STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

For Health and Human Services use only:

General Letter No. 8-AP-504
Employees' Manual, Title 8
Medicaid Appendix

October 7, 2022

Integrated Health Home Program Manual Transmittal No. 22-2

ISSUED BY: Division of Medical Services
SUBJECT: ***Integrated Health Home Program (IHH),*** Chapter III., ***Provider-Specific Policies,*** Title Page 1,Table of Contents Page i, Title Page 2, Table of Contents Page 1 and 2, pages 1-31, revised; 32-40, removed.

Summary

The Integrated Health Home Program (IHH) manual is revised to update policy, procedure, and information, as well as style and formatting throughout.

Date Effective

Immediately.

Material Superseded

This material replaces the following pages from the ***Integrated Health Home Program (IHH)*** manual:

Page	Date
Title Page 1	February 25, 2022
Contents Page i	February 25, 2022
Title Page 2	February 25, 2022
Contents 1 and 2	February 25, 2022
1-40	February 25, 2022

Additional Information

The updated provider manual containing the revised pages can be found at:
http://dhs.iowa.gov/sites/default/files/IHH.pdf

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.

Integrated Health Home

Provider Manual

IOWA HHS

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. Integrated Health Home Program

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.

A record of past and current General Letters outlining the content changes to this chapter is available online at: http://dhs.iowa.gov/sites/default/files/IHH_GL.pdf

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.

1. Legal Basis

The Affordable Care Act of 2010, Section 2703 (1945 of the Social Security Act), created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. The Centers for Medicare & Medicaid Services (CMS) expects states Health Home providers to operate under a "whole-person" philosophy. Health Home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

The portions of the Code of Federal Regulations specifically dealing with Health Home Services are in Title 42, Chapter 7, Subtitle XIX, § 1396w–4 State option to provide coordinated care through a Health Home for individuals with chronic conditions and, in addition to the Social Security Act, serve as the basis for state law and administrative rules.

Health Home Programs are administered by the designated state Medicaid agency that is the Iowa Medicaid. The Iowa Medicaid has the authority for the operation of the Health Home Programs.

There are currently two Health Home Programs that include:

- Chronic Condition Health Home July 1, 2012
- Integrated Health Home July 1, 2013

2. Definitions

Legal reference: 441 IAC 77.47(249A) Conditions of Participation For Providers of Medical and Remedial Care,
78.53(249A) Amount, Duration and Scope of Medical and Remedial Services,
79(249A) Other Policies Relating to Providers of Medical and Remedial Care,
83.121(249A) Children's Mental Health, and
90(249A) Case Management Services.

"**Adult**" means a person aged 18 years or over.

"**Appropriate**" means that the services or supports or activities provided or undertaken by the organization are relevant and medically necessary to the member's needs, situation, problems, or desires.

"**Assessment**" means the review of the member's current functioning in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"**Care Coordinator**" means the professional who assists members in care coordination as described in paragraph 78.53(1)"b."

"**Case management**" means services provided according to rule 441 IAC 90.5(249A) and 441 IAC 90.8(249A).

"**Child**" means a person aged 17 or under.

"**CMS**" means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

"**Community**" means a natural setting where people live, learn, work, and socialize.

"Comprehensive Assessment" includes all aspects of a member's life and meets criteria outlined in 78.53 (5).

"**Core Standardized Assessment (CSA)**" is a tool for gathering information from the individuals in the same HCBS population by asking a standard set of questions about basic functional skills and abilities. CSA tools are designed to be welcoming and easy to use, identify the strengths and support needs of the individual, and take into account the opinions of the individual, as well as the needs of the person's family and caregivers.

"**Deemed status**" means acceptance by the Department of Accreditation or Licensure of a program or service by another accrediting body in lieu of accreditation based on review and evaluation by the Department.

"**Department**" means the Iowa Department of Human Services.

"Designated provider" means a Health Home that is a Medicaid enrolled entity and meets the Health Home enrollment criteria specified in 441-subrule 77.47(2) or 77.47(3)

"**Functional impairment**" means the loss of functional capacity that (1) is episodic, recurrent, or continuous;(2) substantially interferes with or limits the achievement of or maintenance of one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills; and (3) substantially interfere with or limits the individual's functional capacity with family, employment, school or community. It does not include difficulties resulting from temporary and expected responses to stressful events in a person's environment. The level of functional impairment must be identified by the assessment completed by a mental health professional as defined in 441 IAC 24.1(225C).

"**Guardian**" means a guardian appointed in court.

"**HCBS**" means home- and community-based services.

"**Health**" means a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. This includes the maintenance of one's health including:

- Diet and nutrition
- Illness identification, treatment, and prevention
- Basic first aid
- Physical fitness
- Regular health and wellness screenings
- Personal habits

"Integrated Health Home (IHH)" means a provider enrolled to integrate medical, social, and behavioral health care needs for adults with a serious mental illness and children with a serious emotional disturbance and that is determined through the provider enrollment process to have the qualifications, systems, and infrastructure in place to provide Integrated Health Home services pursuant to 441 IAC 77.47(240A). Integrated Health Home covered services and member eligibility for Integrated Health Home enrollment is pursuant to 441 IAC 78.53(249A).

"Intensive Care Management" means the provision of case management services to enrollees who are also enrolled in the 1915(i) state Plan HCBS Habilitation program or the 1915 (c) Children's Mental Health Waiver.

"**Interdisciplinary Team**" means a collection of persons with varied backgrounds chosen by the member who meet with the member to develop a service plan to meet the member's need for services. At a minimum, the member and case manager must be part of the interdisciplinary team.

"**IoWANS**" is the Iowa Department of Human Services' *Institutional and Waiver Authorization and Narrative System.* The purpose of IoWANS is to assist workers in the facility and waiver programs in both processing and tracking requests starting with entry from the ABC system through approval or denial.

"**Lead Entity**" means a managed care organization that supports and oversees the integrated health home network.

"**Local office**" means the county Department of Human Services office as described in rule 441 IAC 1.4(2).

"**Maintenance needs**" means costs associated with rent or mortgage, utilities, telephone, food, and household supplies.

"**Managed Care Organization (MCO)**" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"**Medical institution**" means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

"**Member**" means a person who is eligible for Medicaid under rule 441 IAC Chapter 75.

"**Mental health professional**" means a person who meets all of the following conditions:

- Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and
- Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and
- Has at least two years of post-degree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"**Natural supports**" means services and supports an individual identifies as wanted or needed that are provided at no cost by family, friends, neighbors, and others in the community, or by organizations or entities that serve the general public at no cost to the Medicaid program.

"**Patient-centered care plan**" means a care plan created through the person-centered planning process, directed by the member or the member's guardian or representative, for a member receiving non-intensive care management or chronic condition health home services, to identify the member's strengths, capabilities, preferences, needs, goals, and desired outcomes.

"**Person-centered service plan**" or "**service plan**" means a service plan (1) created through the person-centered planning process in accordance with rules 441--78.27(249A) and 441--83.127(249) and 441-paragraph 90.4(1) "b"; (2) which is directed by the member or the member's guardian or representative; (3) for a member receiving intensive care management services; and (4) for the purposes of identifying the member's strengths, capabilities, preferences, needs, and desired outcomes.

"**Policies**" means the principles and statements of intent of the organization.

"**Procedures**" means the steps taken to implement the policies of the organization.

"**Process**" means service or support provided by an agency to a member that will allow the member to achieve an outcome. This may include a written, formal, consistent or an informal method that is not written but is a verifiable method.

"**Program**" means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

"**Psychiatric medical institutions for children (PMIC)**" means a psychiatric medical institution for children that use a team of professionals to direct an organized program of diagnostic services, psychiatric services, nursing care, and rehabilitative services to meet the needs of residents in accordance with a medical care plan developed for each resident.

"**Registered nurse (RN)**" means a person licensed to practice nursing in the state of Iowa according to Iowa Code Chapter 152.

"**Serious emotional disturbance**" means a diagnosable mental, behavioral, or emotional disorder that:

- Is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association; and
- Has resulted in a functional impairment that substantially interferes with or limits a consumer's role or functioning in family, school, or community activities.

Serious emotional disturbance shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as "other conditions that may be a focus of clinical attention," unless these conditions co-occur with another diagnosable serious emotional disturbance.

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.

"**Serious Mental Illness**" means, for an adult, a persistent or chronic mental health, behavioral, or emotional disorder that (1) is 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, and (2) 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. "Serious mental illness" 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.

"**Service coordination**" means activities designed to help individuals and families locate, access, and coordinate a network of natural supports and services that will allow them to live a full life in the community. Included are using natural supports and services, other payment sources, and state plan use before the use of waiver services to provide the most cost-effective coordination for the member.

"**Service plan**" means an individualized goal-oriented plan of services written in a language understandable by the member or the member's representative using the service and developed collaboratively by the individual and the interdisciplinary team.

"**Skill development**" means that the service provided is intended to impart an ability or capacity to the member.

"**Staff**" means a person under the direction of the organization to perform duties and responsibilities of the organization.

B. Conditions Of Participation

Legal reference: 441 IAC 78.53(249A) Health Home Services

1. Qualified Providers

A provider of Integrated Health Home services is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies to provide community based mental health services:

- The Joint Commission accreditation (TJC), or
- The Healthcare Facilities Accreditation Program (HFAP), or
- The Commission on Accreditation of Rehabilitation Facilities (CARF), or
- The Council on Accreditation (COA), or
- The Accreditation Association for Ambulatory Health Care (AAAHC), or
- Iowa Administrative Code 441 IAC Chapter 24, "Accreditation of Providers of Services to Persons with Mental Illness, Intellectual Disabilities, or Developmental Disabilities
- Licensed Psychiatric Medical Institution for Children (PMIC) facility,
- Licensed Group Care provider

2. Provider Standards and Requirements

- Providers must complete an annual self-assessment and submit to the State at the time of enrollment
- Providers must meet requirements throughout the state plan amendment
- Providers must participate in monthly, quarterly, and annual outcomes data collection and reporting

The Health Home shall have policies and processes in place to ensure compliance with federal and state requirements, including but not limited to statutes, rules and regulations, and sub-regulatory guidance. The Health Home shall maintain documentation of its policies and processes and make those policies and processes readily available to any state or federal officials upon request.

C. Team of Health Care Professionals

At a minimum, an Integrated Health Home must fill the following roles:

1. If Serving Adults

- Nurse care manager: The Integrated Health Home must have a nurse care manager who is a registered nurse or has a Bachelor of Science in nursing with an active Iowa license
- Care coordinator: The Integrated Health Home must have a care coordinator who has a Bachelor of Science in social work, or a Bachelor of Science or Bachelor of Arts degree in a related field
- Trained peer support specialist: The Integrated Health Home must have a peer support specialist who has completed a department-recognized training program and passed the competency exam within six months of hire

2. If Serving Children

- Nurse care manager: The Integrated Health Home must have a nurse care manager who is a registered nurse or has a Bachelor of Science in nursing with an active Iowa license
- Care coordinator: The Integrated Health Home must have a care coordinator who has a Bachelor of Science in social work or a Bachelor of Science or Bachelor of Arts degree in a related field
- Family peer support specialist: The Integrated Health Home must have a family peer support specialist who has completed a department-recognized training program and passed the competency exam within six months of hire

D. Health Information Technology

The Health Home shall use a certified electronic health record to support clinical decision making within the practice workflow and establish a plan to meaningfully use health information in accordance with the federal law.

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.

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

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

The Health Home shall use an interoperable patient registry and certified electronic health record within a timeline approved by the Lead Entity or the department, to input clinical information to track and measure care of members, automate care reminders, and produce exception reports for care planning.

E. Personal Provider

- Ensure a personal provider for each member
- Ensure each member has an ongoing relationship with a personal provider, physician, nurse practitioner, or physician assistant

F. 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 Health Home

G. Whole-Person Care

Whole-person orientation. The Health Home is responsible for providing whole-person care which includes:

- The Health Home shall 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
- The Health Home shall complete status reports to document member's housing, legal, employment status, education, custody, and other social determinants of health, as applicable
- The Health Home shall implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs
- The Health Home shall work with the lead entity or Iowa Medicaid 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
- The Health Home shall provide bi-directional and integrated primary care and behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the department
- The Health Home shall initially and annually provide letters of support from at least one area hospital and two area primary care practices that agree to collaborate with the health home on care coordination and hospital/emergency department notification
- The Health Home shall advocate in the community on behalf of their members, as needed
- The Health Home shall be responsible for preventing fragmentation or duplication of services provided to members

H. Coordinated Integrated Care

The Health Home shall provide coordinated integrated care.

- The Health Home shall ensure that the nurse care manager 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 changes
- The Health Home shall utilize member-level information, member profiles, and care coordination plans for high-risk individuals
- The Health Home shall 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
- The Health Home shall conduct interventions as indicated based on the member's level of risk

- The Health Home shall communicate with the member, authorized representative, and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives
- The Health Home shall monitor, arrange, and evaluate appropriate evidence-based and evidence-informed preventive services
- The Health Home shall coordinate or provide access to the following services:
  - Mental health
  - Oral health
  - Long-term care
  - Chronic disease management
  - Recovery services and social health services available in the community
  - Behavior modification interventions aimed at supporting health management (including, but not limited to, obesity counseling, tobacco cessation, and health coaching)
  - Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
  - Crisis services
- The Health Home shall assess social, educational, housing, transportation, and vocational needs that may contribute to disease and present as barriers to self-management
- The Health Home shall coordinate with community-based case managers, case managers, and service coordinators for members that receive service coordination activities
- The Health Home shall maintain a system and written standards and protocols for tracking member referrals

I. Enhanced Access

The Health Home shall provide enhanced access for members and member caregivers, including access to Health Home Services 24 hours per day, seven days per week. The Health Home shall use email, text messaging, patient portals and other technology to communicate with members.

Emphasis on Quality and Safety. The Health Home shall emphasize quality and safety in the delivery of health home services.

- The Health Home shall have an ongoing quality improvement plan to address gaps and identify opportunities for improvement
- The Health Home shall participate in ongoing process improvement on clinical indicators and overall cost effectiveness
- The Health Home shall demonstrate continuing development of fundamental Health Home functionality through an assessment process applied by the department

- The health home shall have strong, engaged organizational leadership who are personally committed to and capable of:
  - Leading the health home through the transformation process and sustain transformed practice, and
  - Participating in learning activities including in person sessions, webinars, and regularly scheduled meetings
- The Health Home shall participate in or convene ad hoc or scheduled meetings with lead entities and the department to plan and discuss implementation of goals and objectives for practice transformation, with ongoing consideration of the unique practice needs for adult members with serious emotional disturbance and child members with a serious emotional disturbance and their families
- The Health Home shall participate in CMS and department-required evaluation activities
- The Health Home shall submit information as requested by the department
- The Health Home shall maintain compliance with all of the terms and conditions of the Integrated Health Home provider agreement
- The Health Home shall implement state-required disease management programs based on population-specific disease burdens. The health home may choose to identify and operate additional disease management programs at any time

All Medicaid providers are expected to adhere to the state and federal rules applicable to each service and business operation including the Department of Labor, Fair Labor Standards Act.

J. Quality Improvement System

The Integrated Health Home will participate in ongoing quality management and improvement activities.

1. Learning Collaborative

The State facilitates a Learning Collaborative where Lead Entities assist Health Homes in meeting 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

2. Quality Reviews

A Health Home must participate in monthly, quarterly, and annual outcomes data collection and reporting.

Member surveys are completed on an annual basis.

- Each Health Home is reviewed annually
- Lead Entities provides individual technical assistance based on identified needed improvements

- Lead Entities and the Department review documentation review to determine at risk Health Homes to strategize support needed
- Lead Entities and IME review Health Home documentation to ensure documentation meets Health Home Program requirements
- Focused review. Providers will submit evidence of the implementation of provider policies upon request from the Health Home Program. The Health Home Program may issue commendations, recommendations, corrective actions, or sanctions as a result of the review
- Targeted Review. Reviews shall occur at the discretion of the Department. The Health Home Program may issue commendations, recommendations, corrective actions, or sanctions as a result of the review
- Periodic on-site review. Reviews shall occur on a cyclical basis of at least once every five years. Periodic on-site reviews shall be conducted with providers
- Quality reviewers may evaluate the following provider documentation in conjunction with quality reviews:
    - Personnel records
    - Member service records
    - Agency policies and procedures
    - Evidence to support implementation of agency policy and quality improvement activities
    - Other information as requested
- Quality reviewers may interview the following:
    - Agency staff
    - Members accessing the services and their legal representatives
    - Others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws

The Health Home Program may issue commendations, recommendations, corrective actions, or sanctions as a result of the review.

Corrective action shall be required when noncompliance with the agency policies, Iowa Code, Iowa Administrative Code, or Federal Code of Regulations are identified. A compliance review of any corrective action will occur within 60 business days of the HCBS program's approval of the plan.

3. Quality Management Self-Assessment

Health Home Provider Quality Management Self-Assessment is completed on enrollment and annually. The provider will verify the accuracy of the self-assessment through the submission of the Guarantee of Accuracy statement.

K. Member Eligibly And Enrollment

Legal reference: 441 IAC 78.53 (3)

To be eligible for Health Home Services, the member must have a serious mental illness or serious emotional disturbance.

Eligible members are identified though a referral from the department, Lead Entity, primary care provider, hospital, other providers, or the member.

The Health Home confirms eligibility for Health Home Services by obtaining assessment documentation from the member's licensed mental health professional.

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 Health Home must explain to the member, in a format easily understood by the member, how the team works together with the member at the center to improve the member's care as well as all team member's roles and responsibilities.

The Health Home must advise members of their ability and the process to opt-out of Health Home Services at any time.

Eligible members must agree to participate in the Health Home Program and the Health Home must document the member's agreement in the member's record before submitting an enrollment request. A member cannot be in more than one Health Home at the same time.

The Health Home must assess the member's continued eligibility for Health Home services on an annual basis to ensure the member remains eligible to participate in the program.

L. Health Home Service Descriptions

The services included in this section are available to members enrolled in both fee-for-service and managed care. Health Home Services provide team-based, whole-person, patient-centered, coordinated care for all aspects of the member's life and for transitions of care that the individual may experience.

Legal reference: 441 IAC 78.53(2) (249A) Amount, Duration and Scope of Medical and Remedial Services

1. Health Home 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.

- 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

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 Health Home.

- 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

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

- 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

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

- 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

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.

- 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

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.

- 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

2. Expected Outcome of Service

- 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

3. Exclusions

Duplicate Services

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.

Costs for Health Home services are not reimbursable while the member resides in a Mental Health Institution or Long-Term Care Facility (SNF, NF, or ICF for members with intellectual disabilities).

M. Intensive Care Management For HCBS Enrolled Members

Integrated Health Homes provides case management services for IHH enrollees that are also enrolled in the State Plan HCBS Habilitation program and the Children's Mental Health Waiver.

1. Comprehensive Assessment

The comprehensive assessment for members enrolled to receive intensive care management shall be in a format designated by the department and shall include:

- The member's relevant history including the findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to complete the comprehensive assessment
- The member's physical, cognitive, and behavioral health care and support needs, strengths and preferences, available service, and housing options, and if unpaid caregivers will be relied upon to implement any elements of the person-centered service plan, a caregiver assessment
- Documentation that no state plan HCBS are provided which would otherwise be available to the member through other Medicaid services or other federally funded programs
- For members receiving state plan HCBS and HCBS approved under 441 IAC Chapter 83, documentation that HCBS provided through the state plan and waiver are not duplicative

2. Person-Centered Service Planning

The member shall have a service plan approved by the Department which is developed by the interdisciplinary team. This must be completed before service provision and annually thereafter or more often if there is a change in the member's needs.

At initial enrollment the case manager or integrated health home shall:

- Establish the interdisciplinary team with input from the member. The team will identify the member's "need for service" based on the member's needs and desires as well as the availability and appropriateness of services
- The Medicaid case manager, integrated health home, shall complete an annual review thereafter
- In addition to the service plan, each service provider must document the activities associated with implementing the goals identified in the service plan
- The following criteria are used for the initial and ongoing assessments:
    - Members aged 17 or under shall receive services based on development of adaptive, behavioral, or health skills
    - Service plans must be developed or reviewed, to reflect use of all appropriate non-waiver services, so as not to replace or duplicate services

Person-centered planning shall be implemented in a manner that supports the member, makes the member central to the process, and recognizes the member as the expert on goals and needs. For this to occur, there are certain process elements that must be included in the process. These include:

- The member, guardian or representative must have control over who is included in the planning process, as well as have the authority to request meetings and revise the person-centered service plan (and any related budget) whenever reasonably necessary
- The process is timely and occurs at times and locations of convenience to the member, the member's guardian or representative and family members, and others, as practicable
- Necessary information and support are provided to ensure that the member or the member's guardian or representative is central to the process and understands the information. This includes the provision of auxiliary aids and services when needed for effective communication
- A strengths-based approach to identifying the positive attributes of the member shall be used, including an assessment of the member's strengths and needs. The member should be able to choose the specific planning format or tool used for the planning process
- The member's personal preferences shall be considered to develop goals and to meet the member's HCBS needs
- The member's cultural preferences must be acknowledged in the planning process, and policies/practices should be consistent with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) of the Office of Minority Health, U.S. Department of Health and Human Services
- The planning process must provide meaningful access to members and their guardians or representatives with limited English proficiency (LEP), including low literacy materials and interpreters
- Members who are under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, must have the opportunity in the planning process to address any concerns
- There shall be mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines.
- Members shall be offered information on the full range of HCBS available to support achievement of personally identified goals
- The member or the member's guardian or representative shall be central in determining what available HCBS are appropriate and will be used
- The member shall be able to choose between providers or provider entities, including the option of self-directed services when available
- The person-centered service plan shall be reviewed at least every 365 days or sooner if the member's functional needs change, circumstances change, or quality of life goals change, or at the member's request. There shall be a clear process for members to request reviews. The case management entity must respond to such requests in a timely manner that does not jeopardize the member's health or safety

- The planning process should not be constrained by any case manager's or guardian's or representative's preconceived limits on the member's ability to make choices
- Employment and housing in integrated settings shall be explored, and planning should be consistent with the member's goals and preferences, including where the member resides and with whom the member lives

3. Interdisciplinary Team

An interdisciplinary team must include the member, the integrated health home, community-based case manager (as applicable) and other persons designated by the member. Other persons on the team may be:

- The parents when the member is a minor
- The member's legally authorized representative
- The member's family, unless the family's participation is limited by court order or is contrary to the wishes of the adult member who has not been legally determined to be unable to make decisions independently
- All current service providers
- Any other professional representation including, but not limited to:
  - Vocational rehabilitation counselors,
  - Court appointed mental health advocates,
  - Correction officers,
  - Educators, and
  - Other professionals as appropriate.
- Persons identified by the member or family, provided the family's wishes are not in conflict with the desires of the member
- The team shall be convened to develop the initial service plan and to revise the service plan, at least annually or whenever there is a significant change in the member's needs or conditions

4. HCBS Comprehensive Service Plan

Services must be included in a comprehensive person-centered service plan. The comprehensive person-centered service plan must be developed through a person-centered planning process driven by the member in collaboration with the member's interdisciplinary team, as established with the case manager or integrated health home coordinator.

The member's comprehensive service plan must be updated at least annually, when a change in the member's circumstances or needs change significantly, or at the request of the member.

The comprehensive person-centered plan:

- Includes people chosen by the member
- Provides necessary information and support to the member to ensure that the member directs the process to the maximum extent possible
- Is timely and occurs at times and locations of convenience to the member
- Reflects cultural considerations and uses plain language
- Includes strategies for solving a disagreement
- Offers choices to the member regarding services and supports the member receives and from whom
- Provides method to request update
- Conducted to reflect what is important to the member to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare
- Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the member
- May include whether and what services are self-directed
- Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education, and others
- Includes risk factors and plans to minimize them
- Is signed by all individuals and providers responsible for its implementation and a copy of the plan must be provided to the member and the member's representative

The HCBS waiver written comprehensive service plan documentation:

- Reflects the member's strengths and preferences
- Reflects clinical and support needs
- Includes observable and measurable goals and desired outcomes:
    - Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate
    - Identify the staff people, businesses, or organizations responsible for carrying out the interventions or supports
- Identifies for a member receiving supported community living services:
    - The member's living environment at the time of enrollment,
    - The number of hours per day of direct staff supervision needed by the member, and
    - The number of other members who will live with the member in the living unit

- Reflects providers of services and supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS, including:
  - Name of the provider
  - Service authorized
  - Units of service authorized
- Includes risk factors and measures in place to minimize risk
- Includes individualized backup plans and strategies when needed
  - Identify any health and safety issues that apply to the member based on information gathered before the team meeting, including a risk assessment
  - Identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change
  - Providers of applicable services shall provide for emergency backup staff
- Includes the names of the individuals responsible for monitoring the plan
- Is written in plain language and understandable to the member
- Documents who is responsible for monitoring the plan
- Documents the informed consent of the member for any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications, the need for the restriction, and either a plan to restore those rights or written documentation that a plan is not necessary or appropriate
- Includes the signatures of all individuals and providers responsible
- Is distributed to the member and others involved in the plan
- Includes purchase and control of self-directed services
- Excludes unnecessary or inappropriate services and support
- Any restraint, restriction, behavior intervention and rights restrictions must be implemented in accordance with 441 IAC 77.25(4) and 78.27. These requirements include but are not limited to:
  - Informed consent of the member or member's legal guardian
  - Documentation of any and all rights restrictions in the HCBS member's person-centered comprehensive service plan or treatment plan
  - Documentation of any service specific restrictions in the HCBS provider's service specific service plan or treatment plan for the member
  - Documentation of a plan to restore those rights or written documentation that a plan is not necessary or appropriate
  - Regular collection and review of data to measure the ongoing effectiveness of the restriction

Referral and Related Activities

The IHH shall assist, as needed, the member in obtaining needed services, such as by scheduling appointments for the member and by connecting the member with medical, social, educational, housing, transportation, vocational or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the person-centered service plan.

Monitoring and Follow-Up

The IHH shall perform monitoring activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the person-centered service plan is effectively implemented and adequately addresses the needs of the member.

At a minimum, monitoring shall include:

- Assessing the member,
- Assessing the places of service (including the member's home, when applicable),
- Monitoring of all services regardless of the service funding stream
- Reviewing service provider documentation
- Monitoring of the following aspects of the person-centered service plan shall lead to revisions of the plan if deficiencies are noted:
    - Services are being furnished in accordance with the member's person-centered service plan, including the amount of service provided and the member's attendance and participation in the service
    - The member has declined services in the service plan
    - Communication among providers is occurring, as practicable, to ensure coordination of services
    - Services in the person-centered service plan are adequate, including the member's progress toward achieving the goals and actions determined in the person-centered service plan; and
    - There are changes in the needs or circumstances of the member

Follow-up activities shall include making necessary adjustments in the person-centered service plan and service arrangements with providers.

Contacts

IHHs 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:

- The IHH shall have at least one face-to-face contact with the member in the member's residence at least quarterly
- The IHH shall have at least one contact per month with the member or the member's guardians or representatives. This contact may be face to face or by telephone

N. Documentation of the Provision of Services

1. Maintenance of Records

Legal reference: 441 IAC 79.3(1), 441 IAC 79.3(2, 78.53(5)

A provider of Health Home program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the Department or to its authorized representative timely upon request shall result in claim denial or recoupment.

Providers shall maintain service and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service.

A health home shall maintain adequate supporting documentation in readily reviewable form to assure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441--79.3(249A). At a minimum, the Health Home shall document the following:

- Member eligibility
- Comprehensive Assessment
- Person centered care plan and patient centered care plan
- Core services
- Intensive health home services
- Continuity of Care
- Disenrollment

2. Documentation of Eligibility

The Health Home must document the Medicaid member's eligibility for Health Home services and document verification of the member's eligibility for health home services every 12 months.

Eligibility documentation includes but not limited to:

- How the member presented to the health home, including the referral
- Identified needs and plan to assess for eligibility
- Documentation that the member is eligible for health home services
- If a member is not eligible, the health home must document the plan to support the member
- Qualifying diagnosis that makes the member eligible for health home services
- Member agreement and understanding of the program
- Enrollment request
- Enrollment with the Health Home
- Plan to complete the comprehensive assessment
- Documentation of eligibility and member's agreement to continue participation in the program, obtained on an annual basis

3. Comprehensive Assessment

The comprehensive assessment must be completed within 30 days of enrollment, and at least every 365 days, or more frequently when the member's needs or circumstances change significantly or at the request of the member or member's support.

- The comprehensive assessment for non-ICM members shall include all aspects of a member's life, and satisfy the following requirements:
  - The comprehensive assessment must be completed within 30 days of enrollment, and at least every 365 days, or more frequently when the member's needs or circumstances change significantly or at the request of the member or member's support
  - Assessment of the member's current and historical information provided by the member, the lead entity, and other health care providers that support the member
  - A physical and behavioral assessment, medication reconciliation, functional limitations, and appropriate screenings
  - Assessment of the member's social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors
  - Assessment of the member's readiness for self-management using screenings and assessments with standardized tools
- The comprehensive assessment for members enrolled to receive intensive care management shall be in a format designated by the department and shall include:
  - The member's relevant history including the findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to complete the comprehensive assessment
  - The member's physical, cognitive, and behavioral health care and support needs, strengths and preferences, available service, and housing options, and if unpaid caregivers will be relied upon to implement any elements of the person-centered service plan, a caregiver assessment
  - Documentation that no state plan HCBS are provided which would otherwise be available to the member through other Medicaid services or other federally funded programs

For members receiving state plan HCBS and HCBS approved under 441 IAC Chapter 83, documentation that HCBS provided through the state plan and waiver are not duplicative.

4. Person-Centered Service Plan and Patient-Centered Care Plan.

For members receiving non-intensive care management or enrolled in the chronic condition health home, documentation must include a patient-centered care plan that meets the requirements of subrule 78.53(1) and the health home state plan amendment.

For members receiving intensive care management, documentation must include a service plan that meets the requirements of rule 441 IAC 78.27(249A) or 83.127(249A), and 441 IAC 90.4(1)"b."

Documentation must reflect an update of the plan no less often than every 365 days and when significant changes occur in the member's support needs, situation, condition, or circumstances

5. Documentation of Health Home Services

Documentation must reflect monthly provision of one of the six core health home services as outlined in subrule 78.53(2), based on the member's identified needs in the member's patient-centered care plan or person-centered service plan.

Intensive health home services. A health home must provide documentation to justify provision of more intensive health home services, including documentation that the member is enrolled to receive services through the HCBS Habilitation program or the HCBS Children's Mental Health Waiver program.

The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

- The specific Health Home Services performed
- The complete date of the service
- The complete time of the service, including the beginning and ending time (including AM and PM designation)
- The location where the service was provided
- The first and last name and professional credentials, and role of the person providing the service. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity

6. Continuity of Care

The health home must maintain a continuity of care document in each enrolled member's record and provide this document to the department, lead entity and the member's treating providers upon request.

The continuity of care document must include, at a minimum, all aspects of the member's medical and behavioral health needs, treatment plan, and medication list.

7. Disenrollment

Members are able to opt-out of health home services at any time.

The health home shall document a member's request to disenroll from health home services, the reason for disenrollment, how the member's needs will be supported after disenrollment, and that the health home has advised the member of his or her ability to re-enroll if circumstances change.

8. Outcome of the Service

Legal reference: 441 IAC 79.3(2)"d"(40)

The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of plan of care, or diagnosis.

O. Provider Enrollment With Iowa Medicaid

1. Certification and Enrollment of New Providers

To apply for enrollment as an Iowa Medicaid-enrolled provider of Health Home services, contact Iowa Medicaid Provider Services by phone at (800) 338-7909 or locally in Des Moines at (515) 256-4609, or in writing at:

Iowa Medicaid
Provider Services
PO Box 36450
Des Moines, IA 50315

The Iowa Medicaid Provider Services Unit provides telephone support to answer any billing questions from providers. The number is (800) 338-7909 or locally in Des Moines at (515) 256-4609.

Upon request, an application packet will be sent containing:

- Form 470-5160, *Iowa Medicaid Integrated Health Home Provider Agreement*
- Form 470-5273, *Iowa Medicaid Health Home and Integrated Health Home Provider Application*
- This Provider Manual

Submit the completed application and agreement to the Iowa Medicaid Provider Services address listed previously. The Iowa Medicaid must receive the application for enrollment at least 90 days before the planned implementation date. Also provide the following credentials:

- Chapter 24 accreditation for a Community Mental Health Center.
- Licensed Mental Health Service Provider.
- Licensed residential group care setting.
- Licensed Psychiatric Medical Institution for Children (PMIC) facility.
- Provider accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide behavioral health services.
- Provider accredited by the Joint Commission for behavioral health care services.

A Health Home may include multiple sites when those sites are identified as a single organization or medical group that shares policies, procedures, and electronic systems across all of their practice sites.

The Iowa Medicaid Provider Services Unit will review the submitted application and any required documentation necessary to qualify as a provider of the service for which application is being made. This may include:

- Current accreditations,
- Evaluations,
- Inspections, and
- Reviews by regulatory and licensing agencies and associations policies, procedures, and forms.

NOTE: If deemed status has been granted due to CARF or Council accreditation, but when a new CARF or Council survey is completed, the agency is not recertified for two or three years (as applicable), then the agency must notify Iowa Medicaid regarding the change in status.

Iowa Medicaid may complete an on-site review to determine if the agency is to remain eligible for certification, based on:

- The fiscal capacity to initiate and operate the specified programs on an ongoing basis
- A written agreement to work cooperatively with the state and the counties that will be served
- This is requested of those applying for all certified services and is not specific to deemed status

The Provider Services Unit has 60 days from the receipt of all required documentation and completed background checks to determine whether the provider meets the applicable standards for providing waiver services. (This deadline may be extended by mutual consent.)

When an application is approved, Provider Services will recommend enrollment. Review of a provider may occur at any time that it is determined to be necessary.

The provider shall also be enrolled with one or more of the MCOs to provide Health Home Services to the target population.

2. Change in Ownership, Agency Name, or Satellite Offices

If the ownership or name change does not involve the issuance of a new federal tax identification number, the agency is not required to complete a new 470-5160, *Iowa Medicaid Integrated Health Home Provider Agreement* and 470-5273, *Iowa Medicaid Health Home and Integrated Health Home Provider Application*. However, if the provider changes federal tax identification number, the provider must complete the enrollment process as a new provider.

Adding a satellite office does not require the completion of an application if the satellite office uses the main office's provider number for billing purposes. If the agency chooses to have a separate provider number for the satellite office, it must submit another application for that new satellite office.

3. Recertification

The agency must be recertified when its current certification ends. The agency must demonstrate substantial continued compliance with standards for recertification to occur.

The recertification procedures for Health Home Services are initiated:

- Before the expiration of the current certification, and
- To determine compliance with Iowa Administrative Code service standards or determination that the agency remains accredited by a recognized national accrediting body.

4. Termination

- The Health Home shall be terminated by the State if it has been found that it cannot meet the Health Home Requirements contained in 441 IAC 77.47 and 78.53, and the State Plan Amendment for Health Home Services.
- The Health Home may also terminate the agreement by completing and submitting form 470-5465, *Provider Request to Terminate Enrollment* to the department.
- The Health Home shall provide advance notice of termination to the department a minimum of sixty (60) days prior to the date of termination.
- The Health Home must ensure members are notified 60 days prior to the termination date and provide for a seamless transition of enrollees to other Health Home Providers.

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.

P. Basis of Payment

Legal reference: 441 IAC 78.53(6)

Payment will be made for Health Home services when:

- The member is eligible for Medicaid and enrolled in the health home for the month of service
- The Health Home provides at least one of the six core health home services described in subrule 78.53(2) during the month
- The Health Home maintains the documentation outlined in this manual and paragraph 78.53(5)"e."

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

A unit of service is one member month.

Q. Procedure Codes and Nomenclature

The Integrated Health Home will bill procedure code 99490 with the appropriate level II modifier to identify the enrolled member's service tier along with the informational only codes on the subsequent lines of the claim to attest to the Health Home services provided.

Procedure Code Health Home PMPM 99490

Tier	Modifier	PMPM Rate
5 (Adult)	TF	$160.46
6 (Child)	TG	$200.97
7 (HAB ICM)	U1	$199.09
8 (CMH ICM)	U2	$200.97

Informational Only Codes

Health Home Service	Code
Chronic 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

R. Billing and Claims Instructions and Form

Claims for Integrated Health Home services are billed on federal form **CMS-1500, Health Insurance Claim Form.**

Click here to view a sample of the CMS-1500.

Click here to view billing instructions for the CMS-1500.

Refer to Chapter IV. **Billing Iowa Medicaid** for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at: http://dhs.iowa.gov/sites/default/files/All-IV.pdf