Iowa Medicaid Integrated Health Home Provider Agreement General Terms

This Agreement is between the state of Iowa, Department of Human Services, (the "Department") and the Provider (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Assistance Program and all provisions of that Agreement shall remain in full force and effect, except to the extent superseded by the specific terms of this Iowa Medicaid Integrated Health Home ("IHH") Provider Agreement.

A Health Home is a specific designation under 42 U.S.C. § 1396w-4. The Iowa IHH identifies certain enrolled Medicaid provider organizations that are capable of providing personal, coordinated care for individuals with a Serious and Persistent Mental Illness (SPMI). For Iowa, only individuals with Serious Mental Illnesses (SMI) or Serious Emotional Disturbance (SED) as defined in 441 Iowa Admin. Code § 78.53(2) may be designated as individuals with SPMI. In return for the enhanced care provided, the IME offers monthly care coordination payments designed to improve patient health outcomes and lower overall Medicaid program costs.

Providers enrolled in the IHH program will provide additional services to members utilizing health information technology (HIT) that will ultimately provide better health outcomes and lower expenditures for qualified members. Those additional services (the six IHH services) are described in detail within the State Plan and are outlined below:

1) Comprehensive Care Management
2) Care Coordination
3) Health Promotion
4) Comprehensive Transitional Care (from inpatient to other setting)
5) Individual and Family Support Services
6) Referral to Social and Community Services

Section 1. Provider Qualifications:

As a Health Home Practice, Provider agrees to:

1. At a minimum, practices must fill the following roles:
    a. Be an Iowa-accredited Community Mental Health Center or Mental Health Service Provider as defined by 441 Iowa Admin. Code, Chapter 24, or a residential group care setting licensed under 441 Iowa Admin. Code, Chapter 114, or Psychiatric Medical Institution for Children (PMIC) facility, or nationally accredited by COA, the Joint Commission, or CARF under the accreditation standards that apply to mental health rehabilitative services.

b. Provider must be able to provide community-based mental health services to the target population.
    i. Adult IHH
    ii. Nurse care manager
    iii. Care coordinator
    iv. Trained peer support specialist as need per population

c. Child IHH
    i. Nurse care manager
    ii. Care coordinator
    iii. Family support specialist positions
    iv. Advocate in the community on behalf of their integrated health home members as needed

d. Have strong, engaged organizational leadership whom are personally committed to and capable of 1) leading the practice through the transformation process and sustaining transformed practice processes as demonstrated through the application process, and 2) agreeing to participate in learning activities including in-person sessions and regularly scheduled phone calls.

e. Meet the state's minimum access requirements as follows: assurance of enhanced member and member caretaker (in the case of a child) access, including coverage 24 hours per day, 7 days per week.

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

g. 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 and ER notification.

2. Ongoing IHH Provider qualifications:

a. Within three months of IHH service implementation, have worked with the state and its lead entity partner 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).

b. Within six months of IHH service implementation, establish evidence of bi-directional and integrated primary care and behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the state.

c. Within 12 months of IHH service implementation, develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process.

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

e. Demonstrate continuing development of fundamental health home functionality at 6 months and 12 months through an assessment process to be applied by the state.

3. Recognition and certification:

Adhere to all federal and state laws regarding Health Home recognition and certification.

4. 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 or care team recognize each other as partners in care. This relationship is initiated by the patient choosing the Health Home.

5. Continuity of Care Document (CCD):

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

6. 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.

7. Coordinated and 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 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 evidence-informed preventive services.

   d. Coordinate or provide:

      i. Mental health and 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, and vocational needs that may contribute to disease and present as barriers to self-management.

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

8. 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 any time 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 any time.
    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 the Department.
9. 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 441 Iowa Admin. Code § 78.53 and the published fee schedule. Attached as Exhibit A is a copy of the fee schedule as of the effective date of this IHH Agreement. The fee schedule may be changed at the discretion of the Department.
2. The IME will pay the Lead Entity a per-member-per-month payment for each patient only when all of the following conditions are met:
    a. The member meets the eligibility requirements as identified by the Lead Entity and as documented in the member's electronic health record (EHR).

b. The member has full Medicaid benefits for the month in which the Lead Entity seeks a per-member-per-month ("PMPM") payment for that patient.

c. The member was enrolled with the IHH Provider during the month in which the Lead Entity seeks a PMPM payment for that patient.

d. The IHH Provider remains in good standing with IME and operates in adherence with all IHH Provider standards.

e. The patient receives within each quarter for which a patient-related PMPM payment is sought one of the following: 1) EHR documented care management monitoring for treatment gaps defined as Health Home Services in this State Plan, or 2) a covered service defined in this State Plan and documented in the patient's EHR.

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

A member in an Integrated Health Home that is eligible for TCM services through the State Plan or a waiver to the State Plan will have those services provided through the Integrated Health Home. The IHH shall provide Targeted Case Management services as defined in Chapter 90 of the IAC to eligible members in an IHH.

Section 4. Utilization of IMPA:

Practices operating under this Agreement as an IHH Provider are required to use the Iowa Medicaid Portal Access for submitting member enrollment and disenrollment requests through a file transfer or manual entry process within the IMPA application.

Section 5. Term and Termination.

1. This Agreement shall be effective on the last date signed below, and the Agreement shall remain in effect for three years, absent earlier termination in accordance with this Section.
1. This Agreement terminates upon the happening of either of the following events:
    a. The termination of the primary Medicaid Provider Agreement (form 470-5160) between the Integrated Health Home and the Iowa Medicaid Enterprise; or
    b. Either party provides 60-days written notice to the other party of its intent to terminate the IHH Agreement. Termination may be for any reason or no reason at all.

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.

IN WITNESS WHEREOF, in consideration of the mutual covenants set forth above and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into the above Agreement and have caused their duly authorized representatives to execute this Agreement.

Provider	Agency, Iowa Department of Human Services
Signature of Authorized Representative	Signature of Authorized Representative
Print Name and Title	Print Name and Title
Date	Date

Attachment to Integrated Health Home Provider Agreement

Payment Rates -

From the fee schedule developed and published by the Iowa Department of Human Services, for each member enrolled in the Integrated Health Home (IHH) program the Department shall pay to the IHH Provider an amount designated as follows:

The age, engagement status, and level of intensity of the individual on the first day of each month shall determine the payment to be made. There will be no partial month enrollment.

Member's Tier	PMPM Rate
Tier 5 (Adult)	$80.39
Tier 6 (Child)	$103.39
Tier 7 (Adult ICM)	$280.39
Tier 8 (Child ICM)	$303.39