Iowa Department of Human Services

Iowa Medicaid
Health Home Provider Agreement

This Agreement is between the State of Iowa, Department of Human Services, (the "Department") and the Provider or Group Provider and its members or Practitioner(s) (the "Provider"). The operations management responsibility for the Iowa Medicaid Program is through the Iowa Medicaid Enterprise (the "IME"). This Agreement is supplementary to the usual provider agreement entered into for participation in the Iowa Medical Assistance Program and all provisions of that agreement shall remain in full force and effect, except to the extent superseded by the specific terms of this Iowa Medicaid Health Home Provider agreement.

A Health Home is a specific designation under section 2703 of the Patient Protection and Affordable Care Act. For Iowa Medicaid, the Health Home identifies certain enrolled Medicaid provider organizations that are capable of providing personal, coordinated care for individuals meeting program eligibility criteria. In return for the enhanced care provided, the IME offers monthly care coordination payments and the potential for annual performance based incentives designed to improve patient health outcomes and lower overall Medicaid program costs.

The Department expects providers enrolled in the Medicaid Health Home program to provide additional services to members that will ultimately provide better health outcomes for members with chronic conditions and lower expenditures for Iowa Medicaid Enterprise. Iowa Medicaid Enterprise expects Health Home practices to:

- Have embedded population health management into their workflow and demonstrate the use of data to drive quality improvements.
- Use evidenced-based guidelines to improve quality and consistency among providers.
- Focus on communication and coordination between referring providers to ensure comprehensive patient-centered care.
- Engage members in their own care plans.
- Have an ongoing performance measurement system in place that allows the practice to measure current performance to evidence-based guidelines.
- Identify gaps in care delivered compared to clinical guidelines and deploy interventions designed to increase guideline compliance.

Section 1. Provider Obligations: As a Health Home Practice, Provider Agrees to:

1. At a minimum, practices must fill the following roles:
   a. Designated Practitioner
   b. Dedicated Care Coordinator
   c. Health Coach
   d. Clinic support staff
2. Recognition/Certification

   Adhere to all federal and state laws regarding Health Home recognition/certification.
3. Personal provider for each patient

   Ensure each patient has an ongoing relationship with a personal provider, physician, nurse practitioner or physician assistant who is trained to provide first contact, continuous and comprehensive care, where both the patient and the provider/care team recognize each other as partners in care. This relationship is initiated by the patient choosing the Health Home.

4. Continuity of Care Document (CCD)

   Update a CCD for all eligible patients, detailing all important aspects of the patient's medical needs, treatment plan and medication list. The CCD shall be updated and maintained by the Health Home Provider.

5. Whole Person Orientation

   Provide or take responsibility for appropriately arranging care with other qualified professionals for all the patient'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.

6. Coordinated/Integrated Care

   a. Dedicate a care coordinator, defined as a member of the Health Home Provider, responsible for assisting members with medication adherence, appointments, referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes.

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

   c. Monitor, arrange, and evaluate appropriate evidence-based and/or evidence-informed preventive services.

   d. Coordinate or provide:

      i. Mental health/behavioral health.

      ii. Oral health.

      iii. Long term care.

      iv. Chronic disease management.

      v. Recovery services and social health services available in the community.

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

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

   e. Assess social, educational, housing, transportation, vocational needs that may contribute to disease and/or present as barriers to self management.

   f. Maintain system and written standards/protocols for tracking patient referrals.

7. Emphasis on Quality and Safety

   a. Demonstrate use of clinical decision support within the practice workflow.

   b. Demonstrate evidence of acquisition, installation and adoption of an electronic health record (EHR) system and establish a plan to meaningfully use health information in accordance with the Federal law.

   c. When available, connect to and participate with the Statewide Health Information Network (HIN).

d. Implement or support a formal diabetes disease management program. The disease management program shall include:

   i. The goal to improve health outcomes using evidence-based guidelines and protocols.

   ii. A measure for diabetes clinical outcomes that include timeliness, completion, and results of A1C, LDL, microalbumin, and eye examinations for each patient identified with a diagnosis of diabetes.

   iii. The Department may choose to implement subsequent required disease management programs anytime after the initial year of the Health Home program. Based on population-specific disease burdens, individual Health Homes may choose to identify and operate additional disease management programs at anytime.

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

f. Provide the Department outcomes and process measure reporting annually as defined by and posted to the Departments website: http://www.ime.state.ia.us/Providers/index.html.

8. Enhanced Access

   a. Provide for 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.

   b. Monitor access outcomes such as the average third next available appointment and same day scheduling availability.

   c. Use email, text messaging, patient portals and other technology as available to the practice to communicate with patients.

Section 2. Payment: The Department agrees to pay Provider:

1. In accordance with Iowa Administrative code 441-78.53 and the published fee schedule referenced within the Iowa Administrative code.

2. A patient management payment for Health Home service is paid when:

   a. The member meets the eligibility requirements as identified by the provider and documented in the member's electronic health record (EHR);
   b. The member has full Medicaid benefits at the time the PMPM payment is made;
   c. The member has agreed and enrolled with the designated Health Home Provider;
   d. The Health Home Provider is in good standing with IME and is operating in adherence with all Health Home Provider standards, and;
   e. The minimum service required to merit a patient management PMPM payment has been met which is that the person has received care management monitoring for treatment gaps defined as "Health Home Services" as set forth in Attachment A or any covered service defined in this state plan was provided that was documented in the member's EHR.

Section 3. Targeted Case Management, Case Management and DHS Service Coordination:

Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)"a"(1) or (2) must collaborate, at least quarterly, with targeted case managers, other case managers, or DHS service workers for each member receiving case management services. Strategies to prevent duplication of coordination efforts by the health home and case managers or service workers must be developed by the health home and documented upon request. Documentation may include but is not limited to records of joint staffing meetings where a member's medical needs, current activities, and waiver services needs are reviewed and appropriately updated.

Section 4. Utilization of IMPA:

Practices operating under this agreement as a Health Home provider are required to use the Iowa Medicaid Portal Access for the following functions:

a. Submitting member enrollment/disenrollment requests.
b. Submitting member tier assessments annually.
c. Viewing roster of members whose tier assessment is approaching 12 months.
d. Viewing roster of assigned members.
e. Attesting to providing Health Home services via submitting a PMPM report at least quarterly.

Section 5. Termination:

This Agreement terminates upon the first day of the month following:

1. The termination of the primary Medicaid Provider Agreement (form 470-2965) between the provider organization and the Iowa Medicaid Enterprise.
2. Written notice from the Department providing 30 days' notice, for any reason.
3. Written notice by the Provider providing 60 days' notice, for any reason.

Section 6. Business Associate Agreement:

The Provider, acting as the Agency's Business Associate, performs certain services on behalf of or for the Agency pursuant to this Agreement that require the exchange of information that is protected by the Health Insurance Portability and Accountability Act of 1996, as amended, and the federal regulations published at 45 CFR part 160 and 164. The Provider agrees to comply with the Business Associate Agreement Addendum (BAA), and any amendments thereof, as posted to the Agency's website:

http://www.dhs.state.ia.us/Consumers/Health/HIPAA/Home.html

This BAA, and any amendments thereof, is incorporated into the Health Home Provider Agreement by reference. By signing this Agreement, the Provider consents to receive notice of future amendments to the BAA through electronic mail. The Provider shall file and maintain a current electronic mail address with the Agency for this purpose. The Agency may amend the BAA by posting an updated version of the BAA on the Agency's website at:

http://www.dhs.state.ia.us/Consumers/Health/HIPAA/Home.html

and providing the Provider electronic notice of the amended BAA. The Provider shall be deemed to have accepted the amendment unless the Provider notifies the Agency of its non-acceptance in accordance with the Notice provisions of the Agreement within 30 days of the Agency's notice referenced herein. Any agreed alteration of the then current Agency BAA shall have no force or effect until the agreed alteration is reduced to an Agreement amendment that must be signed by the Provider, Agency Director, and the Agency Security and Privacy Officer.

Service Name	Definition
1. Comprehensive Care Management	Managing the Comprehensive Care for each member enrolled in the Health Home includes at a minimum: • Providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care. • Developing and maintaining a Continuity of Care Document (CCD) for all patients, detailing all important aspects of the patient's medical needs, treatment plan, and medication list. • Implementing a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs. Comprehensive Care Management services are the responsibility of the Designated Practitioner role within the Health Home.
2. Care Coordination	Care Coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. Coordinate and ensure results are communicated back to the Health Home. The use of HIT is the recommended means of facilitating these processes that include the following components of care: • Mental health/ behavioral health • 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 (e.g., obesity counseling, tobacco cessation, health coaching) • Comprehensive transitional care from inpatient to other settings, including appropriate follow-up The Care Coordinator role is responsible for ensuring these services are performed with the assistance of the entire Health Home team.

Service Name	Definition
3. Health Promotion	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. Use of Clinical Decision Support within the practice workflow. Implementation of a formal Diabetes Disease Management Program. Health Promotion services are the responsibility of the Health Coach role and Designated Practitioner role within the Health Home.
4. Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)	Comprehensive Transitional Care from inpatient to other settings includes the services required for ongoing care coordination. For all patient transitions, a Health Home shall ensure the following: • Receipt of updated information through a CCD. • Receipt of information needed to update the patients care plan (could be included in the CCD) that includes short-term transitional care coordination needs and long term care coordination needs resulting from the transition. The Designated Provider shall establish personal contact with the patient regarding all needed follow up after the transition. Comprehensive Transitional Care services are the responsibility of the Dedicated Care Coordinator role and Designated Practitioner role within the Health Home
5. Individual and Family Support Services (including authorized representatives)	Individual and Family Support Services include communication with patient, family and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives. Activities could include but are not limited to: • Advocating for individuals and families. • Assisting with obtaining and adhering to medications and other prescribed treatments. • Increasing health literacy and self management skills. • Assess the member's physical and social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors. Individual and Family Support services are the responsibility of the Health Coach role within the Health Home.
6. Referral to Community and Social Support Services	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 health care programs, disability benefits, and identifying housing programs. Referral to Community and Social Support services are the responsibility of the Dedicated Care Coordinator role within the Health Home.