Iowa Department of Human Services

Chronic Condition Health Home Program Toolkit

Contents

Preface

This toolkit was created to assist with implementation of the health home program, and to support the Medicaid population to improve outcomes. This toolkit includes information for you to complete your orientation as well as, best practices for staff and patient engagement. This toolkit can assist in beginning to transform your practice and look at innovative ways to work with integrated health homes and the case managers that work with your patients. We hope this toolkit will allow greater success in becoming patient centered in your practice.

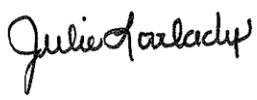
We welcome any feedback to improve the health home program and are happy to provide any assistance that may help you in your journey.

Welcome Letter

Dear Health Home,

Thank you for agreeing to provide health home services to the Iowa Medicaid population members in your clinic. The Iowa Medicaid Enterprise (IME) is excited to work side by side with you to improve outcomes for the Medicaid patient population. Becoming patient centered is a transformation of quality improvement that changes the way care is delivered. Please let the IME know what support you need in the development of your patient centered health home.

Thank you for your support,



Julie Lovelady
Iowa Medicaid Enterprise
Deputy Director
Iowa Department of Human Services

Definition of a Chronic Condition Health Home

Iowa Medicaid's Chronic Condition health home program is based on the foundation that primary care is delivered in a patient-centered medical home (PCMH) model.

According to the Patient-Centered Primary Care Collaborative (PCPCC), the medical home is:

> *"A model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the most simple, to the most complex conditions. It is a place where patients are treated with respect, dignity, and compassion, and enable strong and trusting relationships with providers and staff. Above all, the medical home is not a final destination instead, it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs."*

Adapted from the Agency for Healthcare Research and Quality (AHRQ) definition, the PCPCC describes the medical home as an approach to the delivery of primary care that is:

- **Patient-centered**: A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.
- **Comprehensive**: A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.
- **Coordinated**: Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports.
- **Accessible**: Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access and strong communication through health IT innovations.
- **Committed to quality and safety**: Clinicians and staff enhance quality improvement through the use of health IT and other tools to ensure that patients and families make informed decisions about their health.

Program Overview

When enrolling in the Medicaid health home program, the health home agrees to the minimum requirements listed below:

- Use some form of a Patient Registry
- Electronic Health Records (EHR)
- Agree to participate in the Iowa Health Information Network
- Have dedicated care coordinator(s)
- Have expanded hours for access
- Alternative means to communicate with patients and get them engaged such as email, personal health records, reminders, etc.
- On the path to PCMH recognition or certification

Designated providers must sign an agreement attesting adherence to the below standards:

1. Recognition/Certification –

1. Health home (HH) Providers must adhere to all federal and state laws in regard to HH recognition/certification.
2. Comply with standards specified in the Iowa Department of Public Health rules. Those rules will likely require National Committee for Quality Assurance (NCQA) or other national accreditation.
3. Until those rules are final, providers shall meet the following recognition/certification standards:
    a. Complete the "TransforMed Self-Assessment" form and submit to the State at the time of enrollment in the program.
    b. Achieve PCMH Recognition/Certification, such as NCQA, other national accreditation, or another program recognized by the state within the first year of operation.
        i. Exception applied for health homes past the first year where an application has been submitted and pending ruling. The health home must prove application submission status on demand and the State may terminate health home enrollment if recognition/certification status has not be achieved within 2 years of operation.

2. Personal Provider for Each Patient

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

3. Continuity of Care Document (CCD)

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

4. Whole Person Orientation

a. Provide or take responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care, chronic care, preventive services, long-term care, and end of life care.

5. Coordinated/Integrated Care

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

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

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

d. Coordinate or provide:

- Mental health/behavioral health
- Oral health
- Long term care
- Chronic disease management
- Recovery services and social health services available in the community
- Behavior modification interventions aimed at supporting health management (Including but not limited to, obesity counseling, tobacco cessation, and health coaching)
- 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/or present as barriers to self-management.

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

6. Emphasis on Quality and Safety

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

b. Demonstrate use of a population management tool, (patient registry) and the ability to evaluate results and implement interventions that improve outcomes overtime.

c. 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.

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

e. Each health home shall implement or support a formal diabetes disease management program. The disease management program shall include:

- The goal to improve health outcomes using evidence-based guidelines and protocols.
- A measure for diabetes clinical outcomes that include timeliness, completion, and results of Hemoglobin A1C, low-density Lipoprotein, micro albumin, and eye examinations for each patient identified with a diagnosis of diabetes.
- 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.

f. Each Health Home shall implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs.

g. Provide the Department outcomes and process measure reporting annually.

7. 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 3rd next available appointment and same day scheduling availability.

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

Steps to Complete your Orientation

This section provides information for the newly enrolled health home as you begin to implement these services for your Medicaid population with chronic conditions. This can be used to check off tasks you complete to get the program implemented in the health home.

Kick Off Call
You will receive a call from the program manager to set up a conference call with your health home team. It is important to identify a health coach, care coordinator, payment manager, and any IT support staff prior to participating in this call. During the call we will discuss the health home program, talk through the requirements that must be met to be a health home and discuss

Patient Tier Assessment Tool (PTAT) Training
The PTAT is a tool that is used to identify if the member qualifies for the health home program and determines the per member per month (PMPM) dollar amount the health home will receive for each member. Training is important to understand how to determine the severity of the member's health to receive appropriate payment.

This training walks through the process of the PTAT using case studies that provide different scenarios that enhance the understanding of how to use the tool in identifying eligible members to enroll in the health home program. The tool uses a two part assessment to identify members qualifying chronic conditions and then how to tier them for payment. The information obtained in this tool will be used when an enrollment request is submitted in IMPA. This training takes about one hour and can be done via webinar or call.

- PTAT Guide
- PTAT Tool

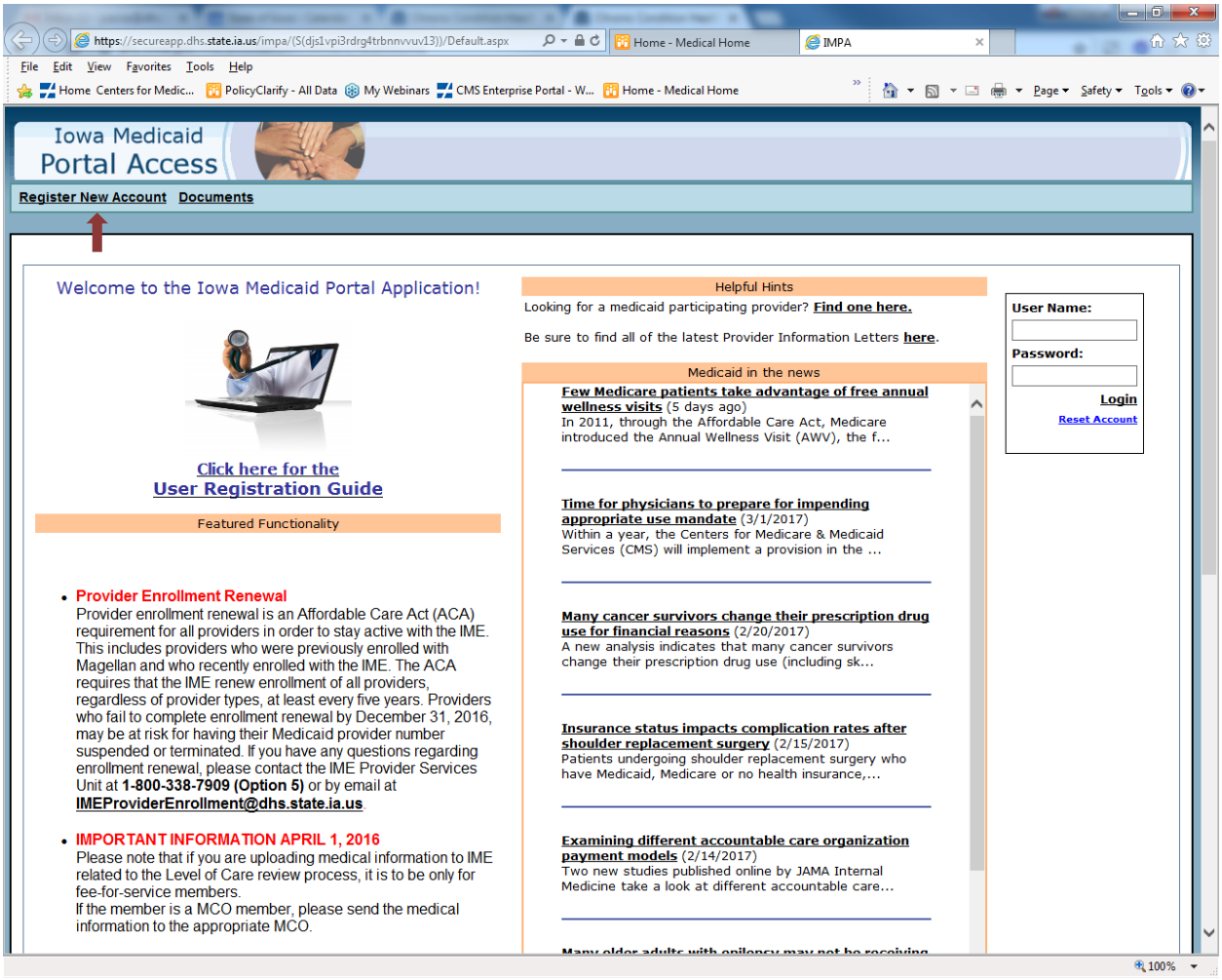
Iowa Medicaid Portal Application (IMPA) Training
The Medicaid Portal (IMPA) assists the health home with enrolling, dis-enrolling, updating and tracking each member's assessment as well as tracking members who are on a waiver. The training will help you to understand how to disenroll members including the different reporting functions within IMPA to show when patients are actively enrolled, when assessments are due, which members are on a waiver and provider attestation for payment. The training takes about one hour and can be done via webinar or call.

- IMPA Access Form

IMPA Access Instructions

If you are not a registered user of IMPA, go to IMPA
Save this to your favorites, it is your log in screen.

Figure 1: Screenshot of Iowa Medicaid Portal Access (IMPA)



1. Each provider completing an enrollment renewal will need to create their own IMPA account. On the top left hand corner, by the IMPA logo, is a link to Register New Account. Please click on the link located on the top left hand corner, by the IMPA logo for you to Register New Account. (See red arrow above).

2. Create a username and password for staff that will be completing enrollment renewal. The username is not case sensitive, but the password must be at least 8 characters (one lowercase letter, one uppercase letter, a symbol and a number). Be sure to write down your username and password to have as a reference.

3. If the password is forgotten, click on reset account and follow prompts to reset your password.

Learning Collaborative Webinars
These webinars occur typically on the third Tuesday of the month. These webinars are held from 12-1 p.m. and provide health homes with updates to the program and various topics to assist in providing health home services. Ask the program manager how to get signed up for this webinar series at jvance@dhs.state.ia.us.

Follow-Up Call
You will receive a call from the program manager to schedule a call with your health home team about three weeks after you have received the patient list. We will be discussing the program, answering questions and talking about how things are going.

Submission of a Per Member per Month (PMPM) Claim
Instructions for submitting a claim to IME for a Per member per Month (PMPM) Claim
INFORMATION LETTER NO. 1662

PCMH Recognition
The clinic has agreed to achieve Recognition/Accreditation such as NCQA, other national accreditation, or another program recognized by the state within the first year of operation. The only exception is if a health home has applied within the first year and their application status/approval is still pending past the first year. The health home must prove application submission status on demand and the state may terminate health home enrollment if recognition/certification status has not be achieved within 2 years of operation. The health home must also maintain recognition/certification once obtained. Changes or updates are to be reported to the program manager.

The National Center for Medical Home Implementation has a list of recognition and accreditation programs available to review.
https://medicalhomeinfo.aap.org/national-state-initiatives/national-initiatives/Pages/default.aspx

Discount for National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) Submission Fees INFORMATIONAL LETTER NO.1272

For further information on the NCQA PCMH program please visit this site:
http://www.ncqa.org/Programs/Recognition.aspx.

More information on the health home program is posted at:
http://www.ime.state.ia.us/Providers/HealthHome.html.

If you have any questions, please contact the IME Provider Services Unit at 1-800-338-7909, locally in Des Moines at 515-256-4609 or by email at imeproviderservices@dhs.state.ia.us.

Staff Engagement

Change is can be difficult for staff. This section provides tips and tools for staff training and engagement to enhance the success of the program. At any time you may request training and technical assistance from IME regarding the health home program. This can be accomplished through a call, webinar or on site visit.

Health Coach Training
Your Accountable Care Organization (ACO) or health system may already have a health coach training program. If not, there are various programs available.

Clinical Health Coach(R) Training Onsite is designed for healthcare organizations that seek to implement or grow a clinical role in the care management of patients with complex medical needs or chronic conditions. Clinical Health Coach(R) training onsite is:

- Onsite training with coaching/care management faculty
- Features motivational interviewing strategies
- Networking with other class participants
- Support for program development
- Leadership training

Clinical Health Coach(R) Online is designed for individuals and healthcare organizations that seek to improve the health outcomes of their patients by actively engaging them in self-management support and providing them with true patient-centered care. Clinical Health Coach(R) Online is:

- Self-paced, can review materials as often as needed
- Scalable to entire healthcare teams
- Convenient
- Reduce time away from the work environment

The Iowa Chronic Care Consortium (ICCC), clinical health coach training may be another option for your health coaches. The ICCC is an independent, not for profit organization. Further information about the program can be found at: http://iowaccc.com/health-coach-programs/

How Many Health Coaches do I Need?
The resource link below provides information on staff roles that can help evaluate and determine staffing models.
http://www.advisory.com/research/health-care-advisory-board/resources/2013/care-management-staff-audit

Change Management
When transforming your practice it is important to address change with the staff and use models to assist with dealing with change.

10 Principles of Leading Change Management http://www.strategy-business.com/article/00255?pg=all

Change Management (Qualis Health) http://medicare.qualishealth.org/qi-basics/change-management

The Learning and Action Network Guidebook for Quality Improvement http://www.healthcarecommunities.org/DesktopModules/Bring2mind/DMX/Download.aspx?portalid=3&EntryId=61856

Health Home Guidance

The Guide for Health Home Services can be used to assist with identifying what health home services qualify for the PMPM.
https://dhs.iowa.gov/sites/default/files/Health_Home_Guidance%5B1%5D.pdf

Required Documentation

Document office visits as you are normally required for all fee-for-service billing (acute visits, etc.). There is an expectation that additional health home services (comprehensive care management, care coordination, transitional care, health promotion, individual and family support services, and referral to social and community services) are provided to members enrolled in your health home as appropriate. There is not a requirement to submit the proof of the heath home services performed that month. However, if you were to be audited, you would want to be able to show documentation that the care plan was up to date and the member was actively monitored and provided appropriate health home services.

Members in the Health Home program have full Medicaid benefits and receive health home services. A member's participation in this program does not impact the prior authorization, referral, or billing process for providers of service outside the health home. The health home collects the information to promote better coordination of patient care. Please contact Iowa Medicaid regarding any medical services that require a referral or prior authorization.

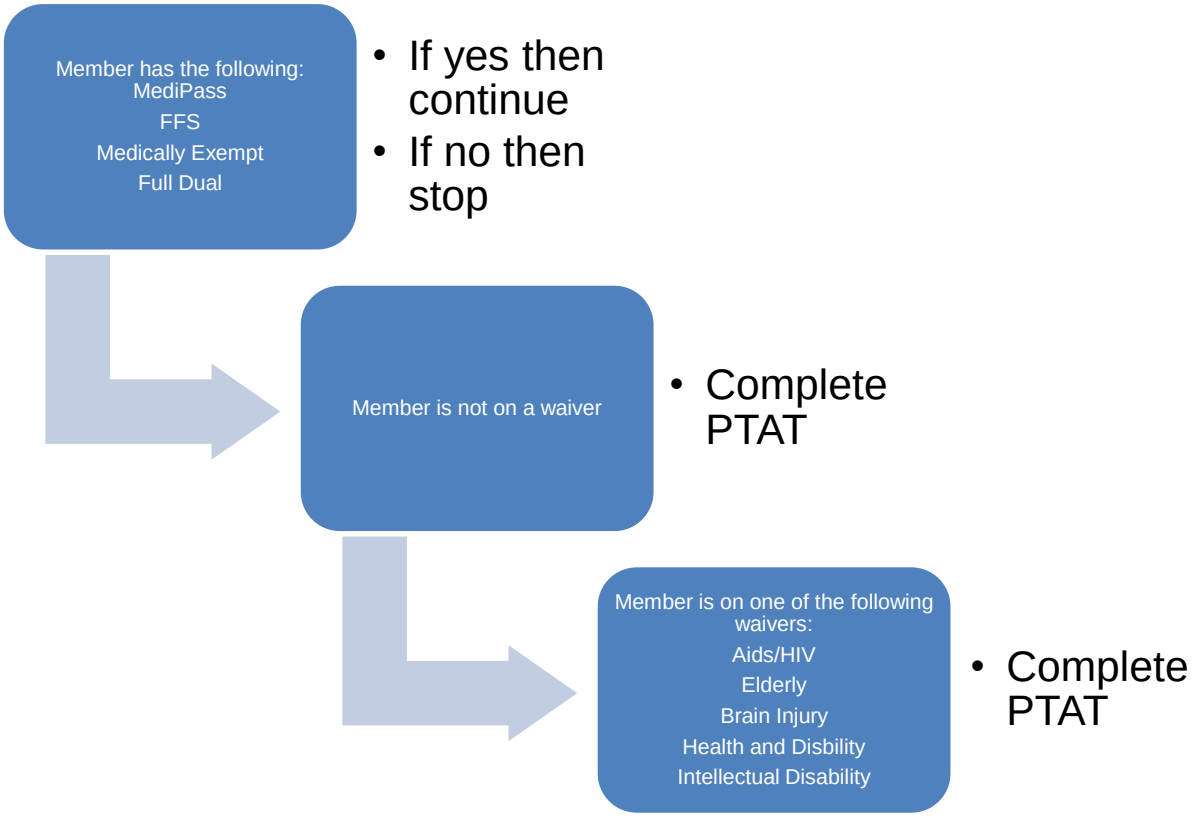
Patient Engagement

This section provides tips and tools for staff to identify and engage members to enhance the success of the program.

How to identify eligible members

- Assess for eligibility using the two following options:
    - For queries, call the Eligibility Verification System (ELVS) phone line at: 515-323-9639 (locally in Des Moines) or 1-800-338-7752 (toll-free)
    - ELVS Portal: Link: http://www.edissweb.com/docs/med/add-access-request-IME.pdf
        - Direct link to the Portal: https://ime-ediss5010.noridian.com/iowaxchange5010/LogonDisplay.do
        - Since the service is administered through our electronic vendor EDISS, contact 1-800-967-7902 regarding any problems or questions.

Figure 1: Eligibility Flow Chart



Outreach education (sample engagement letter and scripts)

Health Home Brochure

When talking about the health home program, this brochure (linked below) can be used to help patients understand what health home has to offer.
https://dhs.iowa.gov/sites/default/files/Health_Home_Brochure%28COMBINED%29.pdf

Member Engagement
There are many different ways to engage a member. A member may be contacted by phone, mail or face-to-face to engage them in their own care as part of the care team.

Health Home Engagement Member Scripting Tool
The Health Home Engagement Member Tool can be used as a script when talking on the phone with the member. It can also be used as a template when sending a letter or talking with the member during a face to face visit.

Adapt for Phone Call or Face-to-Face Visit:

Hello (member name),

My name is and I am calling from (clinic name). Do you have a few minutes to talk with me? I would like to make sure you are aware of a new program offered through Iowa Medicaid, called the health home.

The program offers additional assistance to Medicaid members living with chronic conditions by coordinating care and providing you with extra services.

Your Primary Care Provider, (Insert name of PCP), will work with a medical team to meet all of your healthcare needs. The team will also work to help you with problems you may have with housing; food; transportation, or any other barriers to healthcare.

By enrolling, you have a chance to play a big role in your health care and will have easier access to your medical team for any problems or concerns you may have.

When you have numerous visits to the office for injury or illness, it is easy to overlook routine preventive care and care for your chronic conditions (name those); but the health home team keeps track of those things and will make sure they are not forgotten. We don't want you to end up in the emergency room because your condition worsened or you just needed medication refills and the office was closed.

The health home team will help (provider name) choose your prescriptions from the Medicaid Preferred Drug List; assist with any prior authorizations, if necessary, and make sure your refills are taken care of so you don't run out. This can save you time and extra trips to the pharmacy.

If you need to have tests or see a specialist, we can try to see that those things go smoothly for you and help answer questions you might have. We can help bridge the gap by making sure they know your current plan of care.

Another area we can help with is by arranging transportation assistance to your medical appointments or pharmacy. Our goal is to help you improve your health and well-being.

This program does not cost you anything and does not change your current Medicaid coverage. You appear to be eligible to participate in the health home program and receive this enhanced care coordination. If you agree to participate I can complete the enrollment for you. All I need is your permission. Then, in a few weeks, you will receive a letter from Medicaid confirming your enrollment with our office and (provider name).

If at any time you would like to dis-enroll please call and let me know. We can do this immediately.

Do you have any questions for me at this time? Would you like to receive this extra help by enrolling in the health home program? (Provide your contact information)
Be sure to document the conversation in the patient's EHR record.

Health Home Orientation Factsheet
Create a fact sheet that orientates the member to the health home program. This could also be added to your new patient orientation packet. Consider the following topics:

- What services are they provided?

- How will services be coordinated?
- How should they be involved in their own care planning?
- Who is their contact at the clinic and who is their primary care provider?
- What should they do if they want to disenroll?
- How does this affect their benefits? (It doesn't change their benefits)

Copy of Letters Sent to Members

The IME sends letters to members whenever they are enrolled or dis-enrolled from the program. Letters can be confusing due to the frequency of letters that a member may receive. It is important to educate members on what they will be receiving in the mail and what the letters mean. The following letters will go to the member once the end of the month process has taken place and the member has been either enrolled or dis-enrolled.

IAMR8500-R001 - IOWA HEALTH HOME WELCOME LETTERS

Iowa Department of Human Services
Health Home Confirmation Letter

04/02/2014

(Patient Name)
(Patient Address)

In regard to (Patient Name)

Welcome to your new Health Home. Beginning 08/01/2012, you will have a Health Home that will be in charge of your primary health care needs. This Health Home is much more than a medical office. Here, you will receive primary care and your specialty care will be coordinated by the members of the Health Home team. You will benefit from individualized medical care now in order to improve overall health later. Your Health Home is NORTHEAST IA MED EDUCATION. You may be receiving care at the main location or one of their other locations. The main location contact information is listed below. You may contact that number or call your provider directly for more information.

(Health Home)
(Health Home Adress)
(PHONE NUMBER)

You can expect to build a strong relationship with the Health Home and other health care providers who will help build and carry out a plan of care designed for your chronic health condition. The team is there to comfort and support you, provide resources and encourage participation in your own health needs.

If you are currently enrolled in the medical Managed Health Care(MHC) program, you will be disenrolled effective 08/01/2012 and enrolled with your new Health Home. You will continue to receive care from your current MHC provider until 07/31/2012 when you will be assigned to the Health Home. If you are enrolled in the Iowa Plan for Behavioral Care, you will continue that enrollment.

If you have any questions, please contact Iowa Medicaid Enterprise Member Services at 1-800-338-8366. We are here to help you Monday - Friday 8:00 a.m. - 5:00 p.m.

Sincerely,
Iowa Medicaid Member Services

Si necesita informacion espanol, por favor llame a Servicios de Miembros al 1-800-338-8366. If you need information in Spanish please call Member Services at 1-800-338-8366.

IAMR8600-R001 - HEALTH HOME TERMINATION LETTER

Iowa Department of Human Services
Health Home Termination Letter

03/31/2014

(Patient Name)
(Patient Adress)

In regard to (Patient Name)

This letter is to inform you that as of 03/31/2014, you will be disenrolled with your Health Home listed below.

(Health Home)
(Adress)
(PHONE NUMBER)

You are receiving this letter because you either chose to exit the program or your provider made the request. If you have questions regarding the reason why you have been disenrolled from your Health Home, please contact the Health Home at the phone number listed above.

If you were previously enrolled in a Managed Health Care (MHC) program you will get a new MHC enrollment packet in the next few days.

If you have any questions, please contact Iowa Medicaid Enterprise Member Services at 1-800-338-8366. We are here to help you Monday - Friday 8:00 a.m. - 5:00 p.m.

Sincerely,
Iowa Medicaid Member Services

Si necesita informacion espanol, por favor llame a Servicios de Miembros al 1-800-338-8366. If you need information in Spanish please call Member Services at 1-800-338-8366.

Reasons to Dis-enroll a Member

Remember to educate the member about the letter they will receive on dis-enrollment and that they will not lose their Medicaid benefits.

- Member Request
  - A member can request to dis-enroll from the program as this is a voluntary program to participate in.
- Provider Request
  - A provider can request disenrollment on behalf of a member.
- Death
- Failure to comply
  - This would be when a member is not abiding by the agreement they signed with the provider. The provider can dis-enroll them.
- County Change
  - A member may change counties and Member Services may dis-enroll them.
  - Patient should not be dis-enrolled if moves to a contiguous county.
  - Will be dis-enrolled if moved out of contiguous county.
  - May re-enroll if the patient states they would like to still be enrolled in your health home.
- Enrolled in Home and Community Based Services (HCBS) Waiver
  - This patient has a waiver that requires them to be in the Integrated Health Home (IHH), or the patient has a care manager and you do not agree to talk to the case manager quarterly.

Success Stories

There have been multiple success stories that have been shared with IME regarding the success of the health home programs.

- A patient with a history of a bone marrow and liver transplant came into a health home for a check up on his attention deficit hyperactivity disorder. He had not had a well visit for over two years. He was overdue for immunizations; there was no documentation in the EHR of any history of transplants or office notes and his problem list had not been updated. The clinic health coach met with the family and reconciled the patient's chart. They contacted specialists in Iowa City where the transplants were done to request office notes and medical records and to confirm whether or not it was okay to give the patient his immunizations. The patient is now listed on the high-risk registry and the clinic health coach and health coordinator are prepared to coordinate all of his care.

- Recently the issue of health literacy became very important for health safety and quality for a health coach's patient. The health coach was working with a male who was scheduled for hernia repair surgery and was currently on Warfarin. Due to issues with low health literacy there was a need for education on how to titrate off of the medication in preparation for the surgery. The health coach worked with the member and his daughter to educate them in an easy step by step way to titrate off the Warfarin in combination with giving himself Lovenox injections. The daughter stated that this was the best information she had received and it was easy to understand for both her and her father.

There was another incident with the same member where the health coach prevented a very dangerous situation. The member was taking a medication which was in a 5mg dosage. His daughter did not understand the directions on the medication and thought the 5mg meant he should take five pills a day. Because of the health coach's involvement with this member and his family, the family was able to understand how he should correctly take his medication and a very dangerous situation was diverted.

- A patient's home health nurse contacted a health coach with questions about a patient's thyroid medication. The health coach was able to contact the pharmacy, identified that the e-script had not gone through and resolved the issue so the patient could receive his medications. The patient's continuum of care was greatly improved. The health coach attributes this improved quality of care to the work that IME has done in establishing the health homes responsibilities and standards as well as her positive relationships with the pharmacist and home health nurse.

- A patient with severe diabetes, an A1C of 14.4 percent and was not taking her medications as directed. She was a hoarder and had been offered many different community services to assist with her health conditions. The care coordinator worked closely with the home health nurses to get this patient appropriate care in the home. She was also able to coordinate with the local pharmacy to get weekly med packs for the patient. However, due to the unsafe conditions of the home, services could no longer be provided in the home. The care coordinator and the integrated health home (IHH) workers began to visit and the member's care was transitioned to an IHH so they could provide the member with behavioral health services. Due to the coordination of care between the health home and the IHH, the member has been moved into a care facility where all of her health and mental health needs can be met. If the member would require hospitalization in the future, the care coordinator would be able to ensure that all of her specialty needs were met before the patient left, including the IHH services, provider appointments, and medication reconciliation before returning to the facility.

Health Home Tools

It is important to have appropriate tools for the success of the program. This section provides health home tools that may assist in the management of Medicaid members who qualify to be enrolled in the health home program.

IMPA

IMPA is a portal the health home uses to manage enrollment, dis-enrollment, updates to the member's assessment, and utilization of reports to manage the Medicaid population. Health coaches, care coordinators, and billing staff are some of the staff that may utilize IMPA for the health home program. It is important to provide access to any staff that will be managing this patient population.
https://secureapp.dhs.state.ia.us/impa/(S(uqfxncqaf3lmbmblgoiqe5pb))/Default.aspx

Available Reports through IMPA

- Current Enrollment Activity Report
  The current report provides information on members for a given NPI (national provider identifier). Any patient that has a change in status or an update will show up in this report. This is only for the current month.

- Billing Report
  The current report provides information on all of your current members enrolled in the program.

- Assessment Coming Due
  Members currently enrolled in Medicaid that an assessment coming due within the next three months will be included in the Assessment Coming Due report. Remember that the assessment must be updated at least every 12 months in IMPA before month end of the 12th month. Updating the assessment after this time will result in the inability to be able to attest for the PMPM until month end has passed.

- Health Home Roster
  - The Health Home Roster has three sections:
    - The Assigned report provides a listing of members assigned to a health home or an integrated health home.
    - The Unassigned report provides a listing of members that the health home requested to enroll or enrolled for various reasons are no longer assigned or have never been assigned to a health home or an integrated health home
    - The Not Processed report provides a listing of members that have requested enrollment into a health home or an integrated health home and will be processed at month end processing.

- Participating Waiver Members Report
  This report provides users with a listing of eligible and enrolled members that are also participating in an active waiver program along with their case manager contact information. The information provided in this report is for the current month only. Reminder that at least quarterly contact is required with the case manager to endure there are no gaps in care or duplication in services.
  - HS = Habilitation Services, ID = Intellectual Disability, PD = Physical Disability, HD = Health & Disability, IHS = Iowa Plan Habilitation Services

Iowa Medicaid Electronic Record System (I-MERS)

Health home providers should be aware that the IME has a tool called the Iowa Medicaid Electronic Record System (IMERS) that can assist providers as they coordinate care for their patients. IMERS is a web-based application giving timely information about services that have been paid by the IME for a given member, including medical procedures, prescriptions and rendering provider information. This tool is available to Health Homes and other select providers. Health coaches or care coordinators may be appropriate staff to utilize this system to identify high utilizers of services, members who have been hospitalized, have been seen in the

ER or have been seen by another provider. For more information on connecting, please refer to Informational Letter No. 610.

Health Home Resources

Non-emergency Medical Transportation (NEMT)
To ensure members can make it to medical appointments, the IME also supports a program for NEMT for those who are unable to secure their own, appropriate transportation. NEMT is handled through a vendor called Transportation Management Solutions (TMS). When TMS receives a transportation request, they verify eligibility and ensure the trip meets all other requirements. The service may include bus tokens, public transportation, volunteer services, or mileage reimbursement. TMS requires a 72 hour advance notice to approve and schedule trips. For more information regarding TMS please refer to Informational Letter No. 950. Care coordinators or any staff that may assist the member with setting up transportation may want to have information regarding this service.

Medically Exempt Determination
A Medically Exempt determination only applies to those who are enrolled in the Iowa Wellness Plan and the Iowa Marketplace Choice Plan. This will not affect those that are currently enrolled in the Medicaid State Plan. The goal of making individuals Medically Exempt is to ensure those individuals with a need for more extensive behavioral health, substance abuse and complex chronic services have access to appropriate care. Moving the Medically Exempt Iowa Health and Wellness Plan members to the Medicaid State Plan will allow them to the care they need.

Iowa Health and Wellness Medically exempt Frequently Asked Questions
http://dhs.iowa.gov/sites/default/files/Medically%20Exempt_FAQ_March2014.pdf

Iowa Health and Wellness Plan Medically Exempt Toolkit
http://dhs.iowa.gov/sites/default/files/Medically%20Exempt%20Toolkit.pdf

Iowa Health and Wellness Plan Medically Exempt Individual Definition
http://dhs.iowa.gov/sites/default/files/Medically%20Frail%20Defintion_FINAL_110613.pdf

Iowa Health and Wellness Plan Medically Exempt Training
http://dhs.iowa.gov/sites/default/files/IHAWP_MedExempt_ToolkitTrainingWebinar.pdf

Prescription Monitoring Program (PMP)
The PMP is a health care tool for practitioners to assist in identifying potential diversion misuse, or abuse of controlled substances by their patients while facilitating the most appropriate and effective medical use of those substances.

Users must register to receive their username and password.
http://www.state.ia.us/ibpe/pmp/pmp_info.html

Working with Case Managers for Members on a Waiver

When enrolling a member that receives waiver services, the health home is agreeing to contact the case manager of that waiver at least quarterly to coordinate care and services for the member.

Waivers
The link below provides information about the different waivers and the services included. Use the report in IMPA to assist with tracking members that are on a waiver and contact the case manager at least quarterly. Work with the case manager to create a process on how you will work together and communicate to ensure there are no gaps in care or duplication of services.
http://medicaidwaiver.org/state/iowa.html

Types of Home and Community Based Waivers
The link below provides you with information about all of the waivers.
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers

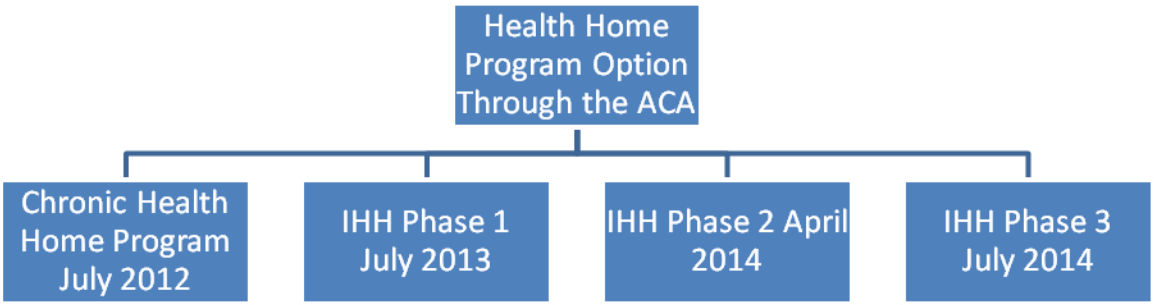
Working with an Integrated Health Home (IHH)

The IHHs are considered a health homes, but are intended to serve a different population than the medical health home (HH). An IHH is a team of professionals working together to provide whole-person, patient-centered coordinated care for adults with a serious mental illness and children with a serious emotional disturbance. Adults enrolled in the HCBS Habilitation program and children enrolled in the HCBS Children's Mental Health Waiver are also enrolled in the IHH, but cannot be enrolled in a medical health home. The IHH is responsible for medical care coordination in addition to mental health care coordination.

How the Integrated Health Home Model Expands Care Coordination:

- Provides an entire team of professionals to assist with comprehensive care coordination.
- Includes the individual and family, as appropriate, as an equal partner in decision making.
- Includes Peer Support and Family support services.
- Provides care coordination using a whole-person, patient-centered approach which removes silos of care and supports an integrated system.
- Assures effectiveness based on health care indicators and quality of life performance and outcome measures.

Figure 2: Health Home Organizational Table


Health Home Program Option Through the ACA
Chronic Health Home Program July 2012
IHH Phase 1 July 2013
IHH Phase 2 April 2014
IHH Phase 3 July 2014

Potentially a member can be enrolled in either or both the IHH and HH. This slide shows examples of where a member could potentially be enrolled.

- Members that can only be enrolled in an Integrated Health Home
    - Includes Children's Mental Health and Habilitation Waivers
- Only in a Chronic Health Home
    - Have a qualifying condition and enrolled in one of the following waivers
        - Aids/HIV
        - Brain Injury
        - Elderly
        - Health and Disability
        - Intellectual Disability
        - Physical Disability
- Can be in either the Integrated Health Home or Health Home
    - Members can choose between the 2 programs with SMI and SED when they are not on a CMH or HAB waiver.

Potential Processes to Consider

- A member is enrolled in an IHH. How do you share and communicate about this member?
- A member could be enrolled in either the IHH or HH. How do you talk with the member and IHH about where the member could be best served?

Acronyms

- Agency for Healthcare Research and Quality (AHRQ)
- Continuity of Care Document (CCD)
- Department of Human Services (DHS)
- Electronic Health Record (EHR)
- Eligibility Verification System (ELVS)
- Fee for Service (FFS)
- Health Home (HH)
- Health Information Network (HIN)
- Home and Community Based Services (HCBS)
- Identification (ID)
- Iowa Medicaid Electronic Record System (I-MERS)
- Integrated Health Home (IHH)
- Iowa Medicaid Enterprise (IME)
- Iowa Medicaid Portal Application (IMPA)
- National Committee for Quality Assurance (NCQA)
- Non-emergency medical transportation (NEMT):
- Patient-centered medical home (PCMH)
- Patient-Centered Primary Care Collaborative (PCPCC)
- Patient Tier Assessment Tool (PTAT)
- Per Member per Month (PMPM)
- Prescription Monitoring Program (PMP)
- Primary Care Provider (PCP)
- State Plan Amendment (SPA)
- Transportation Management Solutions (TMS)

Resources

https://www.pcpcc.org/about/medical-home Defining the Medical Home

http://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html Medicaid.gov

http://www.cms.gov/ Centers for Medicare and Medicaid Services

http://www.ahrq.gov/ the Agency for Healthcare Research and Quality (AHRQ)

http://www.ncqa.org/ The National Committee for Quality Assurance

http://www.nichq.org/how%20we%20improve/resources/qi%20tips%20patients%20connect%20with%20community%20resources NICHQ (National Institute for Children's Health Quality)

http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx The Institute for Healthcare Improvement (IHI)

https://www.resourcesforintegratedcare.com/ Resources for Integrated Care library

http://medicalhomes.aap.org/Pages/Understand-Quality-Improvement.aspx National Center for Medical Home Implementation

http://www.pcdc.org/resources/pcmh-financial-sustainability-toolkit/ Primary Care Development Corporation Patient-Centered Medical Home Financial Sustainability Toolkit