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 assistant, so long as the chronic condition health home has as least one physician.

(2) Nurse 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.

(8) Provider accredited under 441—Chapter 24 to deliver services to persons with mental illness.

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 managers. 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, at the time of enrollment and reenrollment, 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 oversight of the service, including 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 evidence-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 the member's family 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 based on the member's preferred method of communication.

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 mental illness 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 of 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.

[**ARC 6310C**, IAB 5/4/22, effective 7/1/22]