Department of
HUMAN SERVICES

Integrated Health Homes 2022

January 2022

Table of Contents

Integrated Health Homes 2022

Health Homes Introduction

Executive Summary

Summary description including goals and objectives.

A Health Home focused on adults with a Serious Mental Illness (SMI) and children with a Serious Emotional Disturbance (SED). Teams of Health Care Professionals are enrolled to integrate medical, social, and behavioral health care needs for individuals with a SMI or SED.

The Health Home program enrolls Teams of Healthcare Professionals to deliver personalized, coordinated care for individuals meeting program eligibility criteria. In return for the additional Health Home Services to members, the Teams of Healthcare Professionals are paid a per member per month (PMPM) payment to deliver the following Health Home Services.

- **Comprehensive Care Management** is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty healthcare, and community support services, using comprehensive person-centered care plan that addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.
- **Care Coordination** includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, and transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. Coordinate, direct, and ensure results are communicated back to the Health Home.
- **Health Promotion** includes coordinating or providing behavior modification interventions aimed at supporting health management, improving disease outcomes, disease prevention, safety, and an overall healthy lifestyle.
- **Comprehensive Transitional Care** is the facilitation of services for the individual and supports when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community-based group home, family, or self-care, another Health Home).
- **Individual and Family Support Services** include communication with patient, family, and caregivers to maintain and promote the quality of life with particular focus on community living options. Support will be provided in culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.

- **Referral to Community and Social Support Services** includes coordinating or providing recovery services and social health services available in the community, such as understanding eligibility for various healthcare programs, disability benefits, and identifying housing programs.

Services will be a whole-person treatment approach coordinated between multiple delivery systems.

Managed Care Organizations (MCOs) serve as the Lead Entity and:

- Develop a network of Health Homes
- Assess the Integrated Health Home and physical health provider capacity
- Educate and support providers
- Provide oversight and technical support for IHH providers to coordinate with primary care providers
- Provide infrastructure and tools to IHH providers and primary care physical providers
- Perform data analytics
- Provide outcomes tools and measurement protocols to assess effectiveness
- Provide clinical guidelines and other decision support tools
- Provide a repository for member data
- Support providers to share data
- Develop and offer learning activities
- Reimburse providers
- Performing data analysis at the member level and program-wide to inform continuous quality improvement
- Offer Performance Measures Program which may include incentives
- Identify/enroll members

Health Information Technology (HIT) will link services, provide feedback, and facilitate communication among team members. Electronic sharing of health data among Lead Entities, behavioral and physical health providers in a HIPAA compliant manner enables tight coordination with the broader physical health delivery system. Online profiles are able to include medical, behavioral and pharmacy history.

The use of HIT is a means of facilitating these processes that include the following components of care:

- Mental health/behavioral health

- Oral health
- Long term care
- Chronic disease management
- Recovery services and social health services available in the community
- Behavior modification interventions aimed at supporting health management
- (e.g., obesity counseling and tobacco cessation, health coaching)
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Goals and objectives are measured using best practice standards:

- Improved care coordination will be noted through chart reviews, claims, and analysis
- Strengthened community linkages noted through administrative review, chart reviews and claims
- Strengthened team-based care noted through administrative review
- Increased integration of primary and behavioral health care noted through administrative review
- Improved health outcomes noted through analysis
- Improved health status noted through analysis
- Reduction in hospitalizations noted through analysis
- Reduction in hospital readmissions noted through analysis
- Increased access to primary care, with a reduction in inappropriate use of emergency room noted through analysis
- Improved identification of substance use/abuse and engagement in treatment noted through analysis
- Reduction in lifestyle-related risk factors noted through analysis
- Improved experience of care noted through analysis

The Integrated Health Home Provider Website is located https://dhs.iowa.gov/ime/providers/integrated-health-home which provides information and tools to support the MCO and Integrated Health Home Provider.

The Member Health Home Website is located https://dhs.iowa.gov/ime/members/medicaid-a-to-z/health-home and provides information to members looking for additional services.

Health Homes Population and Enrollment Criteria

Population Criteria

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) are eligible
    - Serious mental illness is defined as an adult that has a persistent or chronic mental having (verified within the past year) a, behavioral, or emotional disorder 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 that causes serious functional impairment and substantially interferes with or limits one or more major life activities including functioning in the family, school, employment or community
    - SMI may co-occur with substance use disorder, developmental, neurodevelopmental, or intellectual disabilities but those diagnoses may not be the clinical focus for health home services.
- Members with Serious Emotional Disturbance (SED) are eligible
    - SED is defined by a child having (verified within the past year) a diagnosable mental, behavioral, or emotional disorder 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 which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. SED may co-occur with substance use disorder, developmental, neurodevelopmental, or intellectual disabilities but those diagnoses may not be the clinical focus for health home services

Functional Impairment (FI) as referenced in the definitions above means the loss of functional capacity that is episodic, recurrent, or continuous and that substantially interferes with or limits the achievement of or maintenance of one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive

skills and substantially interfere with or limits the individual's functional capacity with family, employment, school, or community. The level of functional impairment must be identified by the assessment completed by the Licensed Mental Health Professional.

- Does not include difficulties resulting from temporary and expected responses to stressful events in a person's environment

For children three years or younger, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Revised (DC: 03R) may be used as the diagnostic tool. For children four years and older, the Diagnostic Interview Schedule for Children (DISC) may be used as an alternative to the most current DSM

Health Homes Geographic Limitations

Health Home Services will be available statewide

Enrollment of Participants

Describe the process used: Opt-in

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 identify members for referral to a Health Home. In either situation, the member will always be presented with the choice to opt-out at any time.

A member cannot be in more than one health home at the same time.

The State accepts any willing and qualified provider to enroll as a Health Home. Members accessing Health Home Services have access to the full range of Medicaid State Plan covered benefits

- **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
- **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
- **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.

- **The State provides assurance that it will have the systems in places of 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.**
- **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Health Homes Providers

Team of Health Care Professionals

Describe the infrastructure of provider arrangements for Health Home Services:

The Team of Health Care Professionals includes a Lead Entity (when services are delivered via managed care) and a network of qualified IHH providers. The IHH providers will be qualified and designated by the Lead Entity and IME through a provider agreement.

The majority of Medicaid members are served through the Iowa HealthLink. Each of the Health Homes serving both Fee-For-Service and managed care enrollees receive the support of the Lead Entity.

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 if the Lead Entity for managed care members and IME for fee-for-service Members to support the Health Home in meeting the provider standards.

MD/DO must have an active Iowa license and be credentialed.

Nurse Care Coordinators

Describe the Provider Qualifications and Standards:

The Lead Entity and the IHH must have Nurse Care Manager(s) to support the Health Home in meeting the Provider Standards and provide oversight of the delivery of Health Home Services to qualified members. The Nurse Care Managers must be a Registered Nurse (RN) or a Bachelor of Science in Nursing (BSN) with an active Iowa license.

Social Workers

Describe the Provider Qualifications and Standards:

The IHH must have Care Coordinator(s) to support the Health Home in meeting the provider standards and deliver health home services to qualified members. The Care Coordinator must be a Bachelor of Science in Social Work (BSW), or a Bachelor of Science (BS) or Bachelor of Arts (BA) degree in a related field.

The Lead Entity must have a Care Coordinator with a BS/BA in the related field to support the Health Home in meeting the Provider Standards and delivering Health Home Services.

Behavioral Health Professionals

Describe the Provider Qualifications and Standards:

A Psychiatrist must be part of the Lead Entity for managed care enrollees and Iowa Medicaid Enterprise (IME) for fee-for-service enrollees to support the Health Home in meeting the provider standards and to deliver Health Home Services. The Psychiatrist must have a MD/DO and hold an active Iowa license and be credentialed.

Other

Describe the Provider Qualifications and Standards:

- Integrated Health Home (IHH) will include, but not limited to meeting the following criteria:
    - Be an Iowa accredited Community Mental Health Center or Mental Health
    - Service Provider or an Iowa licensed residential group care setting
    - Iowa Licensed Psychiatric Medical Institution for Children (PMIC) facility,
    - Nationally accredited by the Council on Accreditation (COA),
    - The Joint Commission, or Commission on Accreditation of Rehabilitation Facilities (CARF) under the accreditation standards that apply to mental health rehabilitative services

Providers must be enrolled with the Iowa Medicaid Enterprise and enrolled and credentialed with one or more of the MCOs to provide community-based mental health services to the target population

Providers must complete a self-assessment when enrolling as a new Health Home and annually thereafter and submit the self-assessment to the State within designated timelines

Providers must meet the requirements as outlined in the state plan amendment
Providers must participate in monthly, quarterly, and annual outcomes data collection and reporting

- Lead Entity
    - The Lead Entity must be licensed and in good standing in the State of Iowa as a Health maintenance organization (HMO) in accordance with Iowa Administrative Code 191 Chapter 40
    - Have a statewide integrated network of providers to serve members with SMI/SED
    - The Lead Entity must complete an annual self-assessment and submit to the State at the time of enrollment
    - The Lead Entity must meet requirements throughout the state plan amendment
    - The Lead Entity must participate in monthly, quarterly, and annual outcomes data collection and reporting
- Peer Support Specialists/Family Support Specialist

The IHH must have either a Peer Support Specialist or Family Support Specialist. Peer Support Specialists and Family Support Peer Specialists must complete a State recognized training and pass the competency exam within six months of hire if not already trained

Supports for Health Homes Providers

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

- **Provide quality driven, cost effective, culturally appropriate, and person and family-centered Health Homes services,**
- **Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines,**

- **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
- **Coordinate and provide access to mental health and substance abuse services,**
- **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
- **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
- **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
- **Coordinate and provide access to long-term care supports and services, 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:**
- **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
- **Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description

The State will support health Homes to:

- Provide quality driven, cost effective, culturally appropriate, and person and family-centered Health Homes services,
- Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines,
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,
- Coordinate and provide access to mental health and substance abuse services,
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes

appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,

- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,
- Coordinate and provide access to long-term care supports and services, 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:
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:
- Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Program design aligns provider standards and a payment method that ensures that the Health Home Providers have a clear understanding of the expectations and that there is an appropriate reimbursement structure to ensure sustainability for the providers.

The state expects providers to grow into the role of a successful Health Home and has built-in requirements that the Lead Entity both train and facilitate best practices among the network of IHH providers.

The State facilitates a Health Home Focus Group comprised of IME, MCO, Health Home personnel and interested stakeholder associations, to ensure training, communication and alignment on key policy and operational issues.

The State facilitates a Learning Collaborative where Lead Entities will assist IHHs to meet the Provider Standards and to participate in quality improvement activities designed to improve outcomes for the members. The Learning Collaborative consists of:

- Monthly collaborative webinar
- Bi-annual face-to-face training
- Individual provider technical assistance that can be provided by telephone or on site
- Quarterly newsletter

- IME Health Home Webpages
- Process improvement for the Health Homes

The State will develop a program manual to provide clear guidance and expectations to both Lead Entities and Health Homes

The Lead Entity is expected to build capacity among the IHH providers by meeting the following requirements:

- Identification of providers who meet the standards of participation as an Integrated Health Home
- Assessment of the IHH and medical health provider capacity to provide integrated care
- Educate, train and support IHH providers to deliver integrated care
- Provide oversight and technical support for IHH providers to coordinate with primary medical care providers participating in the Iowa Medicaid program
- Provide infrastructure and tools to IHH providers and primary medical care providers to facilitate member care coordination
- Provide tools for IHH providers to assess and customize care management based on the physical/behavioral health risk level of recipient
- Perform data analytics on personal, medical and pharmacy data to identify patterns of care, as well as track, and close gaps in care
- Provide outcome measurement tools and protocols to assess IHH performance
- Provide clinical guidelines and other decision support tools
- Serve as the repository for member data including claims, laboratory, and Continuing Care Document (CCD) data whenever possible
- Support providers to share data including CCD or other data from electronic medical records (EMR)
- Develop and offer learning activities which will support providers of Integrated Health Home services

Provider Standards

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

- Lead Entity Standards

- Meet the Provider Qualifications and Standards of a Lead Entity as described in this State Plan
- Have the following roles to support the Health Homes
    - Psychiatrist
    - Physician
    - Nurse Care Manager
    - Care Coordinators
- Have capacity to evaluate and select Integrated Health Home providers including:
    - Identification of providers who meet the standards of participation to form an Integrated Health Home
    - Assessment of the Integrated Health Home and medical health provider's capacity to coordinate integrated care
    - Educate and support providers to coordinate integrated care
    - Provide oversight, training, and technical support for Integrated
    - Health Home providers to coordinate integrated care
    - Provide infrastructure and tools to Integrated Health Home providers and primary care physical providers for coordination
- Have capacity to provide clinical and care coordination support to Integrated Health Home providers, including:
    - Confirmation of screening and identification of members eligible for Integrated Health Home Services
    - Provide oversight and support of Integrated Health Home providers to develop care plans and identify care management interventions for Integrated Health Home enrollees
    - Providing or contracting for care coordination, including face-to-face meetings, as necessary to ensure implementation of care plan and appropriate receipt of services
    - Gathering and sharing member-level information regarding health care utilization, gaps in care, and medications
    - Monitor and intervene for Integrated Health Home members who are high need with complex treatment plans
    - Facilitate shared treatment planning meetings for members with complex situations
- Have capacity to develop provider information technology infrastructure and provide program tools, including:

- Providing tools for Integrated Health Home providers to assess and customize care management based on the physical/behavioral health risk level of recipient
- Performing data analytics on personal, medical and pharmacy data to identify patterns of care, as well as track, and close gaps in care
- Providing outcomes tools and measurement protocols to assess Integrated Health Home concept effectiveness
- Providing clinical guidelines and other decision support tools
- Repository for member data including claims, laboratory, and Continuing Care Document (CCD) data whenever possible; and
- Support providers to share data including CCD or other data from electronic health records (EHR)

- Have capacity to develop and offer learning activities which will support providers of Integrated Health Home services in addressing the following areas:
  - Providing quality driven, cost effective, culturally appropriate, and person and family driven Health Home Services
  - High quality health care services informed by evidence-based clinical practice guidelines
  - Preventive and health promotion services, including prevention of mental illness and substance use disorders
  - Comprehensive care management, care coordination, and transitional care across settings (transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care)
  - Chronic disease management, including self-management support to members and their families
  - Demonstrating a capacity to use health information technology to link services, facilitate communication among team members and between the Health Home Team and individual and family care givers, and provide feedback to practices, as feasible and appropriate
  - Establishing a continuous quality improvement program, and collecting and reporting on data that permits an evaluation of increased coordination of care and chronic disease management on individual level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

- IHH Provider Standards
    - Meet the Provider Qualifications and Standards of an IHH Provider described in this State Plan.
    - Provider must be able to provide community-based mental health services to the target population
    - Meet the following staff requirements if serving adults:
        - Adult IHH Nurse Care Manager
        - Care Coordinator
        - Trained Peer Support Specialist
    - Meet the following staff requirements if serving children:
        - Child IHH Nurse Care Manager
        - Care Coordinator
        - Family Peer Support Specialist
    - Integrated Health Home Provider will have demonstrated capacity to address the following components, as outlined in SMDL #10-024.
        - Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services
        - Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines
        - Coordinate and provide access to preventive and health promotion services
        - Coordinate and provide access to mental health and substance abuse services
        - Coordinate and provide access to comprehensive care management, care coordination, and transitional care and medication reconciliation across settings. Transitional care includes appropriate follow-up from inpatient care/PMIC/group care to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
        - Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
        - Coordinate and provide access to individual and family supports, including education and referral to community, social support, and recovery and resiliency services
        - Coordinate and provide access to long-term care supports and services

- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services, in collaboration with the lead entity or IME
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

- Recognition/Certification
  - Adhere to all federal and state rules and regulations applicable to the Health Home Program including any Recognition and Certification requirements.
- Ensure a personal provider for each member
  - Ensure each member has an ongoing relationship with a personal provider, physician, nurse practitioner, or physician assistant
- Continuity of Care Document (CCD)
  - Share CCD records with the State and its Lead Entity
  - A CCD details all important aspects of the member's medical needs, treatment plan, and medication list
  - The CCD shall be updated and maintained by the IHH
- Whole Person Orientation
  - Provide or take responsibility for appropriately arranging care with other qualified professionals for all the member's health care needs. This includes care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care
  - Complete status reports to document member's housing, legal, employment status, education, custody, etc.
  - Implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs

        - Work with the Lead Entity or IME to develop capacity to receive members redirected from emergency departments, engage in planning transitions in care with area hospitals, and to follow-up on hospital discharges, including Psychiatric Medical Institutions for Children (PMIC)
        - Have evidence of bi-directional and integrated primary care/behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the State
        - Provide letters of support from at least one area hospital and two area primary care practices that agree to collaborate with the IHH on care coordination and hospital/ER notification
        - Advocate in the community on behalf of their IHH members as needed
    - Coordinated/Integrated Care
        - The Nurse Care Manager or Care Coordinator is responsible for assisting members with medication adherence, appointments, and referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support or lifestyle modification, and behavior change
        - Utilize member level information, member profiles, and care coordination plans for high-risk individuals
        - Incorporate tools and evidenced-based guidelines designed for identifying care opportunities across the age and diagnostic continuum, integrating clinical practices, and coordinating care with other providers
        - Conduct interventions as indicated based on the member's level of risk
        - Communicate with the member and authorized family and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.
        - Monitor, arrange, and evaluate appropriate evidence-based and evidence-informed preventive services
        - Coordinate or provide access to:
            - Mental healthcare
            - Oral health
            - Long-term care

- Chronic disease management
- Recovery services and social health services available in the community
- Behavior modification interventions aimed at supporting health management (including, but not limited to, obesity counseling, tobacco cessation, and health coaching)

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

▪ Crisis services

▪ Assess social, educational, housing, transportation, and vocational needs that may contribute to disease and present as barriers to self-management

▪ Coordinate with Community-based Case Managers (CBCM), Case Manager and Service Coordinators for members that receive service coordination activities

▪ Maintain system and written standards and protocols for tracking member referrals

o Enhanced Access

▪ Assurance of enhanced member and member caregiver (in the case of a child) access, including coverage 24 hours per day, 7 days per week

▪ Use of email, text messaging, patient portals and other technology to communicate with members is encouraged

o Emphasis on Quality and Safety

▪ An ongoing quality improvement plan to address gaps and opportunities for improvement

▪ Participate in ongoing process improvement on clinical indicators and overall cost effectiveness specified by and reported to the State

▪ Demonstrate continuing development of fundamental Health Home functionality through an assessment process to be applied by the State. o Have strong, engaged organizational leadership whom are personally committed to and capable of:

- Leading the practice through the transformation process and sustaining transformed practice

- Agreeing to participate in learning activities including in person sessions, webinars, and regularly scheduled phone calls
- Agree to participate in or convene ad hoc or scheduled meetings to plan and discuss implementation of goals and objectives for practice transformation with ongoing consideration of the unique practice needs for adult members with SMI and child members with SED and their families

- Participate in CMS and State required evaluation activities
- Submit reports as required by the State (e.g., describe IHH activities, efforts, and progress in implementing IHH services)
- Maintain compliance with all of the terms and conditions as an IHH provider
- Commit to the use of an interoperable patient registry and certified
- Electronic Health Record (EHR) within a timeline approved by the Lead Entity or IME, to input information such as annual metabolic screening results, and clinical information to track and measure care of members, automate care reminders, and produce exception reports for care planning
- Complete web-based member enrollment, disenrollment, members' consent to release to information, and health risk questionnaires for all members
- Demonstrate use of a certified EHR to support clinical decision making within the practice workflow.
- Demonstrate evidence of acquisition, installation, and adoption of an EHR system and establish a plan to meaningfully use health information in accordance with the federal law
- Implement state required disease management programs based on population-specific disease burdens. Individual Health Homes may choose to identify and operate additional disease management programs at any time

Health Homes Service Delivery Systems

FFS and Risk-Based Managed Care

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.

Health Plan Contract Language:

3.2.9 Health Homes: The Contractor shall administer and fund the State's Health Home services, or like functions, within the approved State Plan Amendment. If the Contractor chooses to meet the State Plan Amendment criteria related to the functions that provide comprehensive care coordination in a manner other than use of Health Home provider types, this shall be communicated to the Agency and shall be subject to periodic monitoring to ensure all functions are met. In accordance with federal requirements, the Contractor shall ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) HCBS waivers, other forms of community-based case management, or value-based purchasing arrangements. If supplemental services are required to ensure quality of Health Home services to members, the cost of such supplemental services provided to ensure quality may be deducted from Health Home payments.

6.3.6 Health Homes: The Contractor shall develop a network of Integrated Health Homes and Health Homes. The Contractor shall develop strategies to encourage additional participation, particularly in areas of the State where participation has been low. In developing the Integrated Health Homes and Health Homes networks, the Contractor shall ensure all providers meet the minimum requirements for participation as defined in the State Plan and the Agency policy. Refer to Section 3.2.9 for additional detail on all health home requirements.

9.1.1 Comprehensive Health Risk Assessment: The initial health screening described in Section 9.1.1 shall be followed by a comprehensive health risk assessment by a health care professional when a member is identified in the initial screening process as having a special health care need, or when there is a need to follow-up on problem areas identified in the initial screening. The comprehensive health risk assessment shall include an assessment of a member's need for assignment to a health home.

The Lead Entities are contractually required to conduct the following IHH tasks:

- Identify providers who meet the standards of participation as an IHH
- Assess 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
- Provide infrastructure and tools to IHH providers and primary care physical providers for coordination
- Provide tools for IHH providers to assess and customize care coordination based on the physical/behavioral health risk level of the member

- Perform data analytics on personal, medical and pharmacy data to identify patterns of care, as well as track, and close gaps in care member level and program wide
- Provide outcomes tools and measurement protocols to assess IHH concept effectiveness
- Provide clinical guidelines and other decision support tools
- Provide a repository for member data including claims, laboratory, and CCD data whenever possible
- Support providers to share data including CCD or other data from electronic medical records
- Develop and offer learning activities which will support providers of Health Homes services
- Provider reimbursement
- Offer Performance Measures Program which may include incentives
- Identify and enroll members to Health Homes

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

Additionally, the Lead Entity is required to provide clinical and care coordination support to the Health Homes.

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.

Health Homes Payment Methodologies

FFS

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.

Health Home Services, as described in the six service definitions applies to all members enrolled in a Health Home.

Minimum Criteria:

- The member meets the eligibility requirements for health home enrollment as identified in this SPA and documented in the members electronic health record (EHR)
- Member’s eligibility requirements verified within the last 12 months. The member has full Medicaid benefits at the time the PMPM payment is made
- The member has enrolled with the IHH provider
- The Health Home Provider is in good standing with IME and is operating in adherence with all Health Home Provider Standards

- The minimum service required to merit a PMPM payment is that the person has received care management monitoring for treatment gaps defined as Health Home Services in this State Plan. The Health Home must document Health Home Services that were provided for the member.

Minimum Criteria for Intensive Care Management (ICM) members that are enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver. Case managers shall make contacts with the member, the member's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements: in accordance with 441 Iowa Administrative Code Chapter 90.

Claims analysis identified a total count of eligible Health Home Members. Using industry standards for staffing, clinical staffing ratios were determined. The development of the PMPM considers the marketplace value of professional staff to provide the six health home services.

The IHH is eligible to be reimbursed according to the member's tier for any month in which any of the six core services has been provided. Adults and children shall be grouped into four tiers:

- Tier 5 is an adult that qualifies for an IHH but without approved HCBS Habilitation Services
- Tier 6 is a child that qualifies for an IHH but without approved HCBS Children's Mental Health Waiver (CMHW)
- Tier 7 is a member with approved HCBS Habilitation Services
- Tier 8 is a child with approved for the HCBS CMHW

The payment rate may vary between adult and child and with or without the intensive care management (ICM).

The rate is developed according to the actual cost of providing each component of the service for the adult population with and without intensive care management and the child population with and without intensive care management service. No other payments for these services shall be made.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Health Home services. The agency's fee schedule rate was set as of January 1, 2022 and is effective for services provided on or after that date. All rates are published https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

For dates of service on or after January 1, 2022, the Agency fee schedule rates will be updated and posted at https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

The Health Home will bill a 99490 with the appropriate modifier to identify the tier with the informational codes on subsequent line items to attest to Health Home Services Provided.

Procedure Code Health Home PMPM 99490

Tier	Modifier
5 (Adult)	TF
6 (Child)	TG
7 (HAB ICM)	U1
8 (CMH ICM)	U2

Informational Only Codes

Health Home Service	Code
Comprehensive Care Management	G0506
Care Coordination	G9008
Health Promotion	99439
Comprehensive Transitional Care	99426
Individual &Family Support Services	H0038
Referral to Community and Social Support Services	S0281

Rate Development

1) **In the SPA, please provide the cost data and assumptions that were used to develop each of the rates.**

The rate is developed according to the actual cost of providing each component of the service for the adult population with and without intensive care management and the child population with and without intensive care management service. No other payments for these services shall be made.

Salaries are pulled from Iowa Wage Report data (https://www.iowaworkforcedevelopment.gov/iowa-wage-report) using applicable codes for each individual role. Costs were allocated based on caseloads and enrollment, with budget neutrality

2) **Please identify the reimbursable unit(s) of service**

   a. Tier 5 Adults

   b. Tier 6 Children

   c. Tier 7 Habilitation

   d. Tier 8 Children' Mental Health Waiver

3) **Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit.**

The minimum service is that the Provider document one of the six Health Home Services.

4) **Please describe the state's standards and process required for service documentation**

All Health Home Services must be documented in the member record and identified with a specific code on the claim.

5) **Please describe in the SPA the procedures for reviewing and rebasing the rates, including**

   a. **The frequency with which the state will review the rates, and**

   b. **The factors that will be reviewed by the state in order to understand if the rates are economic, efficient, and sufficient to ensure quality services. The rates will be reviewed on an annual basis using the same methodology described in this section.**

The rates will be reviewed on an annual basis using the same methodology described in this section.

Risk-Based Managed Care

Same as FFS

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as1915(c) waivers or targeted case management.

To avoid duplication of services, members who are enrolled in the 1915i Habilitation program and concurrently enrolled in a 1915c waiver program, will receive their coordination of services through the Community-Based Case Manager. Members may choose to be enrolled with the Integrated Health Home at a tier 5 or 6. The CBCM and Integrated Health Home will work together to ensure non-duplication of services. Additionally, Lead Entities are contractually required to ensure non-duplication of payment for similar services. The State reviews and approves Lead Entity nonduplication strategies and conducts ongoing monitoring to assure continued compliance.

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

Integrated Health Home Provider. If a member receives case management through a waiver to the State Plan and also qualifies for the Integrated Health Home, the Health Home must collaborate with the Community-Based Case Manager (CBCM), and Service Coordinators to ensure the care plan is complete and not duplicative between the two entities at a minimum of at least quarterly.

The State provides assurance that all governmental and private providers are reimbursed according to the same rates schedule.

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

Health Homes Services

Comprehensive Care Management

Comprehensive care management is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty healthcare, and community support services, using comprehensive person-centered care plan that addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

Service Definition:

- Outreach and engagement activities to members to gather information and engage in comprehensive care management
- Assessment of the member's current and historical information provided by the member, the Lead Entity, and other health care providers that supports the member
- Assessment includes a physical and behavioral assessment, medication reconciliation, functional limitations, and appropriate screenings, completed by a licensed health care professional within 30 days of enrolling
- Assess the member's social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors
- Assessing member's readiness for self-management using screenings and assessments with standardized tools
- Comprehensive Assessment is conducted at least every 12 months or more frequently as needed when the member's needs or circumstances change significantly or at the request of the member or member's support

- Creation of a person-centered care plans by a licensed health care professional with the member and individuals chosen by the member that address the needs of the whole person with input from the interdisciplinary team and other key providers
- Organize, authorize, and administer joint treatment planning with local providers, members, families, and other social supports to address total health needs of members
- Wraparound planning process: identification, development and implementation of strengths-based individualized person-centered care plans addressing the needs of the whole child and family
- 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
- Information technology functionality developed to allow online receipt of standardized Continuity of Care Document (CCD)
- 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
- Assignment of team roles and responsibilities

Health Information Technology:

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 Lead Entities, 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
- Assessment-driven whole person member profile development provided to inform local IHH provider
- Administration of online provider tools, including Health and Wellness
- Questionnaire to assess initial risk level, and Care Coordination Plan

- Member profile summarizing key information about the members medications, healthcare 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
- Regular report distribution to the local IHH Provider teams
- A member website

The benefit/service can only be provided by certain provider types:

- Nurse Care Coordinators known as Nurse Care Managers
- Social Workers known as Care Coordinators
- Other
    - Lead Entity MD/DO (including Psychiatrist)
    - Peer Support Specialist or Family Support Specialist

Description:

- Nurse Care Managers from the IHH will be responsible for the oversight of this service
- Care Coordinators may assist the Nurse Care Manager in the delivery of this service
- Peer Support Specialist or Family Support Specialist may assist with the development of and contribute information to support the Comprehensive Assessment and Person-Centered Care Plan
- Lead Entity
    - Participate in joint treatment planning with local providers, members, families, and other social supports to address total health needs of members as needed

Care Coordination

Care Coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, and transition of care, wellness education, health support and/or lifestyle

modification, and behavior changes. Coordinate, direct, and ensure results are communicated back to the IHH.

Service Definition:

- Implementation of a Person-Centered Care Plan
- Outreach activities to members to engage in care coordination
- Continuous monitoring of progress towards goals identified in the person-centered care plan though face-to-face and collateral contacts with member, member's supports, primary care, and specialty care
- Scheduling appointments
- Making referrals
- Tracking referrals and appointments
- Follow-up monitoring
- Communicating with providers on interventions/goals
- Conducting joint treatment staffing: 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
- Addressing barriers to treatment plan
- Coordinate multiple systems for children with SED as part of a child and family-driven team process
- Appropriately arrange care with other qualified professionals for all the member's health care needs. This includes care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care

When the member receives care coordination from a Community-Based Case Manager as a Home and Community-Based Waiver Service or Service Coordination through the MCO, the Health Home must collaborate with Community-Based Case Manager or Service Coordinator to ensure the care plan is complete and not duplicative between the two entities.

Health Information Technology:

The Lead Entity will provide a secure portal to assist the IHH to coordinate care. The establishment of an EHR system will assist care coordinators with maintaining a comprehensive medication list, allow providers access to evidenced-based decisions and assist with referral protocols.

Health IT can assist care coordinators providing and disseminating wellness education, informative tracks, and resources that supports lifestyle modification and behavior changes.

The benefit/service can only be provided by certain provider types:

- Nurse Care Coordinators known as Nurse Care Managers
- Social Workers known as Care Coordinators
- Other
    - Lead Entity
        - MD/DO (including Psychiatrist)
    - Peer Support Specialist or Family Support Specialist

Description:

- Nurse Care Managers will be responsible for the oversight of this service.
- Care Coordinators may assist the Nurse Care Manager with the delivery of this service
- Other
    - Peer Support Specialist or Family Support Specialist may assist with the following Care Coordination services:
        - Outreach
        - Follow-up monitoring
        - Assist the member to schedule appointments
        - Attending joint staffing treatment meetings
        - Support coordination of care with providers and specialist
- The Lead Entity assists the IHH in performing 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

Health Promotion means the education and engagement of an individual in making decisions that promotes health management, improved disease outcomes, disease prevention, safety, and an overall healthy lifestyle.

Service 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
- Provide prevention education to members and family members about health screening, childhood developmental assessments and immunization standards
- Providing self-management support and development of self-management plans and/or relapse prevention plans so that members can attain personal health goals
- Using motivational interviewing, trauma-informed care, and other evidenced based practices to engage and help the member in participating and managing their own care
- Promoting self-direction and skill development in the area of independent administering of medication and medication adherence
- Provide prevention education to members and family members about health screening, childhood developmental assessments and immunization standards
- Increasing health literacy and self-management skills (i.e., WRAP)
- Education or training in self-management of chronic diseases

Health Information Technology:

The patient-centered care plan will be used to plan, communicate, and document individualized goals, interventions, and track status. Continuity of Care Documents will be useful in tracking treatment progress and coordination with providers.

The benefit/service can only be provided by certain provider types:

- Nurse Care Coordinators known as Nurse Care Managers
- Social Workers known as Care Coordinators
- Other
    - Lead Entity
    - Peer Support Specialist or Family Support Specialist

Description:

- Nurse Care Managers will be responsible for the oversight of this service
- Care Coordinators can assist the Nurse Care Manager with the delivery of this service
- Other
    - Peer support specialist may assist with this service through peer lead programs i.e., Wellness Recovery Action Plan (WRAP)
    - The Lead Entity assists the IHH in performing health promotion

Comprehensive Transitional Care

Comprehensive transitional care is the facilitation of services for the individual and supports when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community-based group home, family, or self-care, another Health Home).

Service Definition:

- Engage member and/or caregiver as an alternative to emergency room or hospital care
- 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
- Develop relationships with hospitals and other institutions and community providers to ensure efficient and effective care transitions
- Provide prompt notification of member's admission/ discharge to and from an emergency department, inpatient residential, rehabilitative, or other treatment settings to the member's medical care physician and community support providers with the intent of coordinating care
- Active participation in discharge planning to ensure consistency in meeting the goals of the member's person-centered plan
- Communicating with and providing education to the provider where the member is currently being served and the location where the member is transitioning
- Ensure the following:
    - Receipt of a CCD from the discharging entity

    - Medication reconciliation
    - Reevaluation of the care plan to include and provide access to needed community supports that includes short-term and long-term care coordination needs resulting from the transition
    - Plan to ensure timely scheduled appointments
- Facilitate transfer from a pediatric to an adult system of health care
- The Teams of Health Care Professionals shall establish personal contact with the member regarding all needed follow-up after the transition

Health Information Technology:

The Lead Entity will provide electronic and telephonic notifications of hospitalizations 24/7.

Care coordination plans and member profiles (including a medication list) are available via the Lead Entity secure portal to support all IHH team members and providers in transitional care management, medication reconciliation, and follow-up care.

The benefit/service can only be provided by certain provider types:

- Nurse Care Coordinators known as Nurse Care Managers
- Social Workers known as Care Coordinators
- Other
    - Lead Entity MD/DO (including Psychiatrist)
    - Peer Support Specialist or Family Support Specialist

Description:

- Nurse Care Managers will be responsible for the oversight of this service
- Care Coordinators can assist the Nurse Care Manager with the delivery of this service
- Other
    - Peer support specialist may assist with this service through peer lead programs service activities include, but are not limited to:
        - Engage member and/or caregiver 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
    - The Lead Entity 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

Individual and Family Support Services include communication with member, family, and caregivers to maintain and promote the quality of life with particular focus on community living options. Support will be provided in culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.

Service Definition:

- Providing assistance to members in accessing needed self-help and peer/family support services
- Advocacy for members and families
- Education regarding concerns applicable to the member
- Education or training in self-management of chronic diseases
- 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
- Assisting members in meeting their goals

Health Information Technology:

An IHH member website is available to all IHH enrollees, potential enrollees, their families and supports. The member website 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.

The benefit/service can only be provided by certain provider types:

- Nurse Care Coordinators known as Nurse Care Managers
- Social Workers known as Care Coordinators
- Other
    - Lead Entity
    - Peer Support Specialist or Family Support Specialist

Description:

- Nurse Case Managers or Care Coordinators at the IHH will be responsible for the oversight of this service and must be noted in the person-centered care plan
- The Lead Entity assists the IHH in performing individual and family support
- Other
    - Peer Support or Family Peer Support Specialist, may assist with the following individual and Family support services:
        - Providing assistance to members in accessing needed self-help and peer/family peer 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 medication 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 psycho educational programs
        - Assisting members in meeting their goals

Referral to Community and Social Support Services

Referral to Community and Social Support Services includes coordinating or providing recovery services and social health services available in the community, such as understanding eligibility for various healthcare programs, disability benefits, and identifying housing programs.

Service Definition:

Provide resource referrals or coordinate to the following, as needed:

- Resources to reduce barriers to assist members in achieving their highest level of function with independence
- 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
- Iowa Department of Public Health (IDPH) Programs
- Housing services Housing and Urban Development (HUD), rental assistance program through the Iowa Finance authority
- Food Assistance Iowa Department of Human Services (DHS), Food Bank of Iowa
- Transportation services (NEMT), free or low-cost public transportation
- Programs that assist members in their social integration and social skill building
- Faith-based organizations
- Employment and educational programs or training, Iowa Workforce Development
- (IWD), Iowa Vocational Rehab Services (IVRS)
- Volunteer opportunities
- Monitor and follow-up with referral source, member, and member's support to ensure that members are engaged with the service

When the member receives care coordination from a Community-Based Case Manager as a Home and Community-Based Waiver Service or Service Coordination through the MCO, the Health Home must collaborate with Community-Based Case Manager or Service Coordinator to ensure the care plan is complete and not duplicative between the two entities.

Health Information Technology:

The person-centered care 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 website 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.

The benefit/service can only be provided by certain provider types:

- Nurse Care Coordinators Known as Nurse Care Managers
- Social Workers Known as Care Coordinators
- Other
    - Lead Entity
    - Peer Support Specialist or Family Support Specialist

Description:

- Nurse Case Managers or Care Coordinators at the IHH will be responsible for the delivery of this service and must be noted in the person-centered care plan.
- Other
    - Peer Support Specialist or Family Support Specialist
        - Support the member to participate in social supports
    - The Lead Entity assists the IHH in performing referral to community and social support services

Health Homes Monitoring, Quality Measurement and Evaluation

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications.

The State will utilize Medicaid claims and encounter data to assess the difference in incidence rates of 30-day All-cause “Unplanned” Hospital Readmission events between enrolled Health Home members and non-enrolled members. Readmission outcomes exclude “planned” hospitalizations within 30 days of an initial “anchor” hospitalization and “transfer” hospitalizations on the same day of an initial “anchor” hospitalization using institutional claims’ member status codes (discharge codes) and admission/discharge dates. Inferential methods utilize a cross-sectional case/control cohort quasi-experimental design.

Propensity scoring, matching, and/or predictive cost models will be used to identify non-enrolled members (Control cohort) that are similarly matched to enrolled Health Home members (Treatment/Case cohort) in regards to baseline age, gender, predicted expenditures, and multiple chronic/acute condition characteristics. Cohorts are then assessed for differences in outcomes during a specified evaluation period (annual) via doubly robust count-based multivariate regression techniques. Count-based regression models risk adjust final estimates of differences in readmission outcomes through the reuse of select matching covariates (age, gender), additional covariates (county of

residence, long-term service support status), and members' varying time spans of Medicaid enrollment. These methods are used to carry out analyses for each Tier.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Home program, including data sources and measurement specifications.

The State will utilize Medicaid claims and encounter data to assess the difference in average per-member-per-month (PMPM) expenditures (final paid claim allowed amounts) between enrolled Health Home members and non-enrolled members. Inferential methods utilize a longitudinal case/control cohort quasi-experimental design. Propensity scoring, matching, and/or predictive cost models will be used to identify non-enrolled members (Control cohort) that are similarly matched to enrolled Health Home members (Treatment/Case cohort) in regard to baseline age, gender, predicted expenditures, and multiple chronic/acute condition characteristics. Cohorts are then assessed for differences in expenditure outcomes during a specified evaluation period (annual) via doubly robust multivariate linear regression techniques. Regression models include the reuse of select matching covariates (age, gender), additional covariates (time, county of residence, long-term service support status), and adjustment for correlated member-specific expenditure measurements over time (adjust for clustering of repeated measures) to yield risk-adjusted estimates of differences in expenditure outcomes.

Regression models include an interaction term of time and treatment cohort to evaluate the difference in trends of expenditures between cohorts over time. Sensitivity analyses are conducted to explore the impact on measurements after removal of matched cohort members with high-cost severe/acute conditions and where removal of high-cost leverage/outlier situations may be prudent. These methods are used to carry out analyses for each Tier.

Describe how the State will use health information technology in providing Health Home 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 technology infrastructure for health information exchange to be utilized by the Health Homes in order to facilitate collaboration. These capabilities include but are not limited to; member screening and risk stratification, and a web-based profile that integrates Medicaid claims, member self-reported information, and clinical documentation. The Lead Entity will be responsible for sharing health utilization and claims data with the Health Homes to facilitate care coordination and prescription monitoring for members receiving Health Home services. A member website will be available to Health Home enrollees, their families, and supports. It will contain evidence-

based information on conditions, health promotion and wellness information, and links to resources.

As a part of the minimum requirements of an eligible provider to operate as a health Home, the following relate to HIT:

- Demonstrate use of a population management tool (patient registry) and the ability to evaluate results and implement interventions that improve outcomes over time
- Demonstrate evidence of acquisition, instillation, and adoption of an EHR, system and establish a plan to meaningfully use health information in accordance with federal law
- Provide 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
- Utilize email, text, messaging, patient portals and other technology as available to communicate with other providers

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

Hospital Admission Rates

Measure Specification, including a description of the numerator and denominator. The State will consolidate data from Medicaid claims and encounter data and monitor the difference in incidence rates and length of stay between enrolled Health Home Members and like non-enrolled members. (Measure calculations may be impacted by Medicare data availability)

Data Sources: Claims, including MCO encounter data
Frequency: Annually

ER Visit

Measure Specification, including a description of the numerator and denominator. The State will consolidate data from Medicaid claims and encounter data and monitor the difference in incidence rates between enrolled Health Home Members and like non-enrolled members. (Measure calculations may be impacted by Medicare data availability)

Data Sources: Claims, including MCO encounter data
Frequency: Annually

SNF Admissions

Measure Specification, including a description of the numerator and denominator. The State will consolidate data from Medicaid claims and encounter data and monitor the difference in incidence rates and length of stay between enrolled Health Home Members and like non-enrolled members. (Measure calculations may be impacted by Medicare data availability)

Data Sources: Claims, including MCO encounter data
Frequency: Annually

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 and monitor the difference in incidence rates and length of stay between enrolled Health Home Members and like non-enrolled members. (Measure calculations may be impacted by Medicare data availability)

Chronic Disease Management

Clinical data received from providers on Health Home enrollees will provide the best picture for this evaluation.

Coordination of Care for Individuals with Chronic Conditions

Clinical data received from providers on health home enrollees will provide the best picture for this evaluation.

Assessment of Program Implementation

This will consist of a review of the program administrative costs, reported member outcomes, and overall program cost savings and member surveys.

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.

Lead Entity Dashboard

The Lead Entity will have a withhold that can be earned back through meeting identified benchmarks.

Priority	Measure
Structure	Lead Entity Self-Assessment
	Health Home Self-Assessment
Process	Health Home Dashboard
	A15 Report
	CSR Report
	Level of Care Report
Outcomes	Member Surveys
	Performance Measures
	CMS Health Home Core Measures
	Chart Review Results

Health Home Dashboard

The Health Home will have practice transformation assistance by the Lead Entities based on the Health Home Dashboard.

Priority	Measure
Structure	Health Home Self-Assessment
Process	Health Home Dashboard
Outcomes	Member Surveys
	Performance Measures
	CMS Health Home Core Measures
	Chart Review Results

Processes and Lessons Learned

An evaluation that includes provider and member input on the Health Home Program will inform the state on ways to improve the process.

The State Medicaid Agency and the Lead Entity will continue to develop tools to capture feedback from the Health Homes to document and understand any operational barriers to implementing Health Home Services.

As more successful Health Homes are identified via clinical data and claims data, implementation guidelines and suggestions will be documented and trained to further promote success statewide.

Assessment of Quality Improvements and Clinical Outcomes

An evaluation that includes provider and member input on the Health Home Program will inform the state on ways to improve the process.

An evaluation of clinical data shared by providers will allow the state to adjust the clinical outcome measures to ensure the optimal results and continued improvement.

Cost Savings

The State will utilize Medicaid claims and encounter data to assess the difference in average per-member-per-month (PMPM) expenditures (final paid claim allowed amounts) between enrolled Health Home members and non-enrolled members. Inferential methods utilize a longitudinal case/control cohort quasi-experimental design. Propensity scoring, matching, and/or predictive cost models will be used to identify non-enrolled members (Control cohort) that are similarly matched to enrolled Health Home members (Treatment/Case cohort) in regards to baseline age, gender, predicted expenditures, and multiple chronic/acute condition characteristics. Cohorts are then assessed for differences in expenditure outcomes during a specified evaluation period (annual) via doubly robust multivariate linear regression techniques.

Regression models include the reuse of select matching covariates (age, gender), additional covariates (time, county of residence, long-term service support status), and adjustment for correlated member-specific expenditure measurements over time (adjust for clustering of repeated measures) to yield risk-adjusted estimates of differences in expenditure outcomes. Regression models include an interaction term of time and treatment cohort to evaluate the difference in trends of expenditures between cohorts over time. Sensitivity analyses are conducted to explore the impact on measurements after removal of matched cohort members with high-cost severe/acute conditions and where removal of high-cost leverage/outlier situations may be prudent.