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State/Territory Name: Iowa

State Plan Amendment (SPA) #: 21-0003

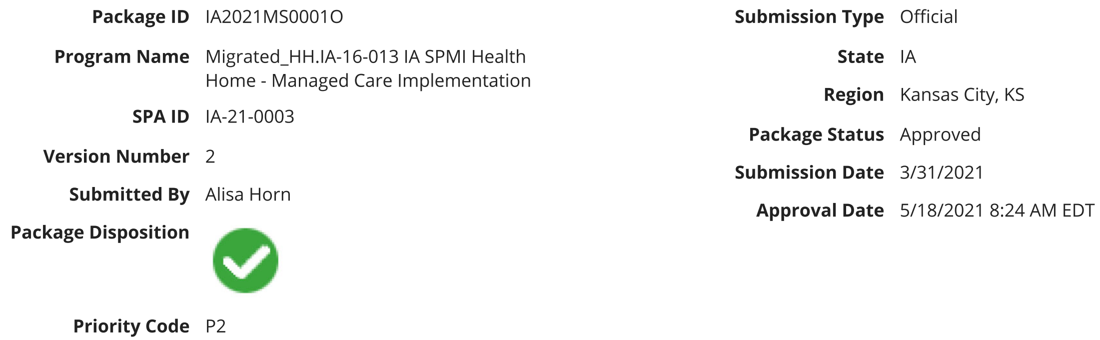
This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

IA - Submission Package - IA2021MS0001O - (IA-21-0003) - Health Homes

CMS-10434 OMB 0938-1188

Package Information



Package ID IA2021MS0001O

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

SPA ID IA-21-0003

Version Number 2

Submitted By Alisa Horn

Package Disposition ✔

Priority Code P2

Submission Type Official

State IA

Region Kansas City, KS

Package Status Approved

Submission Date 3/31/2021

Approval Date 5/18/2021 8:24 AM EDT

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

May 18, 2021

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

Re: Approval of State Plan Amendment IA-21-0003 Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Dear Julie Lovelady,

On March 31, 2021, the Centers for Medicare and Medicaid Services (CMS) received Iowa State Plan Amendment (SPA) IA-21-0003 for Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation to update the billing code for the Health Promotion service, change family peer support requirements to align with the requirements for peer support, and update rates.

We approve Iowa State Plan Amendment (SPA) IA-21-0003 with an effective date(s) of January 01, 2021.

As a reminder, please use the designated category of service Line 43 on the CMS-64 form to report health homes services expenditures for enrollees.

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 | IA2021MS0001O | IA-21-0003 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

Package ID IA2021MS0001O

SPA ID IA-21-0003

Submission Type Official

Initial Submission Date 3/31/2021

Approval Date 5/18/2021

Effective Date N/A

Superseded SPA ID N/A

State Information

State/Territory Name: Iowa

Medicaid Agency Name: Department of Human Services

Submission Component

(selected) State Plan Amendment

(selected) Medicaid

( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0001O | IA-21-0003 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

Package ID IA2021MS0001O

SPA ID IA-21-0003

Submission Type Official

Initial Submission Date 3/31/2021

Approval Date 5/18/2021

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID IA-21-0003

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	1/1/2021	IA-20-0011
Health Homes Providers	1/1/2021	IA-20-0011
Health Homes Payment Methodologies	1/1/2021	IA-20-0011

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0001O | IA-21-0003 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

Package ID	IA2021MS0001O	**SPA ID**	IA-21-0003
Submission Type	Official	**Initial Submission Date**	3/31/2021
Approval Date	5/18/2021	**Effective Date**	N/A
Superseded SPA ID	N/A		

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 Teams of Healthcare Professionals to deliver personalized, coordinated care for individuals meeting program eligibility criteria. In return for the additional Health Home Services to members, the Teams of Healthcare Professionals are 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

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2021	$0
Second	2022	$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 | IA2021MS0001O | IA-21-0003 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

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Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ● Other

Describe Updating the rates

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0001O | IA-21-0003 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

Package ID	IA2021MS0001O	**SPA ID**	IA-21-0003
Submission Type	Official	**Initial Submission Date**	3/31/2021
Approval Date	5/18/2021	**Effective Date**	1/1/2021
Superseded SPA ID	IA-20-0011 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. A Team of Healthcare Professionals 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 Providers

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0001O | IA-21-0003 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

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User-Entered

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: • Be an Iowa accredited Community Mental Health Center or Mental Health Service Provider, or an Iowa licensed residential group care setting • Iowa Licensed Psychiatric Medical Institution for Children (PMIC) facility, or • 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 • 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 • Providers must complete an annual self-assessment and submit to the State at the time of enrollment • Providers must meet requirements throughout the state plan amendment • 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 • Have a statewide integrated network of providers to serve members with SMI/SED • The Lead Entity must complete an annual self-assessment and submit to the State at the time of enrollment • The Lead Entity must meet requirements throughout the state plan amendment • 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. 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.

☐ 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

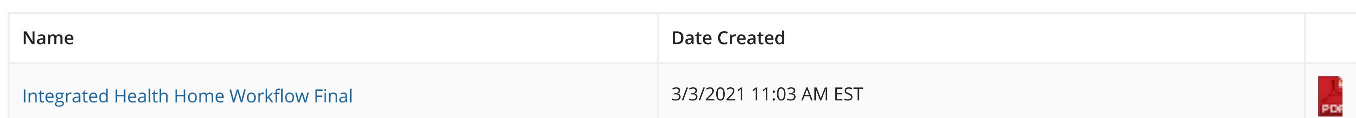
Commit to the use of an interoperable patient registry and certified Electronic Health Record (EHR) within a timeline approved by the Lead Entity or IME, to input information such as annual metabolic screening results, and clinical information to track and measure care of members, automate care reminders, 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	
Integrated Health Home Workflow Final	3/3/2021 11:03 AM EST	

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0001O | IA-21-0003 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

Package ID IA2021MS0001O

SPA ID IA-21-0003

Submission Type Official

Initial Submission Date 3/31/2021

Approval Date 5/18/2021

Effective Date 1/1/2021

Superseded SPA ID IA-20-0011

User-Entered

Payment Methodology

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

- [x] Fee for Service
  - [ ] Individual Rates Per Service
  - [x] Per Member, Per Month Rates
    - [x] 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
      - [x] 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 or Habilitation and 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 July 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 99439
Comprehensive Transitional Care G2065
Individual & Family Support Services H0038
Referral to Community and Social Support Services S0281

☐ PCCM (description included in Service Delivery section)

☑ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Package Header

Package ID	IA2021MS0001O	**SPA ID**	IA-21-0003
Submission Type	Official	**Initial Submission Date**	3/31/2021
Approval Date	5/18/2021	**Effective Date**	1/1/2021
Superseded SPA ID	IA-20-0011 User-Entered		

Agency Rates

Describe the rates used

- (selected) 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

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0001O | IA-21-0003 | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

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Superseded SPA ID	IA-20-0011 User-Entered		

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.

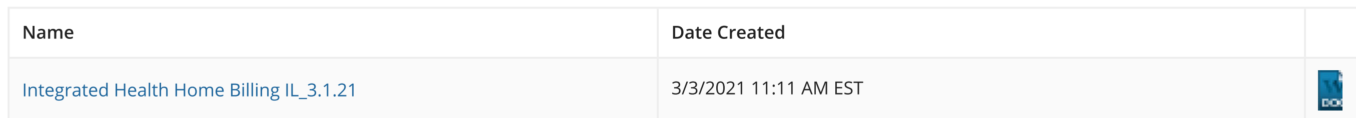
If the individual is already enrolled in a Health Home for members with chronic conditions, the member must choose between the Chronic Condition Health Home (CCHH) and the IHH. A member cannot be in more than one Health Home at the same time. Members in the IHH will have state plan services coordinated 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



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