Health Home State Plan Amendment

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Transmittal Number: IA-16-013 Supersedes Transmittal Number: IA-14-009 Approved Effective Date: Apr 1, 2016 Approval Date: Jul 20, 2016 Attachment 3.1-H Page Number: 1-50

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

IA-16-013

Supersedes Transmittal Number:
Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

IA-14-009

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:

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

State Information

State/Territory name:	**Iowa**
Medicaid agency:	Iowa Medicaid Enterprise

Authorized Submitter and Key Contacts

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Name:	
Title:	
Telephone number:	
Email:	

Proposed Effective Date

04/01/2016 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
A health home focused on adults and children with SPMI. 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.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 0.00
Second Year	2017	$ 0.00

Federal Statute/Regulation Citation

Section 2703 of the PPACA

Governor's Office Review

(●) **No comment.**

( ) **Comments received.**
Describe:

( ) **No response within 45 days.**

( ) **Other.**
Describe:

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Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

- ○ **Public notice was not required and comment was not solicited**
- ○ **Public notice was not required, but comment was solicited**
- ◉ **Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

☑ **Newspaper Announcement**

Newspaper	
Name: Cedar Rapids Gazette Date of Publication: 03/09/2016 (mm/dd/yyyy) Locations Covered: East Central Iowa	
Name: Council Bluffs Non Pareil Date of Publication: 03/09/2016 (mm/dd/yyyy) Locations Covered: South West and West Central Iowa	
Name: Des Moines Register Date of Publication: 03/09/2016 (mm/dd/yyyy) Locations Covered: Central and South Central Iowa	
Name: Dubuque Telegraph Herald Date of Publication: 03/08/2016 (mm/dd/yyyy) Locations Covered: North East Iowa	
Name: Mason City Globe Gazette Date of Publication: 03/10/2016 (mm/dd/yyyy) Locations Covered: North Central Iowa	
Name: Press-Citizen Date of Publication: 03/09/2016 (mm/dd/yyyy) Locations Covered: East Central Iowa	
Name: Quad City Times (Davenport/Bettendorf) Date of Publication:	

Newspaper	
03/10/2016 (mm/dd/yyyy) Locations Covered: East Central and South East Iowa	
Name: Sioux City Journal Date of Publication: 03/10/2016 (mm/dd/yyyy) Locations Covered: North West and West Central Iowa	
Name: Waterloo Courier Date of Publication: 03/10/2016 (mm/dd/yyyy) Locations Covered: North East and East Central Iowa	

☐ **Publication in State's administrative record, in accordance with the administrative procedures requirements.**

Date of Publication: (mm/dd/yyyy)

☐ **Email to Electronic Mailing List or Similar Mechanism.**

Date of Email or other electronic notification: (mm/dd/yyyy)

Description:

☑ **Website Notice**

Select the type of website:

☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting: 03/04/2016 (mm/dd/yyyy)

Website URL: https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization/federal-documents

☐ Website for State Regulations

Date of Posting: (mm/dd/yyyy)

Website URL:

☐ Other

☐ **Public Hearing or Meeting**

☐ **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☑ **Indian Tribes**

Indian Tribes	
Name of Indian Tribe: Kickapoo Tribe Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation: email	
Name of Indian Tribe: Meskwaki Tribe Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation: email	
Name of Indian Tribe: Omaha Tribe Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation: email	
Name of Indian Tribe: Ponca tribe Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation: email	
Name of Indian Tribe: Prairie Band Potawatomi Nation Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation: email	
Name of Indian Tribe: Santee Sioux Nation Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation:	

Indian Tribes	
email	
Name of Indian Tribe: Winnebago Tribe Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation: email	

☐ **Indian Health Programs**

☐ **Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☑ **Other Issue**

Issues	
Issue Name: No issues were raised, no comments were received.	
Summarize Comments	
Summarize Response	

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Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation: 11/19/2012 (mm/dd/yyyy)	

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Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☐ **Two or more chronic conditions**

Specify the conditions included:

- ☐ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

Other Chronic Conditions	

☐ **One chronic condition and the risk of developing another**

Specify the conditions included:

- ☐ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

Other Chronic Conditions	

Specify the criteria for at risk of developing another chronic 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.

SMI is defined as;
Psychotic Disorders,
Schizophrenia,
Schizoaffective disorder,
Major Depression,
Bipolar Disorder,
Delusional Disorder,
Obsessive-Compulsive Disorder.

Exceptions considered through a prior authorization process, for the categories above when the behavioral health condition is chronic functional impairment is present as per the definition below.

SED is a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria 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 that result in functional impairment. SED may co-occur with substance use disorders, learning disorders, or intellectual disorders that may be a focus of clinical attention.

Functional Impairment (FI) is:
Difficulties that substantially interfere with or limit the achievement of or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills and substantially interfere with or limits functioning in family, school or community activities, difficulties of episodic, recurrent and continuous duration.
Does not include difficulties resulting from temporary and expected responses to stressful events in a person environment.
For children 3 yrs or younger, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R) may be used as the diagnostic tool. For children 4 yrs and older, the Diagnostic Interview Schedule for Children (DISC) may be used as an alternative to the most current DSM.
FI will be determined through an assessment provided by the integrated health home that serves children.

Geographic Limitations

☐ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

If no, specify the geographic limitations:

◉ **By county**

Specify which counties:
Effective 7/1/2013 Phase I: Dubuque, Polk, Linn, Warren and Woodbury counties.

Effective 4/1/2014 Phase II: Benton, Black Hawk, Buchanan, Calhoun, Cedar, Cerro Gordo, Clinton, Delaware, Floyd, Grundy, Hancock, Harrison, Humboldt, Iowa, Jackson, Johnson, Jones, Kossuth, Mills, Mitchell, Muscatine, Pocahontas, Pottawattamie, Scott, Webster, Winnebago, Worth, and Wright.

Effective 7/1/2014 Phase III: Adair, Adams, Allamakee, Appanoose, Audubon, Boone, Bremer, Buena Vista, Butler, Carroll, Cass, Cherokee, Chickasaw, Clarke, Clay, Clayton, Crawford, Dallas, Davis, Decatur, Des Moines, Dickinson, Emmet, Fayette, Franklin, Fremont, Greene, Guthrie, Hamilton, Hardin, Henry, Howard, Ida, Jasper, Jefferson, Keokuk, Lee, Louisa, Lucas, Lyon, Madison, Mahaska, Marion, Marshall, Monona, Monroe, Montgomery, O'Brien, Osceola, Page, Palo Alto, Plymouth, Poweshiek, Ringgold, Sac, Shelby, Sioux, Story, Tama, Taylor, Union, Van Buren, Wapello, Washington, Wayne, and Winneshiek.

Phase III, effective 7/1/2014, is the final phase of the SPMI HH and completes the statewide implementation.

○ **By region**

Specify which regions and the make-up of each region:

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

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**

Describe the process used:
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 attribute members to a health home. In either situation, the member will always be presented with the choice to opt-out at any time.

○ **Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:

☐ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**

Describe:

- [x] **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
- [x] **The State 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 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. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**
- [x] **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

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Health Homes Providers

Types of Health Homes Providers

- [ ] **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

- [ ] **Physicians**

Describe the Provider Qualifications and Standards:

- [ ] **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

- [ ] **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☑ **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 enrollees and IME for fee-for-service enrollees to support the health home in meeting the Provider Standards. The MD/DO must have an active Iowa license.

☑ **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 deliver health home services to qualified members. The Nurse Care Managers must be a RN or BSN with an active Iowa license.

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☑ **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 BSW with an active Iowa license, or a BS/BA in the related field.

The lead entity must have a case worker 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 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.

☑ **Other (Specify)**

Provider	
Name: Integrated Health Home (IHH) Provider Qualifications and Standards: IHH will include, but are not limited to meeting the following criteria: a. Be an Iowa-accredited Community Mental Health Center or Mental Health Service Provider, or an Iowa licensed residential group care setting, or Iowa licensed Psychiatric Medical Institution for Children (PMIC) facility, or nationally	

Provider	
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 c. Providers must meet requirements throughout the state plan amendment	
Name: Lead Entity Provider Qualifications and Standards: The Lead Entity must: a. 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. b. Have a statewide integrated network of providers to service members with SPMI/SED.	
Name: Peer Support Specialist/Family Support Specialist Provider Qualifications and Standards: The IHH must have either a Peer Support Specialist or Family Support Specialist. A Peer Support Specialist is a consumer who is in recovery from a mental illness who has completed 20 hours of training and passed a competency exam based on that Peer Support training. Training domains include: Rules of Engagement (Recovery/Wellness) Personal Profile (Recovery/Wellness) What is Peer Support (Mentoring/Education) Pillars of Peer Support (Ethical Responsibility) Iowa Peer Support Code of Ethics (Ethical Responsibility) 5 Degrees of Recovery (Mentoring/Education) Sharing Your Recovery Story (Advocacy) Keys to Effective Listening(Mentoring/Education) Disputing Negative Self-Talk (Recovery/ Wellness) Basics of Solving Challenges (Advocacy) Goal Setting (Advocacy) Maintaining Integrity at Work (Ethical Responsibility) Basics of Whole Health (Recovery/ Wellness, Advocacy) Basics of Reporting (Ethical Responsibility) A Family Support Specialist must have a family member with a mental illness, completed training and pass a competency exam. Training domains include: Conflict Resolution Strategies Empowerment Strategies Education Issues Special Health and Mental Health Diagnosis Cultural and Linguistic Competencies Resources and Referral Processes DHS and Juvenile Court Services.	

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

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 in achieving the 11 components listed above by designing a program that aligns provider standards and a payment method that ensures quality providers enter the program, that they 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 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 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 participating in the Iowa Medicaid program;

Provide infrastructure and tools to Behavioral Health IHH providers and primary care physical providers for 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 outcomes tools and measurement protocols to assess IHH concept effectiveness;

Provide clinical guidelines and other decision support tools;

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); and

Develop and offer learning activities which will support providers of Integrated Health Home services.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes 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 or IME through a provider agreement.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:

1.Lead entity standards:

a. Meet the Provider Qualifications and Standards of a lead entity described in this State Plan.

b. Have capacity to evaluate and select IHH providers, including:

-Identification of providers who meet the standards of participation to form an Integrated Health Home;
-Assessment of the IHH and physical health provider's 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 participating in the Iowa Medicaid program; and
-Provide infrastructure and tools to Behavioral Health IHH providers and primary care physical providers for coordination.

c. Have capacity to provide clinical and care coordination support to IHH providers, including:

- Confirmation of screening and identification of members eligible for IHH Services;
- Provide oversight and support of IHH providers to develop care plans and identify care management interventions for IHH 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 IHH members who are high need with complex treatment plans; and

- Facilitate shared treatment planning meetings for members with complex situations.

d. Have capacity to develop provider information technology infrastructure and provide program tools, including:

- Providing tools for IHH 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 IHH 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).

e. 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 caregivers, and provide feedback to practices, as feasible and appropriate; and
- 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.

2. Initial IHH Provider Standards:
a. Meet the Provider Qualifications and Standards of a Integrated Health Home Provider described in this State Plan.
b. Provider must be able to provide community-based mental health services to the target population.
c. Have capacity to meet the following qualifications:

- Meet staff requirements: Adult IHH - Nurse care manager, care coordinator and trained peer support specialist as needed per population. Child IHH - Nurse care manager, Care coordinator and family support specialist positions are required for child IHH teams;
- Advocate in the community on behalf of their integrated health home members as needed;
- Have strong, engaged organizational leadership whom are personally committed to and capable of a) leading the practice through the transformation process and sustaining transformed practice processes as demonstrated through the application process, and b) agreeing to participate in learning activities including in-person sessions and regularly scheduled phone calls;
- 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;
- Have capacity to complete status reports to document member's housing, legal, employment status, education, custody, etc.;
- Agree to participate in or convene regular, ongoing and documented IHH network 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;
- Agree to participate in CMS and state-required evaluation activities;
- Agree to submit reports 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 or face termination as a provider of IHH services;

- Commit to use of an interoperable patient registry or EHR, within a timeline approved by the lead entity or IME, to input information such as annual metabolic screening results, contribute and use clinical information, track and measure care of members, automate care reminders, and produce exception reports for care planning;
- Demonstrate ability and confirm willingness to participate in the technology infrastructure for the IHH program, including:
i. Completing web-based member enrollment, disenrollment, enrollee authorizations for information sharing, and health risk questionnaires for all members;
ii. Establishing a plan and timeline to be approved by the lead entity or IME, to share continuity of care (CCD) records with the state and its lead entity partner after each visit;
iii. Utilizing member-level information, member profiles, and care coordination plans for high risk individuals;
iv. Incorporating 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; and
- 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.

3. Ongoing IHH Provider Qualifications:

Each IHH must also:
a. Within 3 months of IHH service implementation, have worked 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);
b. Within 6 months of IHH service implementation, establish 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;
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.
f. 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; and
- 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.

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Health Homes Service Delivery Systems

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

☑ **Fee for Service**
☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**
Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☑ **Risk Based Managed Care**

○ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**
☐ **The current capitation rate will be reduced.**

☐ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

☐ **Other**

Describe:

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

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

The MCOs are contractually required to conduct the following Integrated Health Homes (IHH) tasks: (i) identify providers who meet the standards of participation as an IHH; (ii) assess the IHH and physical health provider capacity to provide integrated care; (iii) educate and support providers to deliver integrated care; (iv) provide oversight and technical support for IHH providers to coordinate with primary care physical providers; (v) provide infrastructure and tools to IHH providers and primary care physical providers for coordination; (vi) provide tools for IHH providers to assess and customize care coordination based on the physical/behavioral health risk level of the member; (vii) perform data analytics on personal, medical and pharmacy data to identify patterns of care, as well as track, and close gaps in care; (viii) provide outcomes tools and measurement protocols to assess IHH concept effectiveness; (ix) provide clinical guidelines and other decision support tools; (x) provide a repository for member data including claims, laboratory and continuing care document (CCD) data whenever possible; (xi) support providers to share data including CCD or other data from electronic medical records; (xii) develop and offer learning activities which will support providers of IHH services; (xiii) provider reimbursement; and (xiv) attribute and enroll members to an IHH.

The MCOs shall ensure that the IHHs are using all tools and analytics to develop and implement strategies to effectively coordinate the care of each member across systems.

Additionally, the MCOS are required to provide clinical and care coordination support to IHH providers.

☑ **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.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

◉ **Yes**

☑ **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.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **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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Health Homes Payment Methodologies

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

☑ **Fee for Service**

☐ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

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

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

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

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☑ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.
HH services, as described in the six service definitions may or may not require face–to-face interaction.

Minimum Criteria:
A.The member meets the eligibility requirements for health home enrollment as identified in this SPA 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 enrolled with the IHH provider.
D.The HH provider is in good standing with IME and is operating in adherence with all HH provider standards.
E.The minimum service required to merit a PMPM payment is that the person has received care management monitoring for treatment gaps defined as HH Services in this state plan. The health home must document HH services that were provided for the member.
F. At a minimum, the care coordinator shall contact Intensive Care Management (ICM) members, who are those on the 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver at least monthly either in person or by telephone with an interval of at least fourteen (14) calendar days between contacts. ICM members shall be visited in their residence or location of service face-to-face by their care coordinator as frequently as necessary but at least quarterly with an interval of at least sixty (60) days between visits for quarterly requirements. The location of service cannot be the IHH offices.

Claims analysis identified a total count of eligible HH members. Using industry standards for staffing and relevant IA pilot programs, clinical staffing ratios were determined. The development of the PMPM considers the marketplace value of professional staff to provide the six health home services.

The IME shall pay the health home based on the member needs. Adults and children shall be grouped into two categories. Category one is for those members needing IHH services who are actively engaged in the IHH program. Category two is for those actively engaged members needing IHH with more intense community service case management (CM). The payment rate may vary between adult and child and with or without the intense community service CM. The rate is developed according to the actual cost of providing each component of the service for the adult population with and without intense community service CM and the child population with and without intense community service CM. No other payments for these services shall be made.

The actual rate is posted at (http://dhs.iowa.gov/ime/providers/integrated-home-health) effective for services provided on or after July 1, 2014 and will be reviewed annually, and updated as needed based on evaluation and effectiveness of the program.

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the

frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (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 PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

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

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

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
If the individual is already enrolled in a health home for members with chronic conditions, the member will choose between the chronic condition Health Home and the SPMI Integrated Health Home. A member cannot be in more than one health home at the same time. Members in the SPMI Health Home 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 SPMI Health Home, the member can choose between the SPMI Health Home or the Targeted Case Management Service provided through the waiver.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

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Submission - 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 eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

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:
• Outreach activities to members to engage in comprehensive care management.
• Comprehensive whole person screening conducted for all members using medical and behavioral claims data, medical provider records and patient reporting within 90 days of enrolling.
• Assessment-driven whole person member profile development provided to inform local IHH provider.
• 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.
• Predictive modeling reports generated through Medicaid data mining, identifying whole person risk information to be shared with IHH providers.
• Regular report distribution to the local IHH provider teams.
• Oversight of care management plans that address the needs of the whole person. Care management plan based on information pulled from multiple sources.
• Organize, authorize and administer joint treatment planning with local providers, members, families and other social supports to address total health needs of members.
• Administration of online provider tools, including Health and Wellness Questionnaire to assess initial risk level, and Care Coordination Plan.
• Information technology functionality developed to allow online receipt of standardized Continuity of Care Document (CCD) for SPMI population.
• 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.

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 MCOs, 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;
-a health and wellness screening questionnaire;
-a care coordination plan;
-a member profile which summarizes key information about the members medications, health care 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; and
- a member website.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
MD/DO (including Psychiatrist)

☑ **Nurse Care Coordinators**

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

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name
Lead Entity or IHH

Description
Nurse Case Managers from the Lead Entity or the IHH will be responsible for the delivery of this service

Care Coordination

Definition:
- Outreach activities to members to engage in care coordination
- Conduct individualized, comprehensive whole person assessments
- Scheduling appointments
- Making referrals
- Tracking referrals and appointments
- Follow-up monitoring
- Communicating with providers on interventions/goals
- Conducting joint treatment staffings – 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

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 help health homes teams coordinate care.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

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

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Known as Care Coordinators at the IHH or the Lead Entity

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Lead Entity or IHH Providers, Peer Support Specialist or Family Support Specialist

Description

Peer Support or Family Support Specialist, may assist with the following Care Coordination services:
Follow-up Monitoring, Scheduling Appointments, Attending joint staffing treatment meetings, support coordination of care with Providers and specialist.

Nurse Care Coordinators at the IHH or the Lead Entity will perform 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:

• 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;
• Providing self-management support and development of self-management plans and/or relapse prevention plans so that members can attain personal health goals;
• Promoting self-direction and skill development in the area of independent administering of medication and medication adherence;
• Coordinate multiple systems for children with SED as part of a child and family-driven team process;
• Provide prevention education to members and family members about health screening, childhood developmental assessments and immunizations standards; and
• Wraparound planning process: identification, development and implementation of strengths-based individualized care plans addressing the needs of the whole child and family.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The care coordination plan will be used to plan, communicate and document individualized goals, interventions, and track status.
-When available, Continuity of Care Documents will be useful in tracking treatment progress and coordination with providers.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

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

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Known as Care Coordinators at the IHH or the Lead Entity

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name
Lead Entity or IHH Providers, Peer Support Specialist or Family Support Specialist

Description
Nurse Case Managers or Care Coordinators from the Lead Entity or the IHH will be responsible for the delivery of this service

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

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

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

Definition:
• Engage member and/or caretaker as an alternative to emergency room or hospital care
• Participate in hospital discharge process
• Perform medication reconciliation
• 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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
-Electronic and telephonic 24x7 notifications of hospitalizations.
-Care coordination plans and member profiles (including a medication list) are available via the secure

portal to support all IHH team members and providers in transitional care management, medication reconciliation, and follow up care.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description
Nurse Care Managers from the IHH or Lead Entity.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Known as Care Coordinators from the IHH or Lead Entity

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name
Lead Entity, IHH, Peer Support Specialist, or Family Support Specialist

Description

Peer Support or Family Support Specialist, may assist with the following transitional services:
• Engage member and/or caretaker as an alternative to emergency room or hospital care
• Participate in 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

Nurse Care Coordinators or Care Coordinators at the IHH or the Lead Entity will perform Transitional services. 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:
• Providing assistance to members in accessing needed self-help and peer/family support services;
• Advocacy for members and families;
• 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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
An IHH member web site is available to all IHH enrollees, potential enrollees, their families and supports. The member web site 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 benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description
Nurse Care Managers from the IHH or Lead Entity

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Known as Care Coordinators from the IHH or Lead Entity

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

IHH, Lead Entity, Peer Support Specialist or Family Support Specialist

Description

Peer Support or Family Support Specialist, may assist with the following individual and family support services:

• Providing assistance to members in accessing needed self-help and peer/family support services;
• Advocacy for members and families;
• Family support services for members and their families
• Assisting members to identify and develop social support networks;
• Support Medicaid adherence efforts.
• 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

Nurse Care Coordinators or Care Coordinators at the IHH or the Lead Entity will perform individual and family support services.

Referral to community and social support services, if relevant

Definition:
• Provide resource referrals or coordinate to the following, as needed:
• 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;
• Housing services;
• Transportation services
• Programs that assist members in their social integration and social skill building;
• Faith-based organizations;
• Employment and educational programs or training; Volunteer opportunities

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
The care coordination 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 web site 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 benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description
Nurse Care Managers from the IHH or Lead Entity

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Known as Care Coordinators from the IHH or Lead Entity

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

IHH, Lead Entity, Peer Support Specialist or Family Support Specialist

Description

Nurse Care Coordinators or Care Coordinators at the IHH or the Lead Entity will perform community and social support services.

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:

To be provided separately

☑ **Medically Needy eligibility groups**

◉ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
Data sources will be claims data, including MCO encounter data. (Measure calculations may be impacted by Medicare data availability)

The State will track the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. CMS measure specifications will be used.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
Medicaid claims data, including encounter data. The State-selected evaluator will calculate two types of control groups for the Medicaid enrollees who join a Health Home. First, enrollees in the Health Home will be their own controls through a pre- and post-program comparison. This analysis will compare the PMPM costs for the year prior to entering the program to the PMPM costs for the first six months, first year and first 18 months of the program. We will continue to calculate the PMPM costs every six months. Also, as a component of the within-member analysis, and using a customized risk stratification tool, we will evaluate each member's utilization and cost-based risk at baseline and monitor the trend month-over-month and attempt to correlate with specific coordination of care and care management interventions. Finally, we will attempt to match each enrollee who has been in the Health Home for at least one year with an enrollee that is not in a Health Home but has been enrolled in Medicaid for one year. By controlling for factors such as age, gender, type of SMI condition and medical co-morbidities in the match we are able to lessen the bias that may exist between the two groups. However, we will also use propensity scoring as a means for adjusting for selection bias in studies of changes in PMPM cost as a function of enrollment in the program.

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 IT infrastructure and program tools to the IHHs in order to facilitate collaboration. These capabilities include, but are not limited to; patient screening and risk stratification, and a web-based profile that integrates Medicaid claims, patient self-reported information, and clinical documentation. The lead entity will be responsible for sharing health utilization and claims data with the IHH provider network to facilitate care coordination and prescription monitoring for members receiving HH services. A member website will be available to IHH enrollees, their families and supports. It will contain evidence-based information on conditions, health promotion and wellness information, and links to resources.

Iowa eHealth is is implementing a state-wide Health Information Network (HIN). IME will support the effort to make the exchange available to HH providers. The lead entity technology infrastructure for health information exchange will be utilized while the IHIN is developing.

As part of the minimum requirements of an eligible provider to operate as a health home, the following relate to HIT:
• Commitment to use an interoperable patient registry or EHR to input information such as annual metabolic screening results, contribute and use clinical information, track and measure care of members, automate care reminders, and produce exception reports for care planning;
•Demonstrate ability and confirm willingness to participate in the technology infrastructure of the IHH, including:
Completing web-based health risk questionnaires;
Establishing a plan and timeline to share Continuity of Care (CCD) records with the lead entity after each visit;
Utilizing member profiles and other care coordination tools;
Guiding IHH members in accessing and using the member website;
• Incorporating tools and care guidelines designed for integrating clinical practice and coordinating care with other providers.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **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.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:
Hospital Admissions
Measure Specification, including a description of the numerator and denominator.
Admissions per 1000 members for any diagnosis
Data Sources:
Claims, including MCO encounter data
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Emergency Room Visits

Measure:
ER Visist
Measure Specification, including a description of the numerator and denominator.
Emergency Room Visits per 1000 members for any diagnosis
Data Sources:
Claims, including MCO encounter data
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Skilled Nursing Facility Admissions

Measure:

SNF Admissions

Measure Specification, including a description of the numerator and denominator.
SNF admissions per 1000 members for any diagnosis
Data Sources:
Claims, including MCO encounter data
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates
The State will consolidate data from Medicaid claims and encounter data for the participating health home sites to assess hospital admission rates, by service. The State will track pre/post hospital admission rates among health home participants. Rates will be compared for health home participants and individuals not using health home services. (Measure calculations may be impacted by Medicare data availability)

Chronic Disease Management
The State will monitor each health home practice in regard to chronic disease management (SMI/SED) with a special focus on comprehensive care management.
Audits will assess: a) documented self-management with all beneficiaries identified as high risk, b) Development of symptom response plans

Coordination of Care for Individuals with Chronic Conditions
Provision of care coordination services for members with the chronic conditions specified within this State Plan Amendment will be assessed via the following measures: a) Care Coordinator contact during hospitalization, b) health home telephonic or face-to-face enrollee follow-up within 2 days after hospitalization discharge, c) health home active care coordination for members with chronic conditions d) Health home monitoring of self-reported physical health conditions and indicators of risk (e.g. housing problems, social isolation) e) Availability of bi-directional and integrated primary care /behavioral health services.

Assessment of Program Implementation
The State will monitor implementation through processes developed by the State Medicaid Agency and the lead entity.
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.

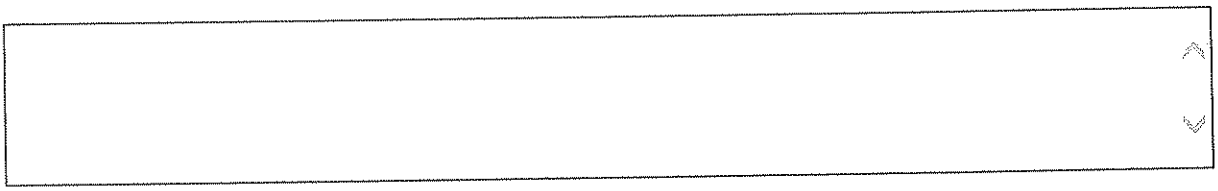
Processes and Lessons Learned
The State Medicaid Agency and the lead entity will develop tools to capture feedback from the health homes to document and understand any operational barriers to implementing health home services.

Assessment of Quality Improvements and Clinical Outcomes
The State will utilize quality process and outcome measures described in the prior section to assess quality improvements and clinical outcomes.

Estimates of Cost Savings

☑ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.



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PRA Disclosure Statement

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