

**441—78.53 (249A) Health home services.** Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

**78.53(1) Covered services.** Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

- a. Comprehensive care management, which means:
  - (1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;
  - (2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and
  - (3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.
  
- b. Care coordination, which means assisting members with:
  - (1) Medication adherence;
  - (2) Chronic disease management;
  - (3) Appointments, referral scheduling, and reminders; and
  - (4) Understanding health insurance coverage.
  
- c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:
  - (1) Supporting health management;
  - (2) Improving disease control; and
  - (3) Enhancing safety, disease prevention, and an overall healthy lifestyle.
  
- d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:
  - (1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and
  - (2) Personal follow-up with the member regarding all needed follow-up after the transition.
  
- e. Member and family support (including authorized representatives). This support may include:
  - (1) Communicating with and advocating for the member or family for the assessment of care decisions;
  - (2) Assisting with obtaining and adhering to medications and other prescribed treatments;
  - (3) Increasing health literacy and self-management skills; and
  - (4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.

f. Referral to community and social support services available in the community.

**78.53(2) Members eligible for health home services.**

a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

- (1) Has at least two chronic conditions;
- (2) Has one chronic condition and is at risk of having a second chronic condition;
- (3) Has a serious mental illness; or
- (4) Has a serious emotional disturbance.

b. For purposes of this rule, the term “chronic condition” means:

- (1) A mental health disorder.
- (2) A substance use disorder.
- (3) Asthma.
- (4) Diabetes.
- (5) Heart disease.
- (6) Being overweight, as evidenced by:
  1. Having a body mass index (BMI) over 25 for an adult, or
  2. Weighing over the 85th percentile for the pediatric population.
- (7) Hypertension.

c. For purposes of this rule, the term “serious mental illness” means:

- (1) A psychotic disorder;
- (2) Schizophrenia;
- (3) Schizoaffective disorder;
- (4) Major depression;
- (5) Bipolar disorder;
- (6) Delusional disorder; or
- (7) Obsessive-compulsive disorder.

d. For purposes of this rule, the term “serious emotional disturbance” means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term “functional impairment” means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person’s role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person’s environment.

**78.53(3)** *Selection of health home services provider.* As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member’s health home, as reported by the provider. A member must select a provider located in the member’s county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.