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**State/Territory Name:**

**State Plan Amendment (SPA) #: IA 21-0005**

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# IA - Submission Package - IA2021MS0002O - (IA-21-0005) - Health Homes

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- Reviewable Units
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CMS-10434 OMB 0938-1188

## Package Information

<b>Package ID</b>	IA2021MS0002O	<b>Submission Type</b>	Official
<b>Program Name</b>	Migrated_HH.IA-16-012 - Chronic Conditions Health Home - Managed Care Implementation	<b>State</b>	IA
<b>SPA ID</b>	IA-21-0005	<b>Region</b>	Kansas City, KS
<b>Version Number</b>	2	<b>Package Status</b>	Approved
<b>Submitted By</b>		<b>Submission Date</b>	2/1/2021
<b>Package Disposition</b>		<b>Approval Date</b>	4/1/2021 10:27 AM EDT
<b>Priority Code</b>	P2		

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Medicaid and CHIP Operations Group  
601 E. 12th Street, Room 355  
Kansas City, MO 64106



## Center for Medicaid & CHIP Services

April 01, 2021

Julie Lovelady  
Interim Medicaid Director  
Department of Human Services  
1305 East Walnut Street  
Des Moines, IA 50309

Re: Approval of State Plan Amendment IA-21-0005 Migrated\_HH.IA-16-012 - Chronic Conditions Health Home - Managed Care Implementation

Dear Julie Lovelady,

On February 01, 2021, the Centers for Medicare and Medicaid Services (CMS) received Iowa State Plan Amendment (SPA) IA-21-0005 for Migrated\_HH.IA-16-012 - Chronic Conditions Health Home - Managed Care Implementation to update the billing code for the Health Promotion service. This change is being made to align with the current Medicare billing code for that service.

We approve Iowa State Plan Amendment (SPA) IA-21-0005 with an effective date(s) of January 01, 2021.

If you have any questions regarding this amendment, please contact Laura D'Angelo at [laura.dangelo1@cms.hhs.gov](mailto:laura.dangelo1@cms.hhs.gov)

Sincerely,  
James G. Scott  
Director, Division of Program  
Operations  
Center for Medicaid & CHIP Services

## Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS00020 | IA-21-0005 | Migrated\_HH.IA-16-012 - Chronic Conditions Health Home - Managed Care Implementation

### Package Header

<b>Package ID</b>	IA2021MS00020	<b>SPA ID</b>	IA-21-0005
<b>Submission Type</b>	Official	<b>Initial Submission Date</b>	2/1/2021
<b>Approval Date</b>	4/1/2021	<b>Effective Date</b>	N/A
<b>Superseded SPA ID</b>	N/A		

### State Information

**State/Territory Name:** Iowa

**Medicaid Agency Name:** Department of Human Services

### Submission Component

- State Plan Amendment
- Medicaid
- CHIP

## Submission - Summary

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<b>Superseded SPA ID</b>	N/A		

### SPA ID and Effective Date

**SPA ID** IA-21-0005

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Payment Methodologies	1/1/2021	IA-20-0010

# Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS00020 | IA-21-0005 | Migrated\_HH.IA-16-012 - Chronic Conditions Health Home - Managed Care Implementation

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<b>Superseded SPA ID</b>	N/A		

## Executive Summary

### Summary Description Including Goals and Objectives

Summary description including goals and objectives:

A Health Home (HH) focused on members with one chronic condition and the risk of developing another.

The Health Home program enrolls Designated Providers to deliver personalized, coordinated care for individuals meeting program eligibility criteria. In return for the additional Health Home Services to members, the Designated Provider is paid a per member per month (PMPM) payment to deliver the following Health Home Services:

- 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 comprehensive person-centered care plan that addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.
  - Care Coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, and transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. Coordinate, direct, and ensure results are communicated back to the health home.
  - Health Promotion includes coordinating or providing behavior modification interventions aimed at supporting health management, improving disease outcomes, disease prevention, safety and an overall healthy lifestyle.
  - Comprehensive transitional care is the facilitation of services for the individual and supports when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community based group home, family, or self-care, another Health Home).
  - Individual and Family Support Services include communication with patient, family and caregivers to maintain and promote the quality of life with particular focus on community living options. Support will be provided in culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.
  - Referral to Community and Social Support Services includes coordinating or providing recovery services and social health services available in the community, such as understanding eligibility for various healthcare programs, disability benefits, and identifying housing programs.
- Managed Care Organizations (MCOs) serve as the Lead Entity and:
- Develop a network of health homes
  - Educate and support providers
  - Provide training, technical assistance, expertise and oversight to the Health Homes
  - Provide oversight and technical support for HH providers to coordinate with primary care providers
  - Provide infrastructure and tools to HH providers
  - Provide outcomes tools and measurement protocols to assess effectiveness
  - Provide clinical guidelines and other decision support tools
  - Provide a repository for member data
  - Support providers to share data
  - Develop and offer learning activities
  - Perform data analysis at the member level and program-wide to inform continuous quality improvement
  - Offer Performance Measures Program which may include incentives
  - Reimburse providers
  - Identify/enroll members

Health Information Technology (HIT) will link services, provide feedback and facilitate communication among team members. Electronic sharing of health data among Lead Entities, behavioral and physical health providers in a HIPAA compliant manner enables tight coordination with the broader physical health delivery system. Online profiles are able to include medical, behavioral and pharmacy history.

The use of HIT is a means of facilitating these processes that include the following components of care:

- Mental health/ behavioral health
- Oral health
- Long-term care
- Chronic disease management
- Recovery services and social health services available in the community
- Behavior modification interventions aimed at supporting health management (e.g., obe

## Federal Budget Impact and Statute/Regulation Citation

### Federal Budget Impact

	Federal Fiscal Year	Amount
First	2021	\$0
Second	2022	\$0

**Federal Statute / Regulation Citation**

2703 Amendment

**Supporting documentation of budget impact is uploaded (optional).**

Name	Date Created	
No items available		

## Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS00020 | IA-21-0005 | Migrated\_HH.IA-16-012 - Chronic Conditions Health Home - Managed Care Implementation

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<b>Superseded SPA ID</b>	N/A		

### Governor's Office Review

- No comment
- Comments received
- No response within 45 days
- Other

# Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0002O | IA-21-0005 | Migrated\_HH.IA-16-012 - Chronic Conditions Health Home - Managed Care Implementation

## Package Header

<b>Package ID</b>	IA2021MS0002O	<b>SPA ID</b>	IA-21-0005
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<b>Approval Date</b>	4/1/2021	<b>Effective Date</b>	1/1/2021
<b>Superseded SPA ID</b>	IA-20-0010		
	System-Derived		

## Payment Methodology

The State's Health Homes payment methodology will contain the following features

Fee for Service

Individual Rates Per Service

Fee for Service Rates based on

Severity of each individual's chronic conditions

Capabilities of the team of health care professionals, designated provider, or health team

Other

Per Member, Per Month Rates

Fee for Service Rates based on

Severity of each individual's chronic conditions

Capabilities of the team of health care professionals, designated provider, or health team

Other

### Describe below

Members are automatically assigned a tier one. To qualify for a higher tier, providers will use a State provided tier tool that looks at Expanded Diagnosis Clusters to score the number of conditions that are chronic, severe and requires a care team.

Comprehensive Methodology Included in the Plan

Incentive Payment Reimbursement

**Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided**

The PMPM payment is a reflection of the added value provided to members receiving this level of care and will be risk-adjusted based on the level of acuity assigned to each patient with no distinction between public or private health home providers. The Health Home provider will tier the eligible members into one of four tiers with a PMPM payment assigned to each tier.

Tier Minutes Per Month Sum of Chronic Conditions

1	15	1-3
2	30	4-6
3	60	7-9
4	90	10+

### Additional Tiering Information

Qualifying members as described in the Population Criteria Section of the document are automatically a Tier 1 member. To qualify for a higher tier, providers will use a State provided tier tool that looks at Expanded Diagnosis Clusters to score the number of conditions that are chronic, severe and requires a care team.

The PMPM payment is a reflection of the added value provided to members receiving this level of care and will be risk-adjusted based on the level of acuity assigned to each patient with no distinction between public or private health home providers. The health home provider will tier the eligible members into one of four tiers with a PMPM payment assigned to each tier.

PCCM (description included in Service Delivery section)

Risk Based Managed Care (description included in Service Delivery section)

Alternative models of payment, other than Fee for Service or PMPM payments (describe below)



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## Agency Rates

### Describe the rates used

- FFS Rates included in plan
- Comprehensive methodology included in plan
- The agency rates are set as of the following date and are effective for services provided on or after that date

### Effective Date

7/1/2020

### Website where rates are displayed

<https://dhs.iowa.gov/ime/providers/enrollment/healthhome>

# Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | IA2021MS0002O | IA-21-0005 | Migrated\_HH.IA-16-012 - Chronic Conditions Health Home - Managed Care Implementation

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## Rate Development

### Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
  - the frequency with which the state will review the rates, and
  - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

**Comprehensive Description** This reimbursement model is designed to only pay for Health Home services as described in the six service definitions (Comprehensive Care Management, Care Coordination, Comprehensive Transitional Care, Health Promotion, Individual and Family Support, and Referral to Community and Social Services) may or may not require face-to-face interaction with a health home patient. However, when these duties do involve such interactions, they are not traditionally clinic treatment interactions that meet the requirements of currently available billing codes.

The criteria required to receive a monthly PMPM payment is:

- The member meets the eligibility requirements as identified by the provider and documented in the members electronic health record (EHR).
- Member's eligibility requirements verified within the last 12 months.
- The member has full Medicaid benefits at the time the PMPM payment is made.
- The member has agreed and enrolled with the designated health home provider.
- The Health Home provider is in good standing with IME and is operating in adherence with all Health Home Provider Standards.
- The minimum service required to merit a Patient Management PMPM payment is that the person has received care management monitoring for treatment gaps defined as Health Home Services in this State Plan. The Health Home must document Health Home services that were provided for the member.
- The patient medical record will document health home service activity and the documentation will include either a specific entry, at least monthly, or an ongoing plan of activity, updated in real time and current at the time of PMPM attestation.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Health Home services. The agency's fee schedule rate was set as of July 1, 2020 and is effective for services provided on or after that date. Rates will be reviewed on an annual basis. All rates are published at <https://dhs.iowa.gov/ime/providers/csrp/fee-schedule>

The rate is developed according to the actual cost of providing each component of the service for the adult population with and without intensive care management and the child population with and without intensive care management service. No other payments for these services shall be made.

The Health Home will bill a S0280 with the appropriate modifier to identify the tier with the informational codes on subsequent line items to attest to Health Home Services Provided.

Tier 1 (1-3 CC)	U1
Tier 2 (4-6 CC)	TF
Tier 3 (7-9 CC)	U2
Tier 4 (+10 CC)	TG
Health Home Service	Code
Chronic Care Management	G0506
Care Coordination	G9008
Health Promotion	99439
Comprehensive Transitional Care	G2065
Individual & Family Support Services	H0038
Referral to Community and Social Support Services	S0281

Salaries are pulled from Iowa Wage Report data (<https://www.iowaworkforcedevelopment.gov/iowa-wage-report>) using applicable codes for each individual role. Benefits and Indirect cost relativities have remained constant from prior rate development.

Minutes by Tier

Tier 1 15min

Tier 2 30min

Tier 3 60min

Tier 4 90min

Distribution is:

20% Physician

30% Care Coordinator

20% Health Coach  
30% Office/Clerical

The State will use this methodology on an annual basis to review rates.

# Health Homes Payment Methodologies

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## Assurances


The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

**Describe below how non-duplication of payment will be achieved** When the member receives care coordination from a Community-Based Case Manager as a Home and Community-Based Waiver Service or Service Coordination through the MCO, the Health Home must collaborate with Community-Based Case Manager or Service Coordinator to ensure the care plan is complete and not duplicative between the two entities. Additionally, Lead Entities are contractually required to ensure non-duplication of payment for similar services; the State reviews and approves Lead Entity non-duplication strategies and conducts ongoing monitoring to assure continued compliance.

If the individual is already enrolled in an Integrated Health Home (IHH) for members with a Serious Mental illness or Serious Emotional Disturbance, the member must choose between the Chronic Condition Health Home (CCHH) and the IHH. A member cannot be in more than one Health Home at the same time. Members in the Health Home will have state plan services coordinated through the Chronic Condition Health Home Provider.

- The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

## Optional Supporting Material Upload

Name	Date Created	
CCHH_PMPM_Billing_Guidance_Effective_July_1_2020	11/20/2020 12:45 PM EST	

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

*This view was generated on 4/12/2021 9:10 AM EDT*