date with the Healthcare Organization within the sequence during which they are continuously enrolled during the measurement period.

Measure 1 – Depression Documentation

Measure Description: The percentage of HHP enrolled Members who have a PHQ-9 documented within 90 days of enrollment.

Source Data: Care Director Data

Measure Denominator:

1. Members must be continuously enrolled during the entire measurement period at attribution plans within the same Healthcare Organization (e.g. patients continuously enrolled at ARMC locations within the measurement period should be included, but a patient enrolled with ARMC and then St. Mary's should not) **AND**
2. Who achieved 90 days of enrollment during the measurement period, **AND**
3. 12 years of age or older on the first date of the measurement period.

Measure Numerator:

1. Members in the denominator who had a PHQ-9 assessment with a status = complete with a contact date within 90 days of their enrollment date

Measure 2 – Depression Monitoring

Measure Description: The percent of HHP enrolled Members who, in response to an elevated PHQ-9, have a subsequent PHQ-9 documented during the measurement period.

Source Data: Care Director Data

Measure Denominator:

1. Members must be continuously enrolled during the entire measurement period at attribution plans within the same Healthcare Organization (i.e. patients continuously enrolled at ARMC locations within the measurement period should be included, but a patient enrolled with ARMC and then St. Mary's should not) **AND**
2. 12 years of age or older on the first date of the measurement period, **AND**
3. Who's last PHQ-9 assessment with a status = complete and a contact date before the start of the measurement period has a score greater than 9.

Measure Numerator:

1. Members in the denominator who have at least one PHQ-9 assessment with a status = complete and with a contact date in the measurement period.

SECTION 4: LEVEL DETERMINATION FOR MEASURES

In order to qualify for measure performance at Level 1 for the Care Plan measure, 20% of enrolled Members must meet the Care Plan measure requirements. Increasing Care Plan measure performance qualifies CB-CMEs to reach Level 2 and 3 as demonstrated in Table 2.

In order to qualify for measure performance at Level 1 for the Blood Pressure measure, 80% of enrolled Members must have a blood pressure documented in Care Director. Once Level 1 is reached, analysis can be conducted to determine if blood pressure is controlled at the performance level to qualify for either Level 2 or 3.

In order to qualify for measure performance at Level 1 for the Depression measure, 80% of patients must have a PHQ9 within 90 days of enrollment. Once Level 1 is reached, analysis can be conducted to determine if Depression is monitored at the performance level to qualify for either Level 2 or 3.

Table 2: Levels of Performance for VBP Measures

VBP Measure	Level 1	Level 2	Level 3
Care Plan (% initiated or updated)	20% - 45.99%	46% - 84.99%	85% - 100%
Blood Pressure (% documentation or control)	80% Documentation	80% Documentation + 35% - 84.99% Control	80% Documentation + 85% - 100% Control
Depression (% documentation or monitored)	80% Documentation	80% Documentation + 46% - 84.99% Monitored	80% Documentation + 85% - 100% Monitored

SECTION 5: PAYMENT METHODOLOGY

Table 3 outlines the HHP Payment structure, including base rate payment and value-based payment. Table 4 provides three examples of an HHP VBP payment calculation.

Table 3: HHP Performance Payment Structure

Performance	**Payment Structure**		
Base Rate			
Enrollment (# of Members)	• $250 PMPM for Medi-Cal Members from 1/1/2021 through 3/31/2021 • $200 PMPM for Medi-Cal Members starting 4/1/2021 through 12/31/2021 • $60 PMPM for Medi-Medi Members Max enrollment per care team is 250 Members		
VBP Measure	**Level 1**	**Level 2**	**Level 3**
Care Plan (% initiated or updated)	$5 PMPM	$15 PMPM	$25 PMPM
Blood Pressure (% documented or controlled)	$5 PMPM	$15 PMPM	$25 PMPM
Depression (% documented or monitored)	$5 PMPM	$15 PMPM	$25 PMPM
Total Maximum Payment (Enrollment + Performance at Level 3 across all VBP Measures)			***$325/$275PMPM**
***$325 PMPM Max: Jan 1 - Mar 31, 2020 and $275 PMPM Max: Apr 1 - Dec 31, 2021**			

Table 4: VBP Payment Calculation Examples

CB-CME	Measurement Period	*Enrollment	Care Plan	BP	Depression	Total VBP Dollar Amount	Total VBP Payment
X	1 (Jan-Mar 2021)	165	Level 2 $15 PMPM	Level 1 $5 PMPM	No Level Achieved	$20 PMPM	$3,300
Y	2 (Feb-Apr 2021)	185	Level 1 $5 PMPM	Level 2 $15 PMPM	Level 3 $25 PMPM	$45 PMPM	$8,325
Z	1 (Jan-Mar 2021)	250	Level 3 $25 PMPM	Level 3 $25 PMPM	Level 3 $25 PMPM	$75 PMPM	$18,750

*Enrollment Number for VBP Calculation

The Enrollment number used for VBP payment calculation is based on the following criteria:

- The highest enrollment number within the first two months of the measurement period where
- Enrolled Members had at least 1 encounter within the past 90 days

IEHP will determine this number during its monthly HHP Encounter Submission to DHCS (on or around the 19th of each month).

For example, for Measurement Period 1 (Jan, Feb, Mar 2020), IEHP will look at January and February's unique encounter submission count to DHCS. Whichever submission count is highest on each of those two cutoff days (around Jan 19th, Feb. 19th) will be the final enrollment number used in the VBP calculation. Each enrolled Member must adhere to the encounter requirements to be included in the overall enrollment number used for the VBP calculation.

Table 5: Total HHP Payment Calculation: Base Rate Payment Calculation + VBP Payment Calculation Example

Base Rate Payment							
CB-CME	**Enrollment as of approximate March 19th cutoff date**	**Number of Medi-Cal Enrollee's**	**Medi-Cal PMPM Rate**	**Number of Medi-Medi Enrollee's**	**Medi-Medi PMPM Rate**	**Total Base Rate Payment**	
X	185	178	$200	7	$60	$36,020	
VBP Payment							
CB-CME	**Measurement Period**	***Enrollment**	**Care Plan**	**BP**	**Depression**	**Total VBP Dollar Amount**	**Total VBP Payment**
X	1 (Jan-March 2021)	185	Level 3 $25 PMPM	Level 1 $5 PMPM	Level 2 $15 PMPM	$45 PMPM	$8,325
Total April 2021 Payment (Base Rate + VBP)						**$44,345**	

*Enrollment used for VBP calculation will follow the logic as described above

ATTACHMENT C

SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

III. HEALTH HOMES PROGRAM REQUIREMENTS

Effective JANUARY 1, 2021 through DECEMBER 31, 2021

Section 1 – Provider's General Responsibilities	
Item #	**Description**
1.1	PROVIDER is intended to serve as a Community-Based Care Management Entity (CB-CME), in conjunction with IEHP Health Plan, with responsibility for ensuring that an assigned Health Homes Program ("HHP") Member receives access to HHP services.
1.2	PROVIDER is responsible for providing HHP services to any of its IEHP assigned Members that are eligible for the HHP and requesting HHP services.
1.3	PROVIDER agrees to demonstrate how it will maintain a strong and direct connection to Members' primary care physicians (PCPs) and ensure the PCPs' participation in Health Action Plan (HAP) development and ongoing coordination with the CB-CME care team.
1.4	PROVIDER warrants and represents that all CB-CME duties and functions will be performed in compliance with applicable state and federal laws and regulations, DMHC requirements, DHCS Health Homes Program requirements, DHCS contract requirements, and other DHCS guidance, including APLs and Policy Letters.
1.5	PROVIDER shall not delegate the performance of any care management activity to another organization or entity without the express written consent of IEHP Health Plan. In the event PROVIDER subcontracts/sub-delegates any duties under the Agreement, PROVIDER understands it retains overall responsibility for all CB-CME duties that PROVIDER has agreed to perform.
1.6	Employ and maintain a multi-disciplinary care team to specifically serve the HHP. The CB-CME care team is comprised of the following positions/disciplines: I. HHP Director (this position can be combined with other positions); II. Registered Nurse Care Manager (RN CM); III. Behavioral Health Care Manager (BH CM); IV. Care Coordinator; and V. Community Health Worker (CHW)

	In the case of position vacancy, CB-CME will, in good faith, promptly attempt to refill vacancies on the CB-CME care team through reassignment of existing staff and/or recruitment of new staff. CB-CME's must report care team member vacancies and new hires within 7 days of notification to IEHP via the Care Team Member Change Request Form.
1.7	Identify a Primary Care Physician (PCP) champion to lead change efforts.
1.8	Clinic management oversees CB-CME care team and ensures that they meet job expectations and backgrounds outlined in the staffing model per the job descriptions for HHP Model 1 - CB-CME.
1.9	Assure that sufficient space is available for the CB-CME care team to share a team office space, as well as provide one-on-one services to patients as needed. Assure that telehealth capability and accessibility is available for the CB-CME team to use in providing HHP services to Members if needed.
1.10	Provider ensures that each CB-CME care team and PCP champion conduct Systematic Caseload Review (SCR) meetings for a minimum of four (4) hours per month.

Section 2 - CB-CME Core Functions	
Item #	**Description**
2.1	Conduct outreach and engagement for eligible members according to IEHP guidance, with priority placed on highest tiered individuals per DHCS requirements.
2.2	Member must be assigned to a PCP at participating HHP Provider organization prior to enrollment into the program (This does not apply to behavioral health CB-CMEs only).
2.3	Enroll and obtain consent from eligible member using a process specified by IEHP.
2.4	Assure that the CB-CME provides the following six (6) core HHP services to eligible Members as per the HHP Program Guide: I. Comprehensive and individualized care management; II. Care coordination III. Health promotion (including connection to medical, mental health, and substance use disorder care); IV. Comprehensive transitional care from inpatient to other setting (including appropriate follow-up); V. Individual and family support, including authorized representatives; and VI. Referral to relevant community and social support services (including connection to housing, transportation, healthy lifestyle supports, child care, and peer recovery support).
2.5	Practice measurement-based care as directed by IEHP which includes regular review of the web-based care management platform measure dashboards and other IEHP provided reports. Measurement-based care includes the systematic administration of standardized, validated symptom rating scales and measures including the PHQ-9, GAD-7, BAM, HbA1c, and BP for screening and ongoing monitoring, and uses the results to drive clinical decision making for an individual patient or population.

2.6	Practice population health as directed by IEHP. Population health includes using the HIT tools provided to review specific indices for the CB-CME's caseload/population. This approach requires active monitoring of the entire caseload to determine which patients are improving and where intervention is required for patients who are not improving as expected.
2.7	The CB-CME shall complete the CHA within 90 days after HHP enrollment and annually or when/if a significant change in health status occurs. Significant changes could include; hospitalization or ED visit; detox episode; or specific medical diagnosis (e.g. diabetes).
2.8	The CB-CME shall complete a Health Action Plan (HAP) within ninety (90) days of enrollment for each enrolled Member, and will reassess and update it to reflect any changes in the Member's progress or status or health care needs (no less than quarterly). The CB-CME care team shall review and update the HAP at every contact with an enrolled Member.
2.9	The CB-CME care team shall assure comprehensive transitional care which includes contact with all HHP enrolled Members within two days of discharge from an Emergency Department or inpatient hospital and administration of TOC assessment provided in the IEHP web-based care management platform.
2.10	The CB-CME shall disenroll or step-down Members at the completion of treatment or for another qualifying disenrollment reason including: I. HHP enrollees who have demonstrated improvement in their conditions such that their outcomes demonstrate that they are well-managed and have remained out of the hospital and/or emergency department for a period of 90 days; II. HHP enrollees who have been unreachable for a period of ninety (90) days; III. HHP enrollees who no longer wish to participate in the program or who no longer benefit from the HHP services; IV. HHP enrollees who opt in to other programs which would exclude them from receiving HHP services.
2.11	Use the CHA to screen all Members for housing instability and connect Members who are homeless or at risk for homelessness with appropriate services. Housing assessment will be conducted when homelessness or housing instability is identified outside of the administration of the CHA.
2.12	CB-CME care team and PCP champion conduct Systematic Caseload Review (SCR) meetings for a minimum of four (4) hours per month.
2.13	Should IEHP determine a corrective action plan ("CAP") is needed for failure to meet the requirements of this Agreement or the Health Homes Program, PROVIDER agrees to create and implement a CAP approved by IEHP.

Section 3 - CB-CME Training and Practice Coaching Requirements	
Item #	**Description**
3.1	Each month, all the members of the CB-CME care team shall be required to participate in practice coaching to support high functioning teams. Practice coaching support could include:

	I. In-person or remote one-on-one with practice coach and CB-CME care team; II. Regional CB-CME care team group practice coaching; and III. Telephonic and email support as needed by the members of the CB-CME care team.
3.2	All the members of the CB-CME shall be required to complete training on IEHP's web-based care management system for the HHP and adhere to documentation expectations.
3.3	All members of the CB-CME care team must complete all five (5) DHCS required webinars as provided by IEHP within four (4) weeks of beginning work as a CB-CME care team member.
3.4	All the members of the CB-CME care team shall be required to attend the weekly HHP webinars.
3.5	All the members of the CB-CME care team shall be required to complete the onboarding process as defined by IEHP and provide services in adherence to these processes. This will include reviewing of the HHP Manual and training in the following HHP Model of Care components and standard workflows: I. Outreach and Engagement II. CHA III. HAP IV. Tier-appropriate care management V. Transitions of care after hospitalization or ED visitation VI. Other as required by IEHP
3.6	All members of the CB-CME care team shall attend the semi-annual learning sessions as provided by IEHP.
3.7	All Community Health Worker members of the CB-CME care team will receive a certificate of completion in the IEHP sponsored 9-week intensive CHW curriculum with the IEHP selected CHW training organization or equivalent complex care training as approved by IEHP.
3.8	All Community Health Worker members of the CB-CME care team will attend the monthly HHP CHW continuing education, as scheduled by CHW training organization.
3.9	All Members of the CB-CME care team will attend other support calls as scheduled by IEHP.

Section 4 - CB-CME Health Information Technology (HIT) Requirements	
Item #	**Description**
4.1	Utilize an IEHP-provided web-based care management platform to document care management activities which includes enrollment, assessments and care planning, and facilitate data and information sharing among the entire CB-CME care team (including the Member, CB-CME, and IEHP) pertaining to the provision of the six (6) core HHP services: I. Comprehensive care management;

	II. Care coordination; III. Health promotion; IV. Comprehensive transitional care; V. Individual and family support services; and VI. Referral to community and social support services.
4.2	Alternatively, CB-CMEs may utilize their own Electronic Health Record (EHR) and/or other systems to satisfy health information technology (HIT) requirements if their systems can demonstrate functionality equivalent to IEHP's web-based care management platform and support data sharing pathways with IEHP using APIs, X12, and HL7 protocols as defined by IEHP. CB-CMEs who wish to pursue this option must participate in an HIT review with IEHP to demonstrate how their system(s) will meet HHP HIT requirements.
4.3	Utilize the IEHP Provider Portal as instructed by IEHP for activities including the submission of referrals for IEHP Direct Members.
4.4	Comply with data reporting requirements as defined by IEHP and in alignment with DHCS regulatory reporting requirements. To satisfy regulatory reporting requirements, Member-level identifiers shall be required for all reports. IEHP shall provide the CB-CME with a data reporting dictionary that includes a description and definition for all reporting requirements.

Section 5 - Other CB-CME Requirements	
Item #	**Description**
5.1	Should a Member be eligible and choose to participate in the program, the CB-CME shall be responsible for securing verbal consent from the member to participate in HHP and signed authorized releases of information, to the extent required by law. The CB-CME shall maintain a record of these consents.
5.2	CB-CME will submit an encounter for each HHP service provided to each HHP Member. Please see Attachment B for a list of HHP service codes for use with encounters and for other purposes.
5.3	The CB-CME care team/HHP Member ratio is 250 Members per care team.
5.4	The aggregate care team member ratio shall not exceed 60:1 for the whole enrolled population as measured at any point in time. Ratios should be no more than as follows: i. RN Care Manager 75:1 ii. BH Care Manager 75:1 iii. Care Coordinator 75:1 iv. Community Health Worker 25:1. If due to Public Health reasons the CHW is not able to provide community-based visits, this number can be increased, as long as the total caseload for the team does not exceed 250.

5.5	Prior to enrollment into the HHP Program, the CB-CME shall adhere to the following Member contact frequency for initial outreach attempts based on the following tiers: i. Tier 1: Minimum one (1) contact per week ii. Tier 2: Minimum two (2) contacts per month iii. Tier 3: Minimum one (1) contact per month
5.6	After enrollment into the HHP Program, the CB-CME shall adhere to these guidelines for contact of the HHP caseload. Contact includes frequent in-person* contact between the care team member delivering HHP services and the Member. The minimum required in-person visits for the aggregated population is 260 visits per 100 enrolled Members per quarter. The contact guidelines and in-person contact requirement is as follows: i. Tier 1: one (1) contact per week with a minimum of two (2) in-person contacts per month ii. Tier 2: two (2) contacts per month with a minimum of one (1) in-person contact per month iii. Tier 3: two (2) contacts during the first month, then one (1) contact per month thereafter. The expectation is that the CB-CME care team shall review and update the HAP at every contact with an enrolled Member. *It is understood that in-person contact will not be enforced during a Public Health or other state of emergency. Telephonic contact is acceptable during this time.
5.7	CB-CME care team shall participate in IEHP-defined care team and Member experience activities.

IEHP Health Plan Representations and Responsibilities

Section 6 – IEHP General Requirements	
Item #	**Description**
6.1	The overall administration of the Health Homes Program.
6.2	Provide CB-CME support for the following six core HHP services: I. Comprehensive and individualized care management; II. Care coordination and health promotion (including connection to medical, mental health, and substance use disorder care); III. Comprehensive transitional care from inpatient to other setting (including appropriate follow-up); IV. Individual and family support, including authorized representatives; V. Referral to relevant community and social support services (including connection to housing, transportation, healthy lifestyle supports, child care, and peer recovery support); and VI. Health information technology to identify eligible individuals and link services, if feasible and appropriate.

6.3	Meet all program and reporting requirements specified in the DHCS Medi-Cal Health Homes Program Guide, all applicable state and federal laws and regulations, IEHP Health Plan's contract with DHCS, and other DHCS guidance and directives.

Section 7 – IEHP Core Responsibilities	
Item #	**Description**
7.1	Attribute HHP Members to CB-CMEs.
7.2	Track and share data with CB-CMEs regarding each Member's health history.
7.3	Track CMS-required quality measures and state-specific measures (see Reporting Template and Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2017 Reporting, or later document).
7.4	Collect, analyze, and report financial measures, health status and other measures, and outcome data for program evaluation purposes.
7.5	Provide HHP Member resources (e.g. customer service, Member grievances).
7.6	Establish and maintain a data-sharing agreement with other providers that is compliant with all federal and state laws and regulations.
7.7	Provide timely information to CB-CME about patient admissions, discharges, and transitions (ADT).
7.8	Ensure participation by HHP Members' other network providers, who are not included formally on the CB-CME care team, but who are responsible for coordinating with the CB-CME care team to conduct case conferences and provide input on the HAP. These providers are separate and distinct from the roles outlined for the CB-CME care team.
7.9	Provide CB-CMEs with access to and training on a web-based care management platform that facilitates Member stratification, care coordination, and care planning as a stand-alone tool or through integration with a CB-CME's EHR. As the license holder, IEHP has access to all IEHP Member-related data and information entered in the care management platform.
7.10	Provide CB-CMEs with access and training on the IEHP Provider Portal.
7.11	In addition to DHCS required training, IEHP will continue development and support of CB-CME training tools that are needed or preferred, including practice coaching.
7.12	Develop CB-CME reporting capabilities.
7.13	IEHP will do its reasonable due diligence to assure non-duplication of services upon Member enrollment into the HHP and ongoing.
7.14	Establish and maintain a connection with the Health Information Exchange (HIE) in order to receive and transmit Member information pertaining to hospitalization and Emergency Department utilization from other facilities and organizations to the CB-CMEs.

IEHP Health Plan Oversight

Section 8 - Health Plan Oversight	
Item #	**Description**
8.1	IEHP is responsible for ensuring that CB-CMEs fulfill all required CB-CME duties and achieve HHP goals, and shall communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including CB-CMEs, as well as any delegated entities and subcontractors.
8.2	IEHP is responsible for ensuring that delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.
8.3	IEHP shall maintain strong oversight and have the right to perform regular auditing and monitoring activities to ensure and verify that the following activities are being properly performed and completed: I. Care Management; II. Systematic Caseload Review (SCR); III. Updates to the HAP as health care events unfold; and IV. All other HHP requirements.
8.4	Should IEHP determine a corrective action plan ("CAP") is needed for failure to meet the requirements of this Agreement or the Health Homes Program, PROVIDER agrees to create and implement a CAP approved by IEHP.
8.5	IEHP shall monitor PROVIDER's performance to ensure corrective actions take place in the mutually agreed-upon time frame. IEHP shall perform additional follow-up audits, as necessary, to verify the completion of a CAP. If PROVIDER fails to implement the approved CAP, IEHP reserves the right to exercise any and all remedies available under the Agreement.
8.6	PROVIDER shall monitor and oversee its subcontractors' performance of approved sub-delegated functions. IEHP reserves the right to monitor and oversee subcontractors' performance of sub-delegated functions.