ARC 0198C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed Emergency After Notice

Pursuant to the authority of Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10, the Department of Human Services amends Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code.

The Eighty-Fourth General Assembly allowed the Department to submit an amendment to the State Medicaid Plan to take advantage of an option given to states in Section 2703 of the federal Patient Protection and Affordable Care Act, Public Law 111-148. That provision allows states to provide to members who have designated chronic medical conditions additional services that are not normally funded by Medicaid. Implementation is subject to federal approval of the state plan amendment. States are allowed to claim 90 percent federal match for the first two years of operation.

Health home services provide comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; support to the patient and family, including authorized representatives; referral to relevant community and social support services; and for the use of health information technology to link services. Providers of health home services are anticipated to be primary care practices, such as community mental health centers, federally qualified health centers, and rural health clinics. However, any Medicaid-enrolled entity that can furnish a designated practitioner, a dedicated care coordinator, a health coach, and support staff and that commits to meeting program requirements may qualify as a health home services provider.

Provision of health home services to eligible Medicaid members will support the plan for implementing a statewide medical home system developed by the Medical Home System Advisory Council pursuant to Iowa Code section 135.159. The expectation is that the provision of more intensive services to people with chronic health conditions will lower the overall cost of their care by reducing emergency room visits and hospital stays. Other benefits expected from medical homes include an emphasis on convenient, comprehensive primary care; quality-driven and comprehensive health care; strong and effective medical management; and patient and provider accountability.

A monthly payment will be made for each eligible member who receives health home services from the provider during the month. The amount of the payment will be determined according to a fee schedule based on the number of chronic health conditions the member has. The conditions that will be considered in determining whether a member is eligible for the services include mental health and substance use disorders, asthma, diabetes, heart disease, being overweight, and hypertension. As a condition of participation, health home services providers must report applicable quality measures. The Department expects to offer incentive payments based on a provider's performance beginning in state fiscal year 2014.

Federal law also requires that hospitals in a state that offers health home services must agree to refer eligible members to a designated health home services provider.

Notice of Intended Action on these amendments was published in the May 2, 2012, Iowa Administrative Bulletin as **ARC 0117C**. The Department received no comments from the public on the Notice. Three nonsubstantive changes from the Notice have been made: An implementation sentence has been added to the end of existing rule 441—77.3(249A) and to new rules 441—77.47(249A) and 441—78.53(249A).

The Council on Human Services adopted these amendments on June 13, 2012.

The Department finds that these amendments confer a benefit on constituents with chronic health conditions by providing coordinated care and services. Therefore, these amendments are filed pursuant to Iowa Code section 17A.5(2)"b"(2), and the normal effective date of these amendments is waived.

These amendments do not provide for waivers in specified situations because health home services are optional and confer a benefit on members who choose to receive them. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

The impact on private-sector jobs is uncertain. While individual practitioners may find additional duties to be performed, it is unknown whether this will result in additional staff being hired or if current staff will be used to fulfill the functions of the program.

These amendments are intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

These amendments became effective July 1, 2012.

The following amendments are adopted.

ITEM 1. Amend rule 441—77.3(249A) as follows:

441—77.3(249A) Hospitals.

77.3(1) *Qualifications.* All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule. ~~Hospitals in other states are also eligible if duly licensed and certified for Medicare participation in that state.~~

77.3(2) *Referral to health home services provider.* As a condition of participation in the medical assistance program, hospitals must establish procedures for referring to health home services providers any members who seek or need treatment in the hospital emergency department and who are eligible for health home services pursuant to 441—subrule 78.53(2).

This rule is intended to implement Iowa Code section 249A.4.

ITEM 2. Adopt the following **new** rule 441—77.47(249A):

441—77.47(249A) Health home services providers. Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as a provider of health home services.

77.47(1) *Qualifications.* A designated provider of health home services must be a Medicaid-enrolled entity or provider that is determined through the provider enrollment process to have the systems and infrastructure in place to provide health home services.

a. Staffing. At a minimum, a qualifying provider must fill the following roles:

(1) Designated practitioner.

(2) Dedicated care coordinator.

(3) Health coach.

(4) Clinic support staff.

b. Data management. A qualifying provider shall ensure that all clinical data related to the member are maintained with the member's medical records through the use of health information technology.

77.47(2) *Report on quality measures.* As a condition of participation in the medical assistance program as a provider of health home services and of receiving payment for health home services provided, a designated provider must report to the Iowa Medicaid enterprise on measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the Iowa Medicaid enterprise with such information.

77.47(3) *Selection.* As a condition of payment for health home services provided to a Medicaid member eligible to receive such services pursuant to 441—subrule 78.53(2), a designated provider must be selected by the member as the member's health home, as reported by provider attestation.

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

ITEM 3. Adopt the following **new** rule 441—78.53(249A):

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.* 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 has at least two chronic conditions or has one chronic condition and is at risk of having a second chronic condition. For purposes of this rule, the term "chronic condition" means:

a. A mental health disorder.

b. A substance use disorder.

c. Asthma.

d. Diabetes.

e. Heart disease.

f. 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.

g. Hypertension.

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.

ITEM 4. Adopt the following **new** provider category in subrule **79.1(2)**:

Provider category	Basis of reimbursement	Upper limit
Health home services provider	Fee schedule based on number of member's chronic conditions (not including conditions for which member is only at risk). Submission of the per-member per-month (PMPM) claim from the provider confirms that health home services are being provided.	Monthly fee schedule amount.

ITEM 5. Adopt the following **new** subparagraph **79.3(2)"d"(40)**:

(40) Health home services:

1. Comprehensive care management plan.
2. Care coordination and health promotion plan.
3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.
4. Documentation of member and family support (including authorized representatives).
5. Documentation of referral to community and social support services, if relevant.

ITEM 6. Adopt the following **new** paragraph **79.14(2)"e"**:

e. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 7/11/12.