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).

"Person-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, person-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 health care, and community support services, using a comprehensive person-centered care plan or service plan that addresses all clinical and nonclinical 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, the member, or the member's authorized representative.

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 continued eligibility, reviewed annually and maintained in the member's service record.

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 person-centered care plan.

(1) For members receiving non-intensive care management or enrolled in the chronic condition health home, documentation must include a person-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).

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 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 subrule 78.53(5).

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.

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