ARC 6206C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rule making related to integrated and chronic health homes and providing an opportunity for public comment

The Human Services Department hereby proposes to amend 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.

Legal Authority for Rule Making

This rule making is proposed under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4.

Purpose and Summary

The Department is proposing to update rules for Integrated Health Homes and for Chronic Health Homes based on the deficiencies identified in the audit completed in 2019 by the Office of Inspector General (OIG) for the Health Home (HH) programs for the state fiscal years 2013 through 2016.

The proposed amendments clarify the standards and requirements for the delivery of Health Home services. The audit recommended the Department improve its monitoring of the HH programs to ensure that HH providers comply with federal and state requirements for maintaining documentation to support the services for which the providers billed and received payments. The audit also recommended the Department revise the state plan to define the documentation requirements that HH providers must follow to bill and receive higher in-home health payments for intensive services and educate providers on these requirements. Recommendations were also made that the state plan be revised to define the documentation requirements the HH providers must follow to bill and receive payments for outreach services and also educate providers on these requirements.

State plan amendments have now been submitted and approved. The Department developed an ongoing audit process to be completed by Iowa Medicaid and the managed care organizations that ensure the HH services are appropriately documented. Iowa Medicaid hosted a face-to-face training and plans additional opportunities for training providers on core services and documentation. Monthly webinars, biannual face-to-face training and individual technical assistance based on provider needs have been implemented.

Fiscal Impact

This rule making has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Public Comment

Any interested person may submit written comments concerning this proposed rule making. Written comments in response to this rule making must be received by the Department no later than 4:30 p.m. on March 15, 2022. Comments should be directed to:

Nancy Freudenberg
Department of Human Services
Hoover State Office Building, Fifth Floor
1305 East Walnut Street
Des Moines, Iowa 50319-0114
Email: appeals@dhs.state.ia.us

Public Hearing

No public hearing is scheduled at this time. As provided in Iowa Code section 17A.4(1)"b," an oral presentation regarding this rule making may be demanded by 25 interested persons, a governmental subdivision, the Administrative Rules Review Committee, an agency, or an association having 25 or more members.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rule-making actions are proposed:

ITEM 1. Adopt the following **new** implementation sentence in rule **441—77.1(249A)**:
This rule is intended to implement Iowa Code section 249A.4.

ITEM 2. Adopt the following **new** implementation sentence in rule **441—77.2(249A)**:
This rule is intended to implement Iowa Code section 249A.4.

ITEM 3. Adopt the following **new** implementation sentence in rule **441—77.4(249A)**:
This rule is intended to implement Iowa Code section 249A.4.

ITEM 4. Adopt the following **new** implementation sentence in rule **441—77.5(249A)**:
This rule is intended to implement Iowa Code section 249A.4.

ITEM 5. Adopt the following **new** implementation sentence in rule **441—77.6(249A)**:
This rule is intended to implement Iowa Code section 249A.4.

ITEM 6. Adopt the following **new** implementation sentence in rule **441—77.7(249A)**:
This rule is intended to implement Iowa Code section 249A.4.

ITEM 7. Adopt the following **new** implementation sentence in rule **441—77.8(249A)**:
This rule is intended to implement Iowa Code section 249A.4.

ITEM 8. Adopt the following **new** implementation sentence in rule **441—77.9(249A)**:
This rule is intended to implement Iowa Code section 249A.4.

ITEM 9. Adopt the following **new** implementation sentence in rule **441—77.10(249A)**:
This rule is intended to implement Iowa Code section 249A.4.

ITEM 10. Adopt the following **new** implementation sentence in rule **441—77.11(249A)**:
This rule is intended to implement Iowa Code section 249A.4.

ITEM 11. Amend rule **441—77.12(249A)**, implementation sentence, as follows:

This rule is intended to implement Iowa Code section 249A.4 ~~and 2010 Iowa Acts, chapter 1192, section 31~~.

ITEM 12. Adopt the following **new** implementation sentence in rule **441—77.21(249A)**:

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

ITEM 13. Adopt the following **new** implementation sentence in rule **441—77.24(249A)**:

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

ITEM 14. Adopt the following **new** implementation sentence in rule **441—77.29(249A)**:

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

ITEM 15. Rescind rule 441—77.47(249A) and adopt the following **new** rule in lieu thereof:

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

77.47(1) *Definitions.*

"Chronic condition" means, for purposes of this rule, one of the conditions outlined in 441—subparagraph 78.53(3)*"a"*(1).

"Chronic condition health home" means a provider enrolled to deliver personalized, coordinated care for members with one chronic condition and at risk of developing another.

"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 interferes with or limits the individual's functional capacity with family, employment, school or community. "Functional impairment" 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 rule 441—24.1(225C).

"Health home" means a chronic condition health home or an integrated health home.

"Integrated health home" 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.

"Lead entity" means a managed care organization that supports and oversees the chronic condition health home and the integrated health home network.

"Managed care organization" 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.

"Serious emotional disturbance" means the same as defined in rule 441—83.121(249A).

"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 disabilities, neurodevelopmental disabilities or intellectual disabilities, but those diagnoses may not be the clinical focus for health home services.

77.47(2) *Chronic condition health home provider qualifications.*

a. A chronic condition health home must be one of the following:

(1) Physician(s).

(2) Clinical practice or clinical group practice.

(3) Rural health clinic.

(4) Community health center.

(5) Community mental health center accredited under 441—Chapter 24.

(6) Federally qualified health clinic.

b. A chronic condition 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 the single organization's or medical group's practice sites.

c. A chronic condition health home must achieve accreditation, recognition, or certification as a patient-centered medical home (PCMH) through a national accreditation or certification entity recognized by the department within the first year of operation and maintain the accreditation, recognition, or certification for the duration of enrollment as a health home. A chronic condition health home that fails to achieve accreditation, recognition, or certification within the first year of enrollment will have the chronic condition health home enrollment terminated unless granted an extension by the department.

d. A chronic condition health home must complete a self-assessment when enrolling as a new health home and annually thereafter.

e. A chronic condition health home must meet the requirements, qualifications, and standards outlined in the chronic condition health home state plan amendment.

f. A chronic condition health home must participate in monthly, quarterly, and annual outcomes data collection and reporting.

g. At a minimum, a chronic condition health home must fill the following roles:

(1) Designated practitioner. The chronic condition health home must have at least one physician with an active Iowa license and credentialed with at least one managed care organization. If a chronic condition health home has multiple sites, a specific site may have a nurse practitioner or physician's assistant, so long as the chronic condition health home has as least one physician.

(2) Dedicated care manager. The chronic condition health home must have at least one nurse care manager who is a registered nurse or has a bachelor of science in nursing with an active Iowa nursing license in accordance with rule 655—3.3(17A,147,152,272C).

(3) Health coach. The chronic condition health home must have at least one trained health coach.

77.47(3) *Integrated health home provider qualifications.*

a. An integrated health home must be one of the following:

(1) Community mental health center accredited under 441—Chapter 24.

(2) Licensed mental health service provider.

(3) Licensed residential group care setting.

(4) Licensed psychiatric medical institution for children (PMIC).

(5) Provider accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide behavioral health services.

(6) Provider accredited by the Council on Accreditation for behavioral health or child, youth and family services.

(7) Provider accredited by the Joint Commission for behavioral health care services.

b. An integrated 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 the single organization's or medical group's practice sites.

c. An integrated health home must complete a self-assessment when enrolling as a new health home and annually thereafter.

d. An integrated health home must meet the requirements, qualifications, and standards outlined in the integrated health home state plan amendment.

e. An integrated health home must participate in monthly, quarterly, and annual outcomes data collection and reporting.

f. At a minimum, an integrated health home must fill the following roles:

(1) If serving adults:

1. 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 nursing license in accordance with rule 655—3.3(17A,147,152,272C).

2. 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.

3. 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 examination within six months of hire.

(2) If serving children:

1. 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 nursing license in accordance with rule 655—3.3(17A,147,152,272C).

2. 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.

3. 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 examination within six months of hire.

77.47(4) *Lead entity qualifications.*

a. A lead entity must meet the following requirements:

(1) The lead entity must be licensed and in good standing in the state of Iowa as a health maintenance organization in accordance with 191—Chapter 40.

(2) The lead entity must have a statewide integrated network of providers to serve members with serious mental illness and serious emotional disturbance.

(3) The lead entity must complete a self-assessment at the time of enrollment and annually thereafter.

(4) The lead entity must meet requirements, qualifications, and standards outlined in the state plan.

(5) The lead entity must participate in monthly, quarterly, and annual outcomes data collection and reporting.

b. At a minimum, a lead entity must fill the following roles:

(1) Physician. The lead entity must have at least one physician to support the health home in meeting provider standards. The physician must have an active Iowa license to practice medicine in accordance with 653—Chapter 9 and be credentialed with at least one managed care organization.

(2) Nurse care coordinators. The lead entity must have nurse care managers to support the health home in meeting provider standards. A nurse care manager must be a registered nurse or have a bachelor of science in nursing with an active Iowa nursing license in accordance with rule 655—3.3(17A,147,152,272C).

(3) Social workers. The lead entity must have a care coordinator with a bachelor of science or bachelor of arts degree in social work or a related field, including sociology, counseling, psychology, or human services, to support the health home in meeting the provider standards and delivering health home services.

(4) Behavioral health professionals. The lead entity must have a psychiatrist to support the health home in meeting provider standards and to deliver health home services. The psychiatrist must have an active Iowa license to practice medicine in accordance with 653—Chapter 9 and be credentialed with at least one managed care organization.

77.47(5) *Health home general requirements.*

a. Whole person orientation. The health home is responsible for providing whole person care.

(1) The health home must 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, including acute care, chronic care, preventive services, long-term care, and end-of-life care.

(2) The health home must complete status reports to document the member's housing, legal status, employment status, education, custody, and other social determinants of health, as applicable.

(3) The health home must implement a formal screening tool to assess behavioral health, including mental health and substance abuse treatment needs, along with physical health care needs.

(4) The health home must 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 follow up on hospital discharges, including psychiatric medical institutions for children.

(5) The health home must provide bidirectional and integrated primary care and behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the department.

(6) The health home must 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 and emergency department notification.

(7) The health home must advocate in the community on behalf of health home members, as needed.

(8) The health home must be responsible for preventing fragmentation or duplication of services provided to members.

b. Coordinated integrated care. The health home must provide coordinated integrated care.

(1) The health home must ensure that the nurse care manager is responsible for assisting members with medication adherence, appointments, 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.

(2) The health home must utilize member-level information, member profiles, and care coordination plans for high-risk individuals.

(3) The health home must 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.

(4) The health home must conduct interventions as indicated based on the member's level of risk.

(5) The health home must 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.

(6) The health home must monitor, arrange, and evaluate appropriate evidence-based and evidence-informed preventive services.

(7) The health home must coordinate or provide access to the following services:

1. Mental health.
2. Oral health.
3. Long-term care.
4. Chronic disease management.
5. Recovery services and social health services available in the community.
6. Behavior modification interventions aimed at supporting health management, including but not limited to obesity counseling, tobacco cessation, and health coaching.
7. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up.
8. Crisis services.

(8) The health home must assess social, educational, housing, transportation, and vocational needs that may contribute to disease and present as barriers to self-management.

(9) The health home must coordinate with community-based case managers, case managers, and service coordinators for members who receive service coordination activities.

(10) The health home must maintain a system and written standards and protocols for tracking member referrals.

c. Enhanced access. The health home must 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 must use email, text messaging, patient portals and other technology to communicate with members.

d. Emphasis on quality and safety. The health home must emphasize quality and safety in the delivery of health home services.

(1) The health home must have an ongoing quality improvement plan to address gaps and identify opportunities for improvement.

(2) The health home must participate in ongoing process improvement on clinical indicators and overall cost-effectiveness.

(3) The health home must demonstrate continuing development of fundamental health home functionality through an assessment process applied by the department.

(4) The health home must have strong, engaged organizational leadership that is personally committed to and capable of:

1. Leading the health home through the transformation process and sustaining transformed practice, and

2. Participating in learning activities including in-person sessions, webinars, and regularly scheduled meetings.

(5) The health home must 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 a serious emotional disturbance and child members with a serious emotional disturbance and those members' families.

(6) The health home must participate in Centers for Medicare and Medicaid Services (CMS)- and department-required evaluation activities.

(7) The health home must submit information as requested by the department.

(8) The health home must maintain compliance with all of the terms and conditions of the integrated health home or chronic condition health home provider agreement.

(9) The health home must 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, track and measure care of members, automate care reminders, and produce exception reports for care planning.

(10) The health home must complete web-based member enrollment, disenrollment, members' consent to release to information, and health risk questionnaires for all members.

(11) The health home must 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.

(12) The health home must 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.

e. Case management. The integrated health home must provide case management services as defined in and required by 441—Chapter 90 to eligible members in an integrated health home. Requirements in 441—Chapter 90 are the minimum criteria for intensive care management for members enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver.

f. Policies and procedures. The health home must 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 must maintain documentation of its policies and processes and make those policies and processes readily available to any state or federal officials upon request.

g. Report on quality measures. A health home must collect and report quality data to the lead entity and the department as specified by the department.

h. Health home termination. If the health home intends to stop providing health home services, the health home must provide notice of termination a minimum of 60 days prior to the date of termination by submitting Form 470-5465, Provider Request to Terminate Enrollment, to the department. The health home must notify members of termination 60 days prior to the termination date and provide for a seamless transition of enrollees to other health home providers.

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

ITEM 16. Adopt the following **new** implementation sentence in rule **441—77.51(249A)**:

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

ITEM 17. Adopt the following **new** implementation sentence in rule **441—77.52(249A)**:

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

ITEM 18. Amend rule **441—78.12(249A)**, implementation sentence, as follows:

This rule is intended to implement Iowa Code section 249A.4 ~~and 2010 Iowa Acts, chapter 1192, section 31~~.

ITEM 19. Adopt the following **new** implementation sentence in rule **441—78.13(249A)**:

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

ITEM 20. Amend subrule **78.27(1)**, definitions of "Care coordinator" and "Integrated health home," as follows:

"Care coordinator" means the professional who assists members in care coordination as described in paragraph ~~78.53(1)*"b."*~~ 78.53(2)*"b."*

"Integrated health home services" means the provision of services to enrolled members as described in subrule ~~78.53(1)~~ 78.53(2).

ITEM 21. Amend rule **441—78.47(249A)**, implementation sentence, as follows:

This rule is intended to implement Iowa Code section 249A.4 ~~and 2000 Iowa Acts, chapter 1228, section 9~~.

ITEM 22. Amend rule **441—78.52(249A)**, implementation sentence, as follows:

This rule is intended to implement Iowa Code section 249A.4 ~~and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3~~.

ITEM 23. Rescind rule 441—78.53(249A) and adopt the following **new** rule in lieu thereof:

441—78.53(249A) Health home services.

78.53(1) *Definitions.*

"Chronic condition" means, for purposes of this rule, one of the conditions outlined in subparagraph 78.53(3)*"a"*(1).

"Chronic condition health home" means a health home that meets the criteria in 441—subrule 77.47(2).

"Health home" means a chronic condition health home or an integrated health home.

"Integrated health home" means a health home that meets the criteria in 441—subrule 77.47(3).

"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 subrule 78.27(4), rule 441—83.127(249A) and 441—paragraph 90.4(1)*"b"*; (2) 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.

78.53(2) *Covered services.* A health home provides team-based, whole-person, patient-centered, coordinated care for all aspects of the member's life and for transitions of care that the member may experience. A health home provides the following core services:

a. 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 a comprehensive person-centered care plan or service plan that addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

b. Care coordination. Care coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, transition of care, wellness education, health support, lifestyle modification, and behavior changes. The health home

must work with providers to coordinate, direct, and ensure results are communicated back to the health home.

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

d. Comprehensive transitional care. Comprehensive transitional care is the facilitation of services for the member that provides support 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).

e. Individual and family support. Individual and family support services include communication with the member and the member's family and caregivers to maintain and promote quality of life, with particular focus on community living options. Support will be provided in a culturally appropriate manner.

f. 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, including resources for understanding eligibility for various health care programs, disability benefits, and identifying housing programs.

78.53(3) *Member eligibility for health home services.*

a. Chronic condition health home member eligibility criteria.

(1) To be eligible for chronic condition health home services, the member must have one of the following chronic conditions and be at risk of having a second chronic condition:

1. A mental health disorder.
2. A substance use disorder.
3. Asthma.
4. Diabetes.
5. Heart disease.
6. Being overweight, as evidenced by:

- Having a body mass index (BMI) over 25 for an adult, or
- Weighing over the 85th percentile for the pediatric population.

7. Hypertension.
8. Chronic obstructive pulmonary disease.
9. Chronic pain.

(2) "At risk" means a documented family history of a verified heritable condition described above, a diagnosed medical condition with an established comorbidity to a condition described above, or a verified environmental exposure to an agent or condition known to be the cause of a condition from the conditions described above.

b. Integrated health home eligible member criteria. To be eligible for integrated health home services, the member must have a serious mental illness or serious emotional disturbance, as such terms are defined in 441—subrule 77.47(1).

78.53(4) *Member identification and enrollment.*

a. Eligible members are identified through a referral from the department, lead entity, primary care provider, hospital, other providers, or the member.

b. The health home confirms eligibility for health home services by obtaining assessment documentation from the member's licensed mental health professional or the patient tiering assignment tool (PTAT).

c. 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 roles and responsibilities.

d. The health home must advise members of their ability and the process to opt out of health home services at any time.

e. 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.

f. 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.

78.53(5) *Health home documentation.* A health home must maintain adequate supporting documentation in readily reviewable form to ensure 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 must document the following:

a. Eligibility. Eligibility documentation includes but is not limited to the following:

(1) How the member presented to the health home, including the referral.

(2) Identified needs and plan to assess for eligibility.

(3) 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.

(4) Qualifying diagnosis that makes the member eligible for health home services.

(5) Member agreement and understanding of the program.

(6) Enrollment request.

(7) Enrollment with the health home.

(8) Plan to complete the comprehensive assessment.

(9) Documentation of eligibility and member's agreement to continue participation in the program, obtained on an annual basis.

b. Comprehensive assessment. The comprehensive assessment must include all aspects of a member's life and satisfy the following requirements:

(1) 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.

(2) The comprehensive assessment for members enrolled to receive non-intensive care management or enrolled in the chronic condition health home must include:

1. 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;

2. Assessment of physical and behavioral health needs, medication reconciliation, functional limitations, and appropriate screenings;

3. Assessment of the member's social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors; and

4. Assessment of the member's readiness for self-management using screenings and assessments with standardized tools.

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

1. 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.

2. 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.

3. Documentation that no state plan HCBS is provided that would otherwise be available to the member through other Medicaid services or other federally funded programs.

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

c. Person-centered service plan and patient-centered care plan.

(1) 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 as defined in subrule 78.53(1) and the health home state plan amendment.

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

(3) 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.

d. Core 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.

e. 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 or the HCBS children's mental health waiver programs.

f. Continuity of care.

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

(2) 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.

g. Disenrollment. Members are able to opt out of health home services at any time. The health home must 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 the ability to re-enroll if circumstances change.

78.53(6) *Payment.*

a. Payment will be made for health home services when:

(1) The member is eligible for Medicaid and enrolled in the health home for the month of service, and

(2) The health home provides at least one of the six core health home services described in subrule 78.53(2) during the month, and

(3) The health home maintains the documentation outlined in paragraph 78.53(5)*"e."*

b. A unit of service is one member month.

c. The health home must report the informational only code in addition to the billing procedure code and modifier for one or more of the core services provided to the member during the month on the claim for payment.

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

ITEM 24. Amend rule **441—78.54(249A)**, implementation sentence, as follows:

This rule is intended to implement Iowa Code section 249A.4 ~~and 2012 Iowa Acts, Senate File 2158~~.

ITEM 25. Amend rule **441—78.55(249A)**, implementation sentence, as follows:

This rule is intended to implement Iowa Code section 249A.4 ~~and 2015 Iowa Acts, Senate File 505, division V, section 12(23)~~.

ITEM 26. Adopt the following **new** implementation sentence in rule **441—78.56(249A)**:

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

ITEM 27. Amend subparagraph **79.3(2)"d"(40)** as follows:

(40) Health home services:

1. Member's eligibility.

2. Comprehensive assessment.

~~1.~~ 3. Comprehensive care management plan for members receiving chronic condition health home services, or comprehensive person-centered care plan or service plan for members receiving integrated health home services.

~~2.~~ 4. Care coordination and health promotion plan.

~~3.~~ 5. Comprehensive transitional care plan, including appropriate follow-up~~, from inpatient to other settings~~.

6. Continuity of care document.

~~4.~~ 7. Documentation of member and family support (including authorized representatives).

~~5.~~ 8. Documentation of referral to community and social support services, if relevant.

9. Service notes or narratives.

10. Other documentation as applicable, including as outlined in 441—subrule 78.53(5).

ITEM 28. Adopt the following **new** implementation sentence in rule **441—79.7(249A)**:

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

ITEM 29. Amend rule **441—79.9(249A)**, implementation sentence, as follows:

This rule is intended to implement Iowa Code section 249A.4 ~~and 2014 Iowa Acts, Senate File 2320~~.

ITEM 30. Amend paragraph **79.14(2)"c"** as follows:

c. With the application ~~form~~ Form 470-5273, or as a supplement to a previously submitted application, providers of health home services ~~shall~~ must submit Form 470-5100, Health Home Provider Agreement, or Form 470-5160, Integrated Health Home Provider Agreement.