# Table of Contents

**State/Territory Name: Iowa**

**State Plan Amendment (SPA) #: 20-0011**

This file contains the following documents in the order listed:

# IA - Submission Package - IA2020MS0003O - (IA-20-0011) - Health Homes



CMS-10434 OMB 0938-1188

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
601 E. 12th Street, Room 355
Kansas City, MO 64106

## Center for Medicaid & CHIP Services

December 04, 2020

Julie Lovelady
Interim Medicaid Director
Department of Human Services
611 5th Avenue
Des Moines, IA 50309

Re: Approval of State Plan Amendment IA-20-0011 Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Dear Julie Lovelady:

On September 16, 2020, the Centers for Medicare and Medicaid Services (CMS) received Iowa State Plan Amendment (SPA) IA-20-0011 for Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation to respond to the deficiencies identified in the Office of Inspector General 2019 Audit of the Health Home (HH) Programs for the period of State Fiscal year (SFY) 2013 through SFY 2016. The SPA is intended to add greater clarification around operationalization of the Integrated Health Home (IHH) program by updating the IHH standards and updating provider roles and activities. The SPA also includes quality improvement activities including a performance measures program, updated anticipated outcomes and measurable goals, and increased monitoring of HH analytics.

We approve Iowa State Plan Amendment (SPA) IA-20-0011 on December 04, 2020 with an effective date(s) of July 01, 2020.

| Name | Date Created | |
|---|---|---|
| No items available | | |

If you have any questions regarding this amendment, please contact Laura D'Angelo at laura.dangelo1@cms.hhs.gov.

Sincerely,

James G. Scott

Director, Division of Program Operations

Center for Medicaid & CHIP Services

## Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IA2020MS0003O | IA-20-0011 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

### Package Header

| | | | |
|---|---|---|---|
| **Package ID** | IA2020MS0003O | **SPA ID** | IA-20-0011 |
| **Submission Type** | Official | **Initial Submission Date** | 9/16/2020 |
| **Approval Date** | 12/4/2020 | **Effective Date** | N/A |
| **Superseded SPA ID** | N/A | | |

## State Information

**State/Territory Name:** Iowa

**Medicaid Agency Name:** Department of Human Services

## Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

# Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IA2020MS0003O | IA-20-0011 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

## Package Header

**Package ID** IA2020MS0003O

**Submission Type** Official

**Approval Date** 12/4/2020

**Superseded SPA ID** N/A

**SPA ID** IA-20-0011

**Initial Submission Date** 9/16/2020

**Effective Date** N/A

## SPA ID and Effective Date

**SPA ID** IA-20-0011

| Reviewable Unit | Proposed Effective Date | Superseded SPA ID |
|---|---|---|
| Health Homes Intro | 7/1/2020 | IA-16-0013-X |
| Health Homes Geographic Limitations | 7/1/2020 | IA-16-0013-X |
| Health Homes Population and Enrollment Criteria | 7/1/2020 | IA-16-0013-X |
| Health Homes Providers | 7/1/2020 | IA-16-0013-X |
| Health Homes Service Delivery Systems | 7/1/2020 | IA-16-0013-X |
| Health Homes Payment Methodologies | 7/1/2020 | IA-16-0013-X |
| Health Homes Services | 7/1/2020 | IA-16-0013-X |
| Health Homes Monitoring, Quality Measurement and Evaluation | 7/1/2020 | IA-16-0013-X |

# Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IA2020MS0003O | IA-20-0011 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

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## Executive Summary

**Summary Description Including Goals and Objectives**

Summary description including goals and objectives:

A Health Home focused on adults with a Serious Mental Illness (SMI) and children with a Serious Emotional Disturbance (SED). Teams of Health Care Professionals are enrolled to integrate medical, social, and behavioral health care needs for individuals with a SMI or SED.
The Health Home program enrolls Designated Providers to deliver personalized, coordinated care for individuals meeting program eligibility criteria. In return for the additional Health Home Services to members, the Designated Provider is paid a per member per month (PMPM) payment to deliver the following Health Home Services:

- Comprehensive care management is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty healthcare, and community support services, using comprehensive person-centered care plan that addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

- Care Coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, and transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. Coordinate, direct, and ensure results are communicated back to the health home.

- Health Promotion includes coordinating or providing behavior modification interventions aimed at supporting health management, improving disease outcomes, disease prevention, safety and an overall healthy lifestyle.

- Comprehensive transitional care is the facilitation of services for the individual and supports when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community based group home, family, or self-care, another Health Home).

- Individual and Family Support Services include communication with patient, family and caregivers to maintain and promote the quality of life with particular focus on community living options. Support will be provided in culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.

- Referral to Community and Social Support Services includes coordinating or providing recovery services and social health services available in the community, such as understanding eligibility for various healthcare programs, disability benefits, and identifying housing programs.

Services will be a whole-person treatment approach coordinated between multiple delivery systems. Managed Care Organizations (MCOs) serve as the Lead Entity and:
- Develop a network of Health Homes
- Assess the Integrated Health Home and physical health provider capacity
- Educate and support providers
- Provide oversight and technical support for IHH providers to coordinate with primary care providers
- Provide infrastructure and tools to IHH providers and primary care physical providers
- Perform data analytics
- Provide outcomes tools and measurement protocols to assess effectiveness
- Provide clinical guidelines and other decision support tools
- Provide a repository for member data
- Support providers to share data
- Develop and offer learning activities
- Reimburse providers
- Performing data analysis at the member level and program-wide to inform continuous quality improvement
- Offer Performance Measures Program which may include incentives
- Identify/enroll members

Health Information Technology (HIT) will link services, provide feedback and facilitate communication among team members. Electronic sharing of health data among Lead Entities, behavioral and physical health providers in a HIPAA compliant manner enables tight coordination with the broader physical health delivery system. Online profiles are able to include medical, behavioral and pharmacy history.

The use of HIT is a means of facilitating

## Federal Budget Impact and Statute/Regulation Citation

**Federal Budget Impact**

| | Federal Fiscal Year | Amount |
|---|---|---|
| First | 2020 | $0 |
| Second | 2021 | $0 |

**Federal Statute / Regulation Citation**

Section 2703 of the PPACA

**Supporting documentation of budget impact is uploaded (optional).**

| Name | Date Created | |
|---|---|---|
| No items available | | |

# Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IA2020MS0003O | IA-20-0011 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

## Package Header

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| **Superseded SPA ID** | N/A | | |

## Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

# Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | IA2020MS0003O | IA-20-0011 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

## Package Header

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|---|---|---|---|
| **Package ID** | IA2020MS0003O | **SPA ID** | IA-20-0011 |
| **Submission Type** | Official | **Initial Submission Date** | 9/16/2020 |
| **Approval Date** | 12/4/2020 | **Effective Date** | 7/1/2020 |
| **Superseded SPA ID** | IA-16-0013-X | | |
| | User-Entered | | |

## Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

**Name of Health Homes Program**

Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

## Executive Summary

**Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used**

A health home focused on adults and children with SMI. Designated providers are enrolled to integrate medical, social, and behavioral health care needs for individuals with a serious mental illness or serious emotional disturbance.
Services will be a whole-person treatment approach coordinated between multiple delivery systems. MCOs serve as the lead entity and (i)identify providers for participation; (ii)assess the IHH and physical health provider capacity; (iii)educate and support providers; (iv)provide oversight and technical support for IHH providers to coordinate with primary care providers; (v)provide infrastructure and tools to IHH providers and primary care physical providers (vi)perform data analytics; (vii)provide outcomes tools and measurement protocols to assess effectiveness; (viii)provide clinical guidelines and other decision support tools; (ix)provide a repository for member data; (x)support providers to share data; (xi)develop and offer learning activities; (xii)reimburse providers; and (xiii)attribute/enroll members.
HIT will link services, provide feedback and facilitate communication among team members. Electronic sharing of health data among behavioral and physical health providers in a HIPAA-compliant manner enables tight coordination with the broader physical health delivery system. Online profiles are able to include medical, behavioral and pharmacy history.

Anticipated Outcomes:
Improved quality of care.
Improved health status.
Increased community tenure and reduction in hospital readmissions.
Increased access to primary care, with a reduction in inappropriate use of emergency room and urgent care.
Reduction in preventable hospitalizations.
Improved measured functional status.
Improved evidence-based prescribing and medication adherence.
Improvement in identifying substance use/abuse and engagement in treatment.
Reduction in lifestyle-related risk factors.
Improved experience of care.

## General Assurances

- [x] The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- [x] The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- [x] The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- [x] The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- [x] The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- [x] The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

# Health Homes Geographic Limitations



## Package Header

| | | | |
|---|---|---|---|
| **Package ID** | IA2020MS0003O | **SPA ID** | IA-20-0011 |
| **Submission Type** | Official | **Initial Submission Date** | 9/16/2020 |
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| **Superseded SPA ID** | IA-16-0013-X | | |
| | User-Entered | | |

- (•) Health Homes services will be available statewide
- ( ) Health Homes services will be limited to the following geographic areas
- ( ) Health Homes services will be provided in a geographic phased-in approach

# Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | IA2020MS0003O | IA-20-0011 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

## Package Header

**Package ID** IA2020MS0003O
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User-Entered

## Categories of Individuals and Populations Provided Health Homes Services

**The state will make Health Homes services available to the following categories of Medicaid participants**

☑ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☑ Medically Needy Eligibility Groups

Mandatory Medically Needy

☑ Medically Needy Pregnant Women

☑ Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

**Families and Adults**

☐ Medically Needy Children Age 18 through 20

☐ Medically Needy Parents and Other Caretaker Relatives

**Aged, Blind and Disabled**

☐ Medically Needy Aged, Blind or Disabled

☐ Medically Needy Blind or Disabled Individuals Eligible in 1973

# Health Homes Population and Enrollment Criteria

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User-Entered

## Population Criteria

**The state elects to offer Health Homes services to individuals with:**

- ☐ Two or more chronic conditions
- ☐ One chronic condition and the risk of developing another
- ☑ One serious and persistent mental health condition

**Specify the criteria for a serious and persistent mental health condition:**

One or more serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition: Members with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) are eligible.

Serious mental illness is defined as an adult that has a persistent or chronic mental having (verified within the past year) a, behavioral, or emotional disorder specified within the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or its most recent International Classification of Diseases that causes serious functional impairment and substantially interferes with or limits one or more major life activities including functioning in the family, school, employment or community

SMI may co-occur with substance use disorder, developmental, neurodevelopmental or intellectual disabilities but those diagnoses may not be the clinical focus for health home services.

SED is defined by a child having (verified within the past year) a diagnosable mental, behavioral or emotional disorder specified within the most current Diagnostic and Statistical Manual of mental disorders published by the American Psychiatric Association or its most recent International Classification of Diseases equivalent which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. SED may co-occur with substance use disorder, developmental, neurodevelopmental or intellectual disabilities but those diagnoses may not be the clinical focus for health home services.

Functional Impairment (FI) as referenced in the definitions above means the loss of functional capacity that is episodic, recurrent or continuous and that substantially interferes with or limits the achievement of or maintenance of one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills and substantially interfere with or limits the individual's functional capacity with family, employment, school or community. The level of functional impairment must be identified by the assessment completed by the Licensed Mental Health Professional.

Does not include difficulties resulting from temporary and expected responses to stressful events in a person's environment.

For children three years or younger, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Revised (DC: 03R) may be used as the diagnostic tool. For children four years and older, the Diagnostic Interview Schedule for Children (DISC) may be used as an alternative to the most current DSM.

# Health Homes Population and Enrollment Criteria



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User-Entered

## Enrollment of Participants

**Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:**

- (•) Opt-In to Health Homes provider
- ( ) Referral and assignment to Health Homes provider with opt-out
- ( ) Other (describe)

**Describe the process used:**

Describe the process used: Opt-in
Eligible individuals agree to participate in the health home at the initial engagement of the provider in a health home practice. A provider presents the qualifying member with the benefits of a health home and the member agrees to opt-in to health home services. The State or MCO may also identify members for referral to a health home. In either situation, the member will always be presented with the choice to opt-out at any time. A member cannot be in more than one health home at the same time.
The State accepts any willing and qualified provider to enroll as a Health Home. Members accessing Health Home Services have access to the full range of Medicaid State Plan covered benefits.

# Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | IA2020MS0003O | IA-20-0011 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

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User-Entered

**SPA ID** IA-20-0011

**Initial Submission Date** 9/16/2020

**Effective Date** 7/1/2020

## Types of Health Homes Providers

☐ Designated Providers

☑ Teams of Health Care Professionals

**Indicate the composition of the Health Homes Teams of Health Care Professionals the state includes in its program. For each type of provider indicate the required qualifications and standards**

☑ Physicians

**Describe the Provider Qualifications and Standards**

At least one MD/DO must be part of the Lead Entity for managed care members and IME for fee-for-service members to support the Health Home in meeting the Provider Standards.
The MD/DO must have an active Iowa license and be credentialed.

☐ Nurse Practitioners

☑ Nurse Care Coordinators

**Describe the Provider Qualifications and Standards**

The Lead Entity and the IHH must have Nurse Care Manager(s) to support the Health Home in meeting the Provider Standards and provide oversight of the delivery of Health Home Services to qualified members. The Nurse Care Managers must be a Registered Nurse (RN) or a Bachelor of Science in Nursing (BSN) with an active Iowa license.

☐ Nutritionists

☑ Social Workers

**Describe the Provider Qualifications and Standards**

The IHH must have Care Coordinator(s) to support the Health Home in meeting the provider standards and deliver health home services to qualified members. The Care Coordinator must be a Bachelor of Science in Social Work (BSW), or a Bachelor of Science (BS) or Bachelor of Arts (BA) degree in a related field.

The Lead Entity must have a Care Coordinator with a BS/BA in the related field to support the Health Home in meeting the Provider Standards and delivering Health Home Services.

☑ Behavioral Health Professionals

**Describe the Provider Qualifications and Standards**

A Psychiatrist must be part of the Lead Entity for managed care enrollees and Iowa Medicaid Enterprise (IME) for fee-for-service enrollees to support the Health Home in meeting the provider standards and to deliver Health Home Services. The Psychiatrist must have a MD/DO and hold an active Iowa license and be credentialed.

☑ Other (Specify)

| Provider Type | Description |
| --- | --- |

| Provider Type | Description |
| --- | --- |
| IHH | IHH will include, but are not limited to meeting the following criteria:<br>• Be an Iowa accredited Community Mental Health Center or Mental Health Service Provider, or an Iowa licensed residential group care setting<br>• Iowa Licensed Psychiatric Medical Institution for Children (PMIC) facility, or<br>• Nationally accredited by the Council on Accreditation (COA), the Joint Commission, or Commission on Accreditation of Rehabilitation Facilities (CARF) under the accreditation standards that apply to mental health rehabilitative services<br>• Providers must be enrolled with the Iowa Medicaid Enterprise and enrolled and credentialed with one or more of the MCOs to provide community-based mental health services to the target population<br>• Providers must complete an annual self-assessment and submit to the State at the time of enrollment<br>• Providers must meet requirements throughout the state plan amendment<br>• Providers must participate in monthly, quarterly, and annual outcomes data collection and reporting |
| Lead Entity | • The Lead Entity must be licensed and in good standing in the State of Iowa as a Health maintenance organization (HMO) in accordance with Iowa Administrative Code 191 Chapter 40<br>• Have a statewide integrated network of providers to serve members with SMI/SED<br>• The Lead Entity must complete an annual self-assessment and submit to the State at the time of enrollment<br>• The Lead Entity must meet requirements throughout the state plan amendment<br>• The Lead Entity must participate in monthly, quarterly, and annual outcomes data collection and reporting |
| Peer Support Specialist | The IHH must have either a Peer Support Specialist or Family Support Specialist. Peer Support Specialists and Family Support Peer Specialists must complete a State recognized training and pass the competency exam within six months of hire if not already trained. |

| Provider Type | Description |
| --- | --- |
| Family Support Specialist | The IHH must have either a Peer Support Specialist or Family Support Specialist.<br>Peer Support Specialists and Family Support Peer Specialists must have 500 hours of experience and 25 hours of direct supervision in addition to successfully passing the competency exam to be a certified Peer Recovery Specialist |

☐ Health Teams

## Provider Infrastructure

**Describe the infrastructure of provider arrangements for Health Home Services**

The Team of Health Care Professionals includes a Lead Entity (when services are delivered via managed care) and a network of qualified IHH providers. The IHH providers will be qualified and designated by the Lead Entity and IME through a provider agreement.
The majority of Medicaid members are served through the Iowa HealthLink. Each of the Health Homes serving both Fee-For-Service and managed care enrollees receive the support of the Lead Entity.

## Supports for Health Homes Providers

**Describe the methods by which the state will support providers of Health Homes services in addressing the following components**

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

**Description**

The State will support Health Homes to:
- Provide quality driven, cost effective, culturally appropriate, and person and family-centered Health Home services,
- Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines,
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,
- Coordinate and provide access to mental health and substance abuse services,
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,
- Coordinate and provide access to long-term care supports and services,
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services:
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:
- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Program design aligns provider standards and a payment method that ensures that the Health Home Providers have a clear understanding of the expectations and that there is an appropriate reimbursement structure to ensure sustainability for the providers.

The state expects providers to grow into the role of a successful Health Home and has built-in requirements that the Lead Entity both train and facilitate best practices among the network of IHH providers.

The State facilitates a Health Home Focus Group comprised of IME, MCO, Health Home personnel and interested stakeholder associations, to ensure training, communication and alignment on key policy and operational issues.

The State facilitates a Learning Collaborative where Lead Entities will assist IHHs to meet the Provider Standards and to participate in quality improvement activities designed to improve outcomes for the members. The Learning Collaborative consists of:
- Monthly collaborative webinar
- Bi-annual face-to-face training
- Individual provider technical assistance that can be provided by telephone or on site
- Quarterly newsletter
- IME Health Home Webpages
- Process improvement for the Health Homes

The State will develop a program manual to provide clear guidance and expectations to both Lead Entities and Health Homes.

The Lead Entity is expected to build capacity among the IHH providers by meeting the following requirements:
- Identification of providers who meet the standards of participation as an Integrated Health Home
- Assessment of the IHH and medical health provider capacity to provide integrated care
- Educate, train and support IHH providers to deliver integrated care
- Provide oversight and technical support for IHH providers to coordinate with primary medical care providers participating in the Iowa Medicaid program
- Provide infrastructure and tools to IHH providers and primary medical care providers to facilitate member care coordination
- Provide tools for IHH providers to assess and customize care management based on the physical/behavioral health risk level of recipient
- Perform data analytics on personal, medical and pharmacy data to identify patterns of care, as well as track, and close gaps in care
- Provide outcome measurement tools and protocols to assess IHH performance
- Provide clinical guidelines and other decision support tools
- Serve as the repository for member data including claims, laboratory, and Continuing Care Document (CCD) data whenever possible
- Support providers to share data including CCD or other data from electronic medical records (EMR)
- Develop and offer learning activities which will support providers of Integrated Health Home services

## Other Health Homes Provider Standards

**The state's requirements and expectations for Health Homes providers are as follows**

Lead Entity Standards:
- Meet the Provider Qualifications and Standards of a Lead Entity described in this State Plan.
- Have the following roles to support the Health Homes
  Psychiatrist
  Physician
  Nurse Care Manager
  Care Coordinators
- Have capacity to evaluate and select Integrated Health Home providers, including:
  Identification of providers who meet the standards of participation to form an Integrated Health Home;
  Assessment of the Integrated Health Home and medical health provider's capacity to coordinate integrated care
  Educate and support providers to coordinate integrated care
  Provide oversight, training, and technical support for Integrated Health Home providers to coordinate integrated care
  Provide infrastructure and tools to Integrated Health Home providers and primary care physical providers for coordination
- Have capacity to provide clinical and care coordination support to Integrated Health Home providers, including:
  Confirmation of screening and identification of members eligible for Integrated Health Home Services
  Provide oversight and support of Integrated Health Home providers to develop care plans and identify care management interventions for Integrated Health Home enrollees
  Providing or contracting for care coordination, including face-to-face meetings, as necessary to ensure implementation of care plan and appropriate receipt of services
  Gathering and sharing member-level information regarding health care utilization, gaps in care, and medications
  Monitor and intervene for Integrated Health Home members who are high need with complex treatment plans
  Facilitate shared treatment planning meetings for members with complex situations
- Have capacity to develop provider information technology infrastructure and provide program tools, including:
  Providing tools for Integrated Health Home providers to assess and customize care management based on the physical behavioral health risk level of recipient
  Performing data analytics on personal, medical and pharmacy data to identify patterns of care, as well as track, and close gaps in care
  Providing outcomes tools and measurement protocols to assess Integrated Health Home concept effectiveness
  Providing clinical guidelines and other decision support tools
  Repository for member data including claims, laboratory, and Continuing Care Document (CCD) data whenever possible; and
  Support providers to share data including CCD or other data from electronic medical records (EMR).
- Have capacity to develop and offer learning activities which will support providers of Integrated Health Home services in addressing the following areas:
  Providing quality driven, cost effective, culturally appropriate, and person and family driven Health Home Services
  High quality health care services informed by evidence-based clinical practice guidelines
  Preventive and health promotion services, including prevention of mental illness and substance use disorders
  Comprehensive care management, care coordination, and transitional care across settings (transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care)
  Chronic disease management, including self-management support to members and their families
  Demonstrating a capacity to use health information technology to link services, facilitate communication among team members and between the Health Home Team and individual and family care givers, and provide feedback to practices, as feasible and appropriate
  Establishing a continuous quality improvement program, and collecting and reporting on data that permits an evaluation of increased coordination of care and chronic disease management on individual level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

IHH Provider Standards:
- Meet the Provider Qualifications and Standards of an IHH Provider described in this State Plan.
- Provider must be able to provide community-based mental health services to the target population
  Meet the following staff requirements if serving adults:
  Adult IHH Nurse Care Manager
  Care Coordinator
  Trained Peer Support Specialist
  Meet the following staff requirements if serving children:
  Child IHH Nurse Care Manager
  Care Coordinator
  Family Peer Support Specialist
- Integrated Health Home Provider will have demonstrated capacity to address the following components, as outlined in SMDL 10-024.
  Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services
  Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines
  Coordinate and provide access to preventive and health promotion services
  Coordinate and provide access to mental health and substance abuse services
  Coordinate and provide access to comprehensive care management, care coordination, and transitional care and medication reconciliation across settings. Transitional care includes appropriate follow-up from inpatient care PMIC group care to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care

Coordinate and provide access to chronic disease management, including self-management support to individuals and their families

Coordinate and provide access to individual and family supports, including education and referral to community, social support, and recovery and resiliency services

Coordinate and provide access to long-term care supports and services

Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services, in collaboration with the lead entity or IME

Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate

Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

- Recognition or Certification

Adhere to all federal and state rules and regulations applicable to the Health Home Program including any Recognition and Certification requirements.

- Ensure a personal provider for each member

Ensure each member has an ongoing relationship with a personal provider, physician, nurse practitioner, or physician assistant

- Continuity of Care Document (CCD)

Share CCD records with the State and its Lead Entity. A CCD details all important aspects of the member's medical needs, treatment plan, and medication list. The CCD shall be updated and maintained by the IHH

- Whole Person Orientation

Provide or take responsibility for appropriately arranging care with other qualified professionals for all the member's health care needs. This includes care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care

Complete status reports to document member's housing, legal, employment status, education, custody, etc.

Implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs

Work with the Lead Entity or IME to develop capacity to receive members redirected from emergency departments, engage in planning transitions in care with area hospitals, and to follow-up on hospital discharges, including Psychiatric Medical Institutions for Children (PMIC)

Have evidence of bi-directional and integrated primary care behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the State

Provide letters of support from at least one area hospital and two area primary care practices that agree to collaborate with the IHH on care coordination and hospital ER notification

Advocate in the community on behalf of their IHH members as needed

- Coordinated Integrated Care

The Nurse Care Manager or Care Coordinator is responsible for assisting members with medication adherence, appointments, and referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support or lifestyle modification, and behavior changes

Utilize member level information, member profiles, and care coordination plans for high risk individuals

Incorporate tools and evidenced-based guidelines designed for identifying care opportunities across the age and diagnostic continuum, integrating clinical practices, and coordinating care with other providers

Conduct interventions as indicated based on the member's level of risk

Communicate with the member and authorized family and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.

Monitor, arrange, and evaluate appropriate evidence-based and evidence-informed preventive services

Coordinate or provide access to:

Mental healthcare

Oral health

Long-term care

Chronic disease management.

Recovery services and social health services available in the community

Behavior modification interventions aimed at supporting health management (including, but not limited to, obesity counseling, tobacco cessation, and health coaching)

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Crisis services

Assess social, educational, housing, transportation, and vocational needs that may contribute to disease and present as barriers to self-management

Coordinate with Community-based Case Managers (CBCM), Case Manager and Service Coordinators for members that receive service coordination activities

Maintain system and written standards and protocols for tracking member referrals

- Enhanced Access

Assurance of enhanced member and member caregiver (in the case of a child) access, including coverage 24 hours per day, 7 days per week

Use of email, text messaging, patient portals and other technology to communicate with members is encouraged

- Emphasis on Quality and Safety

An ongoing quality improvement plan to address gaps and opportunities for improvement

Participate in ongoing process improvement on clinical indicators and overall cost effectiveness specified by and reported to the State

Demonstrate continuing development of fundamental Health Home functionality through an assessment process to be applied by the State.

Have strong, engaged organizational leadership whom are personally committed to and capable of:

Leading the practice through the transformation process and sustaining transformed practice

Agreeing to participate in learning activities including in person sessions, webinars, and regularly scheduled phone calls

Agree to participate in or convene ad hoc or scheduled meetings to plan and discuss implementation of goals and objectives for practice transformation with ongoing consideration of the unique practice needs for adult members with SMI and child members with SED and their families

Participate in CMS and State required evaluation activities

Submit reports as required by the State (e.g., describe IHH activities, efforts and progress in implementing IHH services)

Maintain compliance with all of the terms and conditions as an IHH provider

Commit to the use of an interoperable patient registry and certified Electronic Health Record (EHR) within a timeline approved by the Lead Entity or IME, to input information such as annual metabolic screening results, and clinical information to track and measure care of members, automate care reminders, and produce exception reports for care planning

Complete web-based member enrollment, disenrollment, members' consent to release to information, and health risk questionnaires for all members

Demonstrate use of a certified EHR to support clinical decision making within the practice workflow.

Demonstrate evidence of acquisition, installation, and adoption of an EHR system and establish a plan to meaningfully use health information in accordance with the federal law

Implement state required disease management programs based on population-specific disease burdens. Individual Health Homes may choose to identify and operate additional disease management programs at any time

| Name | Date Created | |
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| Name | Date Created | |
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| No items available | | |

# Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | IA2020MS0003O | IA-20-0011 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

## Package Header

**Package ID** IA2020MS0003O
**SPA ID** IA-20-0011
**Submission Type** Official
**Initial Submission Date** 9/16/2020
**Approval Date** 12/4/2020
**Effective Date** 7/1/2020
**Superseded SPA ID** IA-16-0013-X
User-Entered

**Identify the service delivery system(s) that will be used for individuals receiving Health Homes services**

- [x] Fee for Service
- [ ] PCCM
- [x] Risk Based Managed Care

**The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals**

- (•) Yes
- ( ) No

**Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services**

Health Plan Contract Language:
3.2.9 Health Homes: The Contractor shall administer and fund the State's Health Home services, or like functions, within the approved State Plan Amendment. If the Contractor chooses to meet the State Plan Amendment criteria related to the functions that provide comprehensive care coordination in a manner other than use of Health Home provider types, this shall be communicated to the Agency and shall be subject to periodic monitoring to ensure all functions are met. In accordance with federal requirements, the Contractor shall ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) HCBS waivers, other forms of community-based case management, or value-based purchasing arrangements. If supplemental services are required to ensure quality of Health Home services to members, the cost of such supplemental services provided to ensure quality may be deducted from Health Home payments.

6.3.6 Health Homes: The Contractor shall develop a network of Integrated Health Homes and Health Homes. The Contractor shall develop strategies to encourage additional participation, particularly in areas of the State where participation has been low. In developing the Integrated Health Homes and Health Homes networks, the Contractor shall ensure all providers meet the minimum requirements for participation as defined in the State Plan and the Agency policy. Refer to Section 3.2.9 for additional detail on all health home requirements.
9.1.1 Comprehensive Health Risk Assessment: The initial health screening described in Section 9.1.1 shall be followed by a comprehensive health risk assessment by a health care professional when a member is identified in the initial screening process as having a special health care need, or when there is a need to follow-up on problem areas identified in the initial screening. The comprehensive health risk assessment shall include an assessment of a member's need for assignment to a health home.
The Lead Entities are contractually required to conduct the following IHH tasks:

- Identify providers who meet the standards of participation as an IHH
- Assess the IHH and physical health provider capacity to provide integrated care
- Educate and support providers to deliver integrated care
- Provide oversight and technical support for IHH providers to coordinate with primary care physical providers
- Provide infrastructure and tools to IHH providers and primary care physical providers for coordination
- Provide tools for IHH providers to assess and customize care coordination based on the physical/behavioral health risk level of the member
- Perform data analytics on personal, medical and pharmacy data to identify patterns of care, as well as track, and close gaps in care member level and program wide
- Provide outcomes tools and measurement protocols to assess IHH concept effectiveness
- Provide clinical guidelines and other decision support tools

- Provide a repository for member data including claims, laboratory and CCD data whenever possible
- Support providers to share data including CCD or other data from electronic medical records
- Develop and offer learning activities which will support providers of Health Homes services
- Provider reimbursement
- Offer Performance Measures Program which may include incentives
- Identify and enroll members to Health Homes.

The Lead Entity shall ensure that the Health Homes are using all tools and analytics to develop and implement strategies to effectively coordinate the care of each member across systems.
Additionally, the Lead Entity is required to provide clinical and care coordination support to the Health Homes.

☑ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

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| No items available | | |

**The State intends to include the Health Home payments in the Health Plan capitation rate**

◉ Yes

○ No

**Assurances**

☑ The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:

- Any program changes based on the inclusion of Health Homes services in the health plan benefits
- Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
- Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
- Any risk adjustments made by plan that may be different than overall risk adjustments
- How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

☑ The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services

☑ The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

☐ Other Service Delivery System

# Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | IA2020MS0003O | IA-20-0011 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

## Package Header

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|---|---|---|---|
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| **Superseded SPA ID** | IA-16-0013-X | | |
| | User-Entered | | |

## Payment Methodology

**The State's Health Homes payment methodology will contain the following features**

☑ Fee for Service

☐ Individual Rates Per Service

☑ Per Member, Per Month Rates

☑ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☑ Other

**Describe below**

The rate is developed according to the actual cost of providing each component of the service for the adult population with and without intensive care management and the child population with and without intensive care management service.

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

**Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided**

Health Home Services, as described in the six service definitions applies to all members enrolled in a Health Home.
Minimum Criteria:
• The member meets the eligibility requirements for health home enrollment as identified in this SPA and documented in the members electronic health record (EHR).
• Member's eligibility requirements verified within the last 12 months. The member has full Medicaid benefits at the time the PMPM payment is made.
• The member has enrolled with the IHH provider.
• The Health Home Provider is in good standing with IME and is operating in adherence with all Health Home Provider Standards.
• The minimum service required to merit a PMPM payment is that the person has received care management monitoring for treatment gaps defined as Health Home Services in this State Plan. The Health Home must document Health Home Services that were provided for the member.
Minimum Criteria for ICM (Intensive Care Management (ICM) members that are enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver. Case managers shall make contacts with the member, the member's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements: in accordance with 441 Iowa Administrative Code Chapter 90.

Claims analysis identified a total count of eligible Health Home Members. Using industry standards for staffing, clinical staffing ratios were determined. The development of the PMPM considers the market place value of professional staff to provide the six health home services.

The IHH is eligible to be reimbursed according to the member's tier for any month in which any of the six core services has been provided. Adults and children shall be grouped into four tiers. Tier 5 is an adult that qualifies for an IHH but without approved HCBS Habilitation Services. Tier 6 is a child that qualifies for an IHH but without approved HCBS Children's Mental Health Waiver (CMHW). Tier 7 is a member with approved HCBS Habilitation Services. Tier 8 is a child with approved for the HCBS CMHW. The payment rate may vary between adult and child and with or without the intensive care management (ICM).

The rate is developed according to the actual cost of providing each component of the service for the adult population with and without intensive care management and the child population with and without intensive care management service. No other payments for these services shall be made.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Health Home services. The agency's fee schedule rate was set as of November, 2015 and is effective for services provided on or after that date. All rates are published at https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

For dates of service on or after January 1, 2021, the Agency fee schedule rates will be updated and posted at https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

The Health Home will bill a 99490 with the appropriate modifier to identify the tier with the informational codes on subsequent line items to attest to Health Home Services Provided.

Procedure Code Health Home PMPM 99490
Tier Modifier
5 (Adult) TF
6 (Child) TG
7 (HAB ICM) U1
8 (CMH ICM) U2
Informational Only Codes
Health Home Service Code
Comprehensive Care Management G0506
Care Coordination G9008
Health Promotion G2058
Comprehensive Transitional Care G2065
Individual &Family Support Services H0038
Referral to Community and Social Support Services S0281

- [ ] PCCM (description included in Service Delivery section)
- [x] Risk Based Managed Care (description included in Service Delivery section)
- [ ] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

# Health Homes Payment Methodologies



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| | | | |
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## Agency Rates

**Describe the rates used**

- (•) FFS Rates included in plan
- ( ) Comprehensive methodology included in plan
- ( ) The agency rates are set as of the following date and are effective for services provided on or after that date

# Health Homes Payment Methodologies



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|---|---|---|---|
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## Rate Development

**Provide a comprehensive description in the SPA of the manner in which rates were set**

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

**Comprehensive Description**

1) The rate is developed according to the actual cost of providing each component of the service for the adult population with and without intensive care management and the child population with and without intensive care management service. No other payments for these services shall be made.
Salaries are pulled from Iowa Wage Report data (https://www.iowaworkforcedevelopment.gov/iowa-wage-report) using applicable codes for each individual role.
Costs were allocated based on caseloads and enrollment, with budget neutrality

2) Tier 5 Adults
Tier 6 Children
Tier 7 Habilitation
Tier 8 Children' Mental Health Waiver

3) The minimum service is that the Provider document one of the six Health Home Services.

4) All Health Home Services must be documented in the member record and identified with a specific code on the claim.

5) The rates will be reviewed on an annual basis using the same methodology described in this section.

# Health Homes Payment Methodologies

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## Assurances

☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

**Describe below how non-duplication of payment will be achieved**

To avoid duplication of services, members who are enrolled in the 1915i Habilitation program and concurrently enrolled in a 1915c waiver program, will receive their coordination of services through the Community-Based Case Manager. Members may choose to be enrolled with the Integrated Health Home at a tier 5 or 6. The CBCM and Integrated Health Home will work together to ensure non-duplication of services. Additionally, Lead Entities are contractually required to ensure non-duplication of payment for similar services. The State reviews and approves Lead Entity non-duplication strategies and conducts ongoing monitoring to assure continued compliance.

If the individual is already enrolled in a Health Home for members with chronic conditions, the member must choose between the Chronic Condition Health Home (CCHH) and the IHH. A member cannot be in more than one Health Home at the same time. Members in the IHH will have state plan services coordinated through the Integrated Health Home Provider. If a member receives case management through a waiver to the State Plan and also qualifies for the Integrated Health Home, the Health Home must collaborate with the Community-Based Case Manager (CBCM), and Service Coordinators to ensure the care plan is complete and not duplicative between the two entities at a minimum of at least quarterly.

☑ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☑ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☑ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

## Optional Supporting Material Upload

| Name | Date Created | |
|---|---|---|
| IHH PMPM_Billing_Guidance | 11/20/2020 1:07 PM EST | |

# Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | IA2020MS0003O | IA-20-0011 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

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| | User-Entered | | |

## Service Definitions

**Provide the state's definitions of the following Health Homes services and the specific activities performed under each service**

### Comprehensive Care Management

**Definition**

Comprehensive care management is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty healthcare, and community support services, using comprehensive person-centered care plan that addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

Service Definition:

- Outreach and engagement activities to members to gather information and engage in comprehensive care management
- Assessment of the member's current and historical information provided by the member, the Lead Entity, and other health care providers that supports the member
- Assessment includes a physical and behavioral assessment, medication reconciliation, functional limitations, appropriate screenings, completed by a licensed health care professional within 30 days of enrolling
- Assess the member's social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors
- Assessing member's readiness for self-management using screenings and assessments with standardized tools
- Assess the member's physical and social environment ensuring that the plan of care incorporates areas of needs, strengths, preferences, and risk factors
- Assessment is conducted at least every 12 months or more frequently as needed when the member's needs or circumstances change significantly or at the request of the member or member's support
- Creation of a person-centered care plans by a licensed health care professional with the member and individuals chosen by the member that address the needs of the whole person with input from the interdisciplinary team and other key providers
- Organize, authorize and administer joint treatment planning with local providers, members, families and other social supports to address total health needs of members
- Wraparound planning process: identification, development and implementation of strengths-based individualized person-centered care plans addressing the needs of the whole child and family
- At least monthly reporting of member gaps in care and predicted risks based on medical and behavioral claims data matched to Standard of Care Guidelines
- Information technology functionality developed to allow online receipt of standardized Continuity of Care Document (CCD).
- Continuous claims-based monitoring of care to ensure evidence-based guidelines are being addressed with members /families
- Serve as communication hub facilitating the timely sharing of information across providers 24 hours/day, 7 days/week
- Serve as active team member, monitoring and intervening on progress of member treatment goals using holistic clinical expertise
- Assignment of team roles and responsibilities

**Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

The Lead Entity will provide technology support for comprehensive care management. MCO technology support functions are reviewed and approved by the State. Examples of technology support functions which may be employed by Lead Entities, subject to State review and approval include, but are not limited to the following:

- A secure portal with program and member level information
- An enrollment feature with status and authorization release forms
- Predictive modeling and reporting tool to identify the population at risk including risks for hospital admission, gaps in care, and other claims based data
- Assessment-driven whole person member profile development provided to inform local IHH provider
- Administration of online provider tools, including Health and Wellness Questionnaire to assess initial risk level, and Care Coordination Plan
- Member profile summarizing key information about the members medications, healthcare services, recent claims, and gaps in care
- Ability to exchange and display continuity of care documents sourced from providers' electronic health records to facilitate timely sharing of clinical information among treating providers
- A data warehouse for ongoing monitoring and analysis of program activity, provider engagement, and outcomes
- Regular report distribution to the local IHH Provider teams
- A member website

**Scope of service**

**The service can be provided by the following provider types**

☑ Behavioral Health Professionals or Specialists

**Description**

MD DO (including Psychiatrist) from the Lead Entity

☐ Nurse Practitioner

☑ Nurse Care Coordinators

**Description**

Nurse Care Managers from the Lead Entity or the IHH providers.

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

| Provider Type | Description |
|---|---|
| Lead Entity or IHH | • Nurse Care Managers from the IHH will be responsible for the oversight of this service<br>• Care Coordinators may assist the Nurse Care Manager in the delivery of this service<br>• Peer Support Specialist or Family Support Specialist may assist with the development of and contribute information to support the Comprehensive Assessment and Person-Centered Care Plan<br>• Lead Entity<br>Participate in joint treatment planning with local providers, members, families and other social supports to address total health needs of members as needed |

## Care Coordination

**Definition**

Care Coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, and transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. Coordinate, direct, and ensure results are communicated back to the IHH.

Definition

- Implementation of a Person-Centered Care Plan
- Outreach activities to members to engage in care coordination
- Continuous monitoring of progress towards goals identified in the person-centered care plan though face-to-face and collateral contacts with member, member's supports, primary care, and specialty care
- Scheduling appointments
- Making referrals
- Tracking referrals and appointments
- Follow-up monitoring
- Communicating with providers on interventions/goals
- Conducting joint treatment staffing: meeting with multidisciplinary treatment team and member/parent/guardian to plan for treatment and coordination
- Support coordination of care with primary care providers and specialists
- Addressing barriers to treatment plan
- Coordinate multiple systems for children with SED as part of a child and family-driven team process
- Appropriately arrange care with other qualified professionals for all the member's health care needs. This includes care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care

When the member receives care coordination from a Community-Based Case Manager as a Home and Community-Based Waiver Service or Service Coordination through the MCO, the Health Home must collaborate with Community-Based Case Manager or Service Coordinator to ensure the care plan is complete and not duplicative between the two entities.

**Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

The Lead Entity will provide a secure portal to assist the IHH to coordinate care.
The establishment of an EHR system will assist care coordinators with maintaining a comprehensive medication list, allow providers access to evidenced-based decisions and assist with referral protocols.
Health IT can assist care coordinators providing and disseminating wellness education, informative tracks, and resources that supports lifestyle modification and behavior changes.

**Scope of service**

**The service can be provided by the following provider types**

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators

**Description**

Known as Nurse Care Managers from either the IHH or Lead Entity

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [x] Social Workers

**Description**

Known as Care Coordinators at the IHH or the Lead Entity

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

| Provider Type | Description |
|---|---|
| Lead Entity or IHH Providers, Peer Support Specialist or Family Support Specialist | • Nurse Care Managers will be responsible for the oversight of this service.<br>• Care Coordinators may assist the Nurse Care Manager with the delivery of this service<br>• Other<br>Peer Support Specialist or Family Support Specialist may assist with the following Care Coordination services<br>Outreach, follow-up monitoring, assist the member to schedule appointments, attending joint staffing treatment meetings, support coordination of care with providers and specialist<br>The Lead Entity assists the IHH in performing care coordination. MD/DO and Psychiatrists at the Lead Entity may also support Care Coordination activities by attending joint treatment meetings and provide consultation as needed |

## Health Promotion

**Definition**

Health Promotion means the education and engagement of an individual in making decisions that promotes health management, improved disease outcomes, disease prevention, safety and an overall healthy lifestyle.

Definition:

- Promoting members' health and ensuring that all personal health goals are included in person-centered care management plans
- Promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction, and increased physical activity
- Providing health education to members and family members about preventing and managing chronic conditions using evidence-based sources
- Provide prevention education to members and family members about health screening, childhood developmental assessments and immunization standards
- Providing self-management support and development of self-management plans and/or relapse prevention plans so that members can attain personal health goals
- Using motivational interviewing, trauma-informed care, and other evidenced based practices to engage and help the member in participating and managing their own care
- Promoting self-direction and skill development in the area of independent administering of medication and medication adherence
- Provide prevention education to members and family members about health screening, childhood developmental assessments and immunization standards
- Increasing health literacy and self-management skills (i.e. WRAP)
- Education or training in self-management of chronic diseases

**Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

The patient-centered care plan will be used to plan, communicate and document individualized goals, interventions, and track status. Continuity of Care Documents will be useful in tracking treatment progress and coordination with providers.

**Scope of service**

**The service can be provided by the following provider types**

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators

**Description**

Nurse Care Managers from the Lead Entity or the IHH providers.

- [ ] Nurses
- [ ] Medical Specialists

- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [x] Social Workers

**Description**

Known as Care Coordinators at the IHH or the Lead Entity

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

| Provider Type | Description |
|---|---|
| Lead Entity or IHH Providers, Peer Support Specialist or Family Support Specialist | • Nurse Care Coordinators known as Nurse Care Managers<br>• Social Workers known as Care Coordinators<br>• Other<br>Lead Entity<br>Peer Support Specialist or Family Support Specialist |

### Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

**Definition**

Comprehensive transitional care is the facilitation of services for the individual and supports when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community based group home, family, or self-care, another Health Home).

Definition:

- Engage member and/or caregiver as an alternative to emergency room or hospital care
- Facilitate development of crisis plans
- Monitor for potential crisis escalation/need for intervention
- Follow-up phone calls and face-to-face visits with members/families after discharge from the emergency room or hospital
- Identification and linkage to long-term care and home and community-based services
- Develop relationships with hospitals and other institutions and community providers to ensure efficient and effective care transitions
- Provide prompt notification of member's admission/ discharge to and from an emergency department, inpatient residential, rehabilitative or other treatment settings to the member's medical care physician and community support providers with the intent of coordinating care
- Active participation in discharge planning to ensure consistency in meeting the goals of the member's person-centered plan
- Communicating with and providing education to the provider where the member is currently being served and the location where the member is transitioning
- Ensure the following:
  - Receipt of a CCD from the discharging entity
  - Medication reconciliation
  - Reevaluation of the care plan to include and provide access to needed community supports that includes short-term and long term care coordination needs resulting from the transition
  - Plan to ensure timely scheduled appointments
- Facilitate transfer from a pediatric to an adult system of health care
- The Team of Health Care Professionals shall establish personal contact with the member regarding all needed follow-up after the transition.

**Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

The Lead Entity will provide electronic and telephonic notifications of hospitalizations 24/7.
Care coordination plans and member profiles (including a medication list) are available via the Lead Entity secure portal to support all IHH team members and providers in transitional care management, medication reconciliation, and follow-up care.

**Scope of service**

**The service can be provided by the following provider types**

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators

**Description**

Nurse Care Managers from the IHH or Lead Entity.

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists

☑ Social Workers

**Description**

Known as Care Coordinators from the IHH or Lead Entity

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

| Provider Type | Description |
|---|---|
| Lead Entity, IHH, Peer Support Specialist, or Family Support Specialist | • Nurse Care Managers will be responsible for the oversight of this service.<br>• Care Coordinators can assist the Nurse Care Manager with the delivery of this service<br>• Other<br>Peer support specialist may assist with this service through peer lead programs service activities include, but are not limited to:<br>Engage member and/or caregiver as an alternative to emergency room or hospital care<br>Participate in development of crisis plans<br>Monitor for potential crisis escalation/need for intervention<br>Follow-up phone calls and face-to-face visits with members/families after discharge from the emergency room or hospital<br>The Lead Entity MD/DO and Psychiatrists at the Lead Entity may also support transitional activities by providing consultation as needed and participating in development of crisis plans. |

## Individual and Family Support (which includes authorized representatives)

**Definition**

Individual and Family Support Services include communication with patient, family and caregivers to maintain and promote the quality of life with particular focus on community living options. Support will be provided in culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.

Definition:
Individual and Family Support Services include communication with member, family and caregivers to maintain and promote the quality of life with particular focus on community living options. Support will be provided in culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.

Definition:

- Providing assistance to members in accessing needed self-help and peer/family support services
- Advocacy for members and families
- Education regarding concerns applicable to the member
- Education or training in self-management of chronic diseases
- Family support services for members and their families
- Assisting members to identify and develop social support networks
- Assistance with medication and treatment management and adherence
- Identifying community resources that will help members and their families reduce barriers to their highest level of health and success
- Linkage and support for community resources, insurance assistance, waiver services
- Connection to peer advocacy groups, family support networks, wellness centers, NAMI and family Psychoeducational programs
- Assisting members in meeting their goals

When the member receives care coordination from a Community-Based Case Management as a Home and Community-Based Waiver Service or Service Coordinator, the Health Home must collaborate with Community-Based Case Management as a Home and Community-Based Waiver Service and Service Coordinators to ensure the care plan is complete and not duplicative between the two entities.

**Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

An IHH member website is available to all IHH enrollees, potential enrollees, their families and supports. The member website contains evidence-based health information about medical and behavioral conditions, medications, and treatment options as well as resources and links for national and local support programs and resources.

**Scope of service**

**The service can be provided by the following provider types**

☐ Behavioral Health Professionals or Specialists

☐ Nurse Practitioner

☑ Nurse Care Coordinators

**Description**

Nurse Care Managers from the IHH or Lead Entity

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [x] Social Workers

**Description**

Known as Care Coordinators from the IHH or Lead Entity

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

| Provider Type | Description |
|---|---|
| IHH, Lead Entity, Peer Support Specialist or Family Support Specialist | • Nurse Case Managers or Care Coordinators at the IHH will be responsible for the oversight of this service and must be noted in the person-centered care plan.<br>• The Lead Entity assists the IHH in performing individual and family support.<br>• Peer Support or Family Peer Support Specialist, may assist with the following individual and Family support services:<br>Providing assistance to members in accessing needed self-help and peer/family peer support services<br>Advocacy for members and families<br>Family support services for members and their families<br>Assisting members to identify and develop social support networks<br>Support medication adherence efforts<br>Identifying community resources that will help members and their families reduce barriers to their highest level of health and success<br>Linkage and support for community resources, insurance assistance, waiver services<br>Connection to peer advocacy groups, family support networks, wellness centers, NAMI and family psycho educational programs |

## Referral to Community and Social Support Services

**Definition**

Referral to Community and Social Support Services includes coordinating or providing recovery services and social health services available in the community, such as understanding eligibility for various healthcare programs, disability benefits, and identifying housing programs.

Definition:

Provide resource referrals or coordinate to the following, as needed:
- Resources to reduce barriers to assist members in achieving their highest level of function with independence
- Primary care providers and specialists
- Wellness programs, including tobacco cessation, fitness, nutrition or weight management programs, and exercise facilities or classes
- Specialized support groups (i.e. cancer or diabetes support groups, NAMI psychoeducation)
- School supports
- Substance treatment links in addition to treatment -- supporting recovery with links to support groups, recovery coaches, and 12-step programs
- Iowa Department of Public Health (IDPH) Programs
- Housing services Housing and Urban Development (HUD), rental assistance program through the Iowa Finance authority
- Food Assistance Iowa Department of Human Services (DHS), Food Bank of Iowa
- Transportation services(NEMT), free or low cost public transportation
- Programs that assist members in their social integration and social skill building
- Faith-based organizations
- Employment and educational programs or training Iowa Workforce Development (IWD), Iowa Vocational Rehab Services (IVRS),
- Volunteer opportunities
- Monitor and follow-up with referral source, member and member's support to ensure that members are engaged with the service.

When the member receives care coordination from a Community-Based Case Manager as a Home and Community-Based Waiver Service or Service Coordination through the MCO, the Health Home must collaborate with Community-Based Case Manager or Service Coordinator to ensure the care plan is complete and not duplicative between the two entities.

**Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

The person-centered care plan will be used to plan and manage referrals for community and social support services. Evidence-based care guidelines are also provided for use by Health Home teams and providers.

The IHH member website is available to all IHH enrollees, their families and supports as well as providers and Health Home teams. It contains links for information about community and national support services and resources.

**Scope of service**

**The service can be provided by the following provider types**

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators

**Description**

Nurse Care Managers from the IHH or Lead Entity

- [ ] Nurses
- [ ] Medical Specialists
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**Description**

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- [ ] Doctors of Chiropractic
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- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

| Provider Type | Description |
|---|---|
| IHH, Lead Entity, Peer Support Specialist or Family Support Specialist | • Nurse Case Managers or Care Coordinators at the IHH will be responsible for the delivery of this service and must be noted in the person-centered care plan.<br>• Other<br>Peer Support Specialist or Family Support Specialist<br>Support the member to participate in social supports.<br>The Lead Entity assists the IHH in performing referral to community and social support services. |

# Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | IA2020MS0003O | IA-20-0011 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

## Package Header

**Package ID** IA2020MS0003O

**SPA ID** IA-20-0011

**Submission Type** Official

**Initial Submission Date** 9/16/2020

**Approval Date** 12/4/2020

**Effective Date** 7/1/2020

**Superseded SPA ID** IA-16-0013-X

User-Entered

## Health Homes Patient Flow

**Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter**

see attached SPA and workflow.

| Name | Date Created | |
|---|---|---|
| Integrated Health Homes IA-20-11 | 6/30/2020 6:04 PM EDT | |
| Integrated Health Home Workflow Final | 11/10/2020 10:00 AM EST | |

# Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | IA2020MS0003O | IA-20-0011 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

## Package Header

| | | | |
|---|---|---|---|
| **Package ID** | IA2020MS0003O | **SPA ID** | IA-20-0011 |
| **Submission Type** | Official | **Initial Submission Date** | 9/16/2020 |
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| **Superseded SPA ID** | IA-16-0013-X | | |
| | User-Entered | | |

## Monitoring

**Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates**

The State will utilize Medicaid claims and encounter data to assess the difference in average per-member-per-month (PMPM) expenditures (final paid claim allowed amounts) between enrolled Health Home members and non-enrolled members. Inferential methods utilize a longitudinal case/control cohort quasi-experimental design. Propensity scoring, matching, and/or predictive cost models will be used to identify non-enrolled members (Control cohort) that are similarly matched to enrolled Health Home members (Treatment/Case cohort) in regards to baseline age, gender, predicted expenditures, and multiple chronic/acute condition characteristics. Cohorts are then assessed for differences in expenditure outcomes during a specified evaluation period (annual) via doubly robust multivariate linear regression techniques.

Regression models include the reuse of select matching covariates (age, gender), additional covariates (time, county of residence, long-term service support status), and adjustment for correlated member-specific expenditure measurements over time (adjust for clustering of repeated measures) to yield risk-adjusted estimates of differences in expenditure outcomes. Regression models include an interaction term of time and treatment cohort to evaluate the difference in trends of expenditures between cohorts over time. Sensitivity analyses are conducted to explore the impact on measurements after removal of matched cohort members with high-cost severe/acute conditions and where removal of high-cost leverage/outlier situations may be prudent.
Hospital Admission Rates
The State will consolidate data from Medicaid claims and encounter data and monitor the difference in incidence rates and length of stay between enrolled Health Home Members and like non-enrolled members. (Measure calculations may be impacted by Medicare data availability)

Chronic Disease Management
Clinical data received from providers on Health Home enrollees will provide the best picture for this evaluation.

Coordination of Care for Individuals with Chronic Conditions
Clinical data received from providers on health home enrollees will provide the best picture for this evaluation.

Assessment of Program Implementation
This will consist of a review of the program administrative costs, reported member outcomes, and overall program cost savings and member surveys.
An evaluation that details the process of implementation, as well as the challenges experienced and adaptations that were made during the implementation will be undertaken.

Lead Entity Dashboard
The Lead Entity will have a withhold that can be earned back through meeting identified benchmarks.
Priority Measure
Structure Lead Entity Self-Assessment
Health Home Self-Assessment
Process Health Home Dashboard
A15 Report
CSR Report
Level of Care Report
Outcomes Member Surveys
Performance Measures
CMS Health Home Core Measures
Chart Review Results

Health Home Dashboard
The Health Home will have practice transformation assistance by the Lead Entities based on the Health Home Dashboard.

Priority Measure
Structure Health Home Self-Assessment
Process Health Home Dashboard
Outcomes Member Surveys
Performance Measures
CMS Health Home Core Measures
Chart Review Results

Processes and Lessons Learned
An evaluation that includes provider and member input on the Health Home Program will inform the state on ways to improve the process.
The State Medicaid Agency and the Lead Entity will continue to develop tools to capture feedback from the Health Homes to document and understand any operational barriers to implementing Health Home Services.
As more successful Health Homes are identified via clinical data and claims data, implementation guidelines and suggestions will be documented and trained to further promote success statewide.

Assessment of Quality Improvements and Clinical Outcomes
An evaluation that includes provider and member input on the Health Home Program will inform the state on ways to improv

**Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)**

The Lead Entity will provide technology infrastructure for health information exchange to be utilized by the Health Homes in order to facilitate collaboration. These capabilities include, but are not limited to; member screening and risk stratification, and a web-based profile that integrates Medicaid claims, member self-reported information, and clinical documentation. The Lead Entity will be responsible for sharing health utilization and claims data with the Health Homes to facilitate care coordination and prescription monitoring for members receiving Health Home services. A member website will be available to Health Home enrollees, their families, and supports. It will contain evidence-based information on conditions, health promotion and wellness information, and links to resources.

As a part of the minimum requirements of an eligible provider to operate as a health Home, the following relate to HIT:

- Demonstrate use of a population management tool (patient registry) and the ability to evaluate results and implement interventions that improve outcomes over time.
- Demonstrate evidence of acquisition, instillation and adoption of an EHR, system and establish a plan to meaningfully use health information in accordance with federal law.
- Provide 24/7 access to the care team that includes but is not limited to a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations.
- Utilize email, text, messaging, patient portals and other technology as available to communicate with other providers.

# Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | IA2020MS0003O | IA-20-0011 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

## Package Header

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| **Package ID** | IA2020MS0003O | **SPA ID** | IA-20-0011 |
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| **Superseded SPA ID** | IA-16-0013-X | | |
| | User-Entered | | |

## Quality Measurement and Evaluation

- [x] The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- [x] The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- [x] The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- [x] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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