IA - Submission Package - IA2021MS0005O - (IA-22-0004-IHH) - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID	IA2021MS0005O
Program Name	Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation
SPA ID	IA-22-0004-IHH
Version Number	1
Submission Type	Official
State	IA
Region	Kansas City, KS
Package Status	Pending

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0005O | IA-22-0004-IHH | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

Package ID IA2021MS0005O

SPA ID IA-22-0004-IHH

Submission Type Official

Initial Submission Date N/A

Approval Date N/A

Effective Date N/A

Superseded SPA ID N/A

State Information

State/Territory Name: Iowa

Medicaid Agency Name: Department of Human Services

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0005O | IA-22-0004-IHH | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

Package ID IA2021MS0005O

SPA ID IA-22-0004-IHH

Submission Type Official

Initial Submission Date N/A

Approval Date N/A

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID IA-22-0004-IHH

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Payment Methodologies		IA-21-0003

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0005O | IA-22-0004-IHH | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

Package ID	IA2021MS0005O	**SPA ID**	IA-22-0004-IHH
Submission Type	Official	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	N/A
Superseded SPA ID	N/A		

Executive Summary

Summary Description Including Goals and Objectives

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 phar

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount

	Federal Fiscal Year	Amount
First	2022	$0
Second	2023	$0

Federal Statute / Regulation Citation

2703 Amendment from the Affordable Care Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0005O | IA-22-0004-IHH | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

Package ID	IA2021MS0005O	**SPA ID**	IA-22-0004-IHH
Submission Type	Official	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	N/A
Superseded SPA ID	N/A		

Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0005O | IA-22-0004-IHH | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [ ] Eligibility
- [ ] Benefits and Payments
  - [ ] Health Homes Program

Do not use "Create New Health Homes Program" to amend an existing Health Homes program. Instead, use "Amend existing Health Homes program," below.

- ( ) Create new Health Homes program
- (•) Amend existing Health Homes program
- ( ) Terminate existing Health Homes program

Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Impleme...

Health Homes SPA - Reviewable Units

Only select Reviewable Units to include in the package which you intend to change.

*

	Reviewable Unit Name	Included in Another Submission Package	Source Type
[ ]	Health Homes Intro	(	APPROVED
[ ]	Health Homes Geographic Limitations	(	APPROVED
[ ]	Health Homes Population and Enrollment Criteria	(	APPROVED
[ ]	Health Homes Providers	(	APPROVED
[ ]	Health Homes Service Delivery Systems	(	APPROVED
[ ]	Health Homes Payment Methodologies	(	APPROVED
[ ]	Health Homes Services	(	APPROVED
[ ]	Health Homes Monitoring, Quality Measurement and Evaluation	(	APPROVED

1 – 8 of 8

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0005O | IA-22-0004-IHH | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

Package ID	IA2021MS0005O	**SPA ID**	IA-22-0004-IHH
Submission Type	Official	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	N/A
Superseded SPA ID	IA-21-0003		
	System-Derived		

Payment Methodology

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

- [ ] Fee for Service
  - [ ] Individual Rates Per Service
  - [ ] Per Member, Per Month Rates
  - [ ] Fee for Service Rates based on
    - [ ] Severity of each individual's chronic conditions
    - [ ] Capabilities of the team of health care professionals, designated provider, or health team
    - [ ] Other

      Describe below

      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.
  - [ ] Comprehensive Methodology Included in the Plan
  - [ ] Incentive Payment Reimbursement

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

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 ICM (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 market place 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 or Habilitation and 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 November, 2015 and is effective for services provided on or after that date. All rates are published at 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

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0005O | IA-22-0004-IHH | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

Package ID IA2021MS0005O

SPA ID IA-22-0004-IHH

Submission Type Official

Initial Submission Date N/A

Approval Date N/A

Effective Date N/A

Superseded SPA ID IA-21-0003

System-Derived

Agency Rates

Describe the rates used

- (•) FFS Rates included in plan
- ( ) Comprehensive methodology included in plan
- ( ) The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0005O | IA-22-0004-IHH | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

Package ID	IA2021MS0005O	**SPA ID**	IA-22-0004-IHH
Submission Type	Official	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	N/A
Superseded SPA ID	IA-21-0003 System-Derived		

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

1) 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) Tier 5 Adults
Tier 6 Children
Tier 7 Habilitation
Tier 8 Children' Mental Health Waiver

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

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

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

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0005O | IA-22-0004-IHH | Migrated_HH.IA-16-013 IA SPMI Health Home - Managed Care Implementation

Package Header

Package ID	IA2021MS0005O	**SPA ID**	IA-22-0004-IHH
Submission Type	Official	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	N/A
Superseded SPA ID	IA-21-0003 System-Derived		

Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved

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 non-duplication 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 has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
IHH PMPM Billing Guidance Effective January 1 2022	12/15/2021 9:50 AM EST	

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 12/27/2021 3:13 PM EST