Iowa Health Link
IOWA HHS

Amerigroup

Health Home Program Supplemental Provider Manual

Iowa Health Link and Amerigroup Iowa, Inc.

800-454-3730

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CHAPTER 1: STRUCTURE AND ORGANIZATION

Executive Summary

Amerigroup Iowa, Inc. is committed to supporting the Iowa Department of Health and Human Service's (Iowa HHS) goal to expand and evolve Health Homes, reducing fragmentation in care and enhancing access to services that holistically address the needs of members experiencing serious mental illness, serious emotional disturbance, or chronic health conditions. In establishing the rationale and goals for the Health Home, we embrace the principle that an individual is front and center in addressing his or her preferences, self-identified needs and health goals consistent with their cultural values and beliefs.

A Health Home is a health services team, acting as a health professional champion for the member, which promotes collaboration, coordination and accountability between health service providers, and establishes a person-centered health services plan with person-centered health goals and objectives. The individual is engaged as an active participant in his or her health to take actions in addressing chronic health conditions. Health Homes support the individual's self-care and assists in making referrals to community services and supports. By increasing care coordination, promoting self-care and health promotion, facilitating transitions in care and linking to community services and supports, gaps in service delivery are diminished.

Health information technology (HIT) facilitates care coordination by tracking health services and recommended health visits. The coordination of a member's care is achieved through a dedicated care team overseeing and coordinating access to services a member requires, and in turn, improving a member's health status. Emergency department visits and inpatient stays will be reduced while member health outcomes will improve through appropriate care management. With member consent, health records will be shared amongst providers ensuring the member receives needed and unduplicated services.

The Health Home program is a Medicaid state plan service available to Medicaid enrollees. Health Homes encompass both Integrated Health Homes (IHH) and Chronic Condition Health Homes (CCHH). IHHs are for adult members with a serious mental illness (SMI) or child members with a serious emotional disturbance (SED). CCHHs are for members, adult or child, with two chronic health conditions or one chronic health condition and at risk of developing a second chronic condition.

The Iowa model for a Health Home includes a partnership between Amerigroup and the Health Home provider that is most appropriate for the member. This model offers the greatest flexibility to provide services within the Iowa framework while supporting existing relationships between members and their community providers.

With this model, Amerigroup will serve as the Lead Entity (LE) for Health Homes and contract with qualified providers as Health Homes (HHs).

Statutory Authority of Health Homes

Health Homes is an option afforded to states under the Affordable Care Act (ACA). Section 2703 allows states, under the state plan option, the authority to implement Health Homes. This includes the opportunity to receive additional federal support for the integration and coordination of primary, acute, behavioral health (mental health and substance use) and long-term services and supports for persons with chronic illnesses.

Section 1945(h) (4) of the Social Security Act defines Health Home services as "comprehensive and timely high quality services" and includes six Health Home services to be provided by designated Health Home providers.

State Medicaid Director Letter — Health Homes for Members with Chronic Conditions

State Medicaid Director Letter (SMDL) #10-024 Health Homes for Enrollees with Chronic Conditions provides preliminary guidance to states on the implementation of Section 2703 of the ACA, which is entitled "State Option to Provide Health Homes for Members with Chronic Conditions." The SMDL can be accessed at: **http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.**

The U.S. Department of Health and Human Services (HHS) and the Center for Medicare and Medicaid Services (CMS) approved the implementation of Iowa's State Plan Amendment for persons with chronic health conditions on July 1, 2012, and for adults and children with a serious mental illness (SMI) or serious emotional disturbance (SED) on July 1, 2013, with a staggered roll-out in regions of the state. The State Plan Amendments can be accessed at: **https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization/federal-documents**.

While this manual serves as a source of information for Health Homes within the Amerigroup provider network, Health Homes should refer to the following for additional guidance and requirements:

- Amerigroup Contract (including addendums)
- *Amerigroup Provider Manual*
- Center for Medicaid and Medicare Services
- Code of Federal Regulations
- Iowa HHS Provider Manuals
- Iowa Administrative Code
- State Plan Amendments (SPA)

CHAPTER 2: MEMBERSHIP

Referrals

Member referrals may come from a wide variety of avenues, including family members, Primary Care Physicians (PCPs), homeless shelters, school personnel, hospitals, therapists, community action agencies, religious organizations, IHHs, CCHHs, Amerigroup, or other service providers or individuals who support the member.

Through the Amerigroup care coordination process, members may be identified and referred to a Health Home. Amerigroup uses predictive modeling tools to identify members who may benefit from Health Home services. Each month, the entire member population is evaluated and prioritized to identify members with the highest expected need for services. This information is used by Amerigroup Complex Case Management to make Health Home referrals. Additionally, referrals may be identified through the health risk assessment completion process. If it appears members may benefit from enrollment in a Health Home via completing the health risk assessment, the Amerigroup Complex Case Management team will outreach to the member to discuss Health Home programming and available options and make direct contact with the Health Home with referrals as appropriate.

Enrollment

Once a referral is received, a Health Home will:

1. Verify the member meets Health Home enrollment criteria.
2. Confirm Medicaid eligibility and Managed Care Organization (MCO) assignment.
3. Complete the *Health Home Notification* form (located at **https://provider.amerigroup.com/ia** > Forms > Health Home) within 30 days and fax it to Amerigroup at **844-556-6125**.

Amerigroup will identify, attribute and enroll members to a CCHH or IHH consistent with the State Plan Amendments, located at **https://dhs.iowa.gov/ime/about** > News and Initiatives > Integrated Health Home or Chronic Condition Health Home (see **Figure 2.1 Enrollment Process**).

Health Homes should ensure members meet Health Home population criteria and enrollment monthly, as per the State Plan Amendments.

Medicaid Eligibility

Health Homes should confirm members' Medicaid eligibility and MCO assignment at initial enrollment and then monthly by checking the following:

- Eligibility Verification System (ELVS)*
    - ELVS **Portal**, Electronic Data Interchange Support Services (EDISS). Login ID and password may be obtained through EDI by submitting the ***Additional Access Request* form** to EDI, or by calling EDI at **800-967-7902**.
    - ELVS line at **800-338-7752**
- Amerigroup reports, which are available at **https://www.availity.com**. (Note: For more information on these reports, see the **Reports** chapter.)

*ELVS is the source of truth for Medicaid eligibility and MCO assignment

The following Medicaid plans are not eligible for Health Home enrollment and services:

- Hawki
- Health and Wellness (NOT medically exempt)
- Family Planning Program
- Qualified Medicare Beneficiary (QMB)
- Program of All Inclusive Care for the Elderly (PACE)
- Presumptive eligibility

Current Health Home Assignment

Health Homes should confirm that the member is not enrolled in another Health Home prior to submitting an enrollment. If a member is unsure of prior or current Health Home enrollments, Health Homes can refer to Patient360 on Availity* Essentials to determine if a member is already enrolled in a Health Home.

Notification Form

Once a Health Home identifies a member who qualifies for the program and obtains permission from the member for inclusion in the program, a *Health Home Notification* form (located at **https://provider.amerigroup.com/ia** > Patient Care > Health Home > *Health Home Notification Form*) should be completed within 30 days and faxed to Amerigroup at **844-556-6125**. Amerigroup will activate member enrollment as appropriate for the first day of the month of enrollment. If a member cannot be enrolled, Amerigroup will send an email notification to the Health Home. Reasons for unable to enroll include:

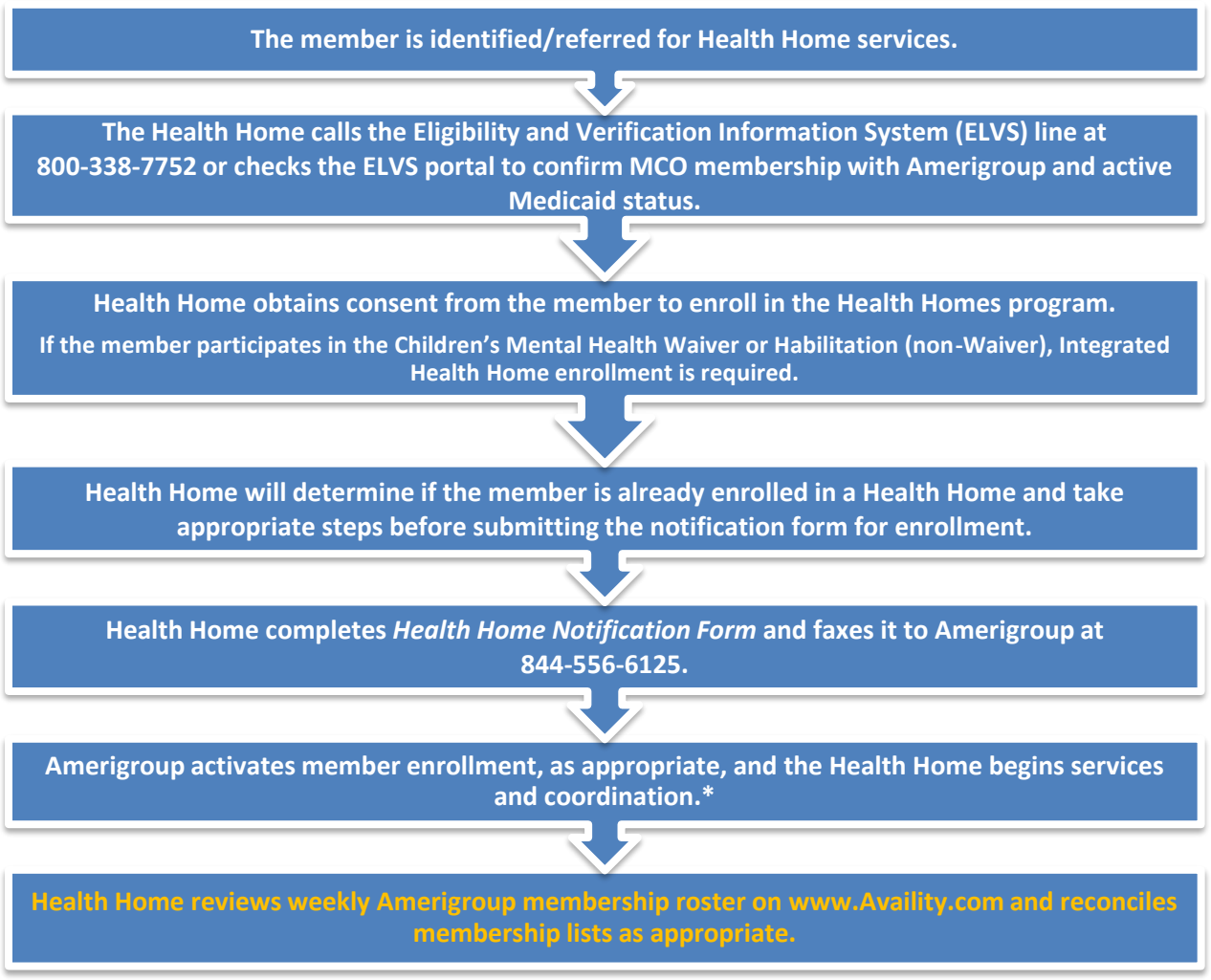
- Member is enrolled in another Health Home.
- Member is not Medicaid-eligible.
- Member is not an Amerigroup member.
- Member is enrolled in the Health and Wellness Plan, Hawki, Family Planning Program, QMB, PACE, or has presumptive eligibility.
- For IHH only: Functional limitations were not met.
- For IHH only: Required clinical documentation is missing or incomplete.
- For CCHH only: Member is on the Children's Mental Health Waiver or Habilitation.
- The *Health Home Notification* form is incomplete.

Health Homes are responsible for resubmitting notification forms once the member becomes eligible and the criteria above are no longer applicable.

Notification forms must be received individually by fax. Batch faxes, or more than one notification form faxed at a time, will be rejected or not processed.

Amerigroup is not responsible for notification forms not received by Amerigroup. Health Homes are responsible for reconciling their membership roster with the weekly Amerigroup Health Home membership report located on Availity Essentials (**www.availity.com** > Provider Online Reporting). The Amerigroup Health Home membership report is the source of truth for universal Health Home enrollment.

Figure 2.1 Enrollment Process



*If a Health Home needs to know if an enrollment or disenrollment has been processed prior to release of the weekly Health Home membership roster, the Health Home may use Patient 360 (alert box) to check the status or email IA-HealthHome@amerigroup.com. Health Homes should not delay or deny care coordination services for a member who needs it because of a delayed membership report or system processing issue.

Member Change of Health Home

Members can request a change to their enrolled Health Home at any time during their participation in the program. A member can choose any Health Home in the Amerigroup network that serves the area where the member lives.

Members can inform Amerigroup of the change by calling Member Services at **800-600-4441** (Monday-Friday, 7:30 am. -6 p.m. CST), or the current Health Home can submit a *Health Home Notification Form* (located at **https://provider.amerigroup.com/ia** Forms > Health Home) indicating disenrollment by faxing it to Amerigroup at **844-556-6125** within 30 days.

Once disenrolled from the current Health Home, the new Health Home will need to submit an enrollment request via the Health Home Notification Form. Immediate and ongoing communication should occur

between the current Health Home and the newly chosen Health Home to ensure member continuity of care (and as a professional courtesy). The "warm" hand-off of member information between Health Home organizations should be timely and complete. Both organizations are equally responsible for communication once it is known that the member wants to change Health Homes. The figure below outlines responsibilities associated with member change of Health Homes.

Figure 2.2 Responsibilities: Member Change of Health Home (HH)[1]

Member[2]	Chosen HH organization	Current HH organization	Amerigroup
1. Expresses the desire to switch HHs or moves from the area. 2. Notifies the current HH of the desire to change HHs. 3. Member may also notify Amerigroup at **800-600-4441** (M-F, 7:30 a.m.-6 p.m. CST).	1. Ensures the member clearly understands the move to a new HH means disenrollment from the current HH. 2. Contacts the current HH to arrange for collaboration meeting/discussion, as allowed by the release of information (ROI). 3. After the member is disenrolled from the current HH, completes and faxes an *HH Notification Form* to Amerigroup. 4. If the member is eligible for Habilitation or CMH Waiver, IHH submits a request via the ICR or fax to change the provider on the 99490 authorization.	1. Obtains ROI for the chosen HH. 2. Submits *HH Notification Form* for disenrollment. 3. Sends pertinent documentation to the chosen HH organization as allowed by the ROI. 4. Communicates upcoming appointments, assessments and care plan deadlines.	1. Processes disenrollment and enrollment forms as appropriate. 2. Monitors HH activity regarding quality of transfer and communication. 3. Confirms change of HH provider.

[1] Amerigroup reserves the right to further review or deny an HH-to-HH transfer.
[2] For individuals younger than 18 years old, *member* refers to the parent/custodian.

Members enrolled in CCHHs can choose to go to another primary care organization with the understanding that the provider may not be enrolled as a Health Home (see disenrollment).

Members who receive Habilitation (non-Waiver) services or participate in the CMH Waiver will need to continue enrollment with an IHH in order to continue receiving Habilitation (non-Waiver) and CMH Waiver services.

Member Moved from Area

For members who move and do not notify the current Health Home, every effort should be made by the current Health Home to locate members and assist them in finding Health Homes and services in their new community to prevent gaps in care and ensure continuity of care.

Member Managed Care Organization (MCO) Change

When a member changes their MCO to Amerigroup (for example, due to annual enrollment or good cause), the Health Home should fax a *Health Home Notification Form* to Amerigroup at **844-556-6125** within 30 days

(located at **https://provider.amerigroup.com/ia** > Forms > Health Home) to enroll the member in the Health Home through Amerigroup.

As a reminder, Health Homes should confirm member MCO assignment at **initial enrollment** and then **monthly** by checking the Eligibility Verification System (ELVS) and monitoring the monthly reports available on our secure website (**https://www.availity.com** > More > Provider Self Service Amerigroup). For more information, see the **Reports** chapter of this manual.

For members with Habilitation (non-Waiver) and Children's Mental Health Waiver services, see chapter **HCBS: Habilitation and CMH Waiver Requirements** for additional information about member MCO changes.

Disenrollment

Health Home members can be disenrolled from the Health Home program. To officially disenroll a member, the Health Home should fax a *Health Home Notification Form* indicating the disenrollment to Amerigroup at **844-556-6125** within 30 days (located at **https://provider.amerigroup.com/ia** > Forms > Health Home). Health Homes should ensure transitions in care for members who are disenrolled (for example, assist the member in reapplying for Medicaid, refer the member to appropriate providers, provide referrals to other Health Homes, etc.). Members can also call Amerigroup at **800-600-4441** (Monday- Friday, 7:30 am.-6 p.m. CST) to disenroll from a Health Home.

Possible disenrollment reasons include:

- The member requested the disenrollment.
- The member is not participating, or the provider is unable to reach the member.[1]
- The member changed MCOs.
- The member transferred to another Health Home.
- The member moved from the area.
- The member no longer meets criteria for the Health Home program.
- The member is effectively self-coordinating services.
- The member is deceased.
- The member has lost Medicaid eligibility long-term.
- The provider requested the disenrollment. [2]
- The provider terminated the member's enrollment.[2]

[1] Health Homes should have a policy that clearly defines when members will be disenrolled due to not participating or because the provider is unable to reach the member.
[2] Health Homes should have a policy that clearly defines the procedures to disenroll a member to ensure continuity of care, including transfer /warm handoff to a new Health Home, consultation with Amerigroup, and communication with the member and providers regarding the discharge plan.

Members who lose Medicaid eligibility or have a change in Medicaid plan that does not qualify for Health Home service will be automatically disenrolled at 60 days (see the **Reports** chapter for assistance with tracking member disenrollment). If a member's full Medicaid is restored after 60 days, the Health Home is responsible for re-enrolling the member by faxing a *Health Home Notification Form* to Amerigroup at **844-556-6125** within 30 days (located at **https://provider.amerigroup.com/ia** > Forms > Health Home).

Notification forms with a disenrollment effective date for the first of the month will be processed for the last date of the previous month (for example, a December 1 effective date will be processed for November 30).

Health Homes should monitor the weekly Amerigroup membership list on Availity Essentials (**https://www.availity.com** > More > Provider Self Service Amerigroup) to ensure disenrollment information was received and processed by Amerigroup. Amerigroup reserves the right to disenroll the member the date the notification form was received by Amerigroup.

Tier Changes

Tier changes should be reported for the following:

Health Home	Tier Change	Method
Chronic Condition Health Home	- When a member changes tiers	Submit the *Health Home Notification Form* with the tier change within 30 days.
Integrated Health Homes	- When a member goes from Intensive Care Management (ICM) to non-ICM (for example, Habilitation to non-Habilitation Waiver or CMH Waiver to non-CMH Waiver - When a member is enrolled as a pediatric patient, turns 18, consents to continue enrollment in the Health Home, and has signed required Health Home enrollment paperwork.	Submit the *Health Home Notification Form* with the tier change within 30 days. The IHH will indicate clearly on the form the reason for the tier change.
	- When a member goes from non-ICM to ICM.	A notification form is not needed. Submit assessment and social history (include signed diagnoses for CMH waiver) via Availity Essentials (or fax) and request 99490 CPT code. To communicate that a 99490 authorization needs to be reopened, submit a 99490 request via Availity Essentials (or fax) and indicate in the notes section the request is to reopen the 99490 authorization.

Waivers and Habilitation Services

Iowa has seven home- and community-based (HCBS) waivers: Health and Disability, AIDS/HIV, Elderly, Intellectual Disability, Brain Injury, Physical Disability and Children's Mental Health (CMH). IHHs provide Intensive Case Management (ICM) to members enrolled in Habilitation services (non-Waiver) and members enrolled in the CMH Waiver program. To avoid duplication of services, members currently receiving a HCBS waiver (excluding CMH Waiver) and Health Home services, will have the delivery of this care coordinated between the entities. The Health Home must collaborate with the Community-Based Case Manager (CBSM)

at least quarterly to ensure the care plan is complete and not duplicative between the two entities. Health Homes should review their weekly Amerigroup Health Home Roster located on Availity Essentials to monitor for waiver enrollment (see Reports). To access Community-based Case Manager (CBCM) direct contact information, Health Homes may email IA-HealthHome@amerigroup.com.

A member cannot be enrolled in a CCHH and IHH at the same time. A member can choose to be enrolled in either a CCHH or an IHH; however, a member with Habilitation (non-Waiver) or CMH Waiver eligibility must be enrolled in an IHH.

CHAPTER 3: DOCUMENTATION

Enrollment

Health Homes should follow their organizational requirements for documentation standards including Iowa Administrative Code and the Amerigroup Provider Manual. At minimum, Health Homes should complete enrollment paperwork including releases of information, informed consent and assessments (for example, ***Patient Tier Assignment Tool (PTAT) for Chronic Condition Health Homes***, whole-person assessment, etc.) within 30 days of enrollment. Prior to submitting the notification form to Amerigroup for enrollment, Health Homes should ensure the following documentation is completed and available: release(s) of information, informed consent, and qualifying assessments (in other words, *PTAT for Chronic Condition Health Homes or Assessment completed by a Mental Health Practitioner outlining diagnosis(es) and functional impairments for Integrated Health Homes)*.

Assessments and Care Plans

Health Homes should follow the State Plan Amendment(s), the Amerigroup Provider Manual, and Iowa Administrative Code for information regarding comprehensive assessments and care plans for members. All Health Home members are required to have comprehensive assessments and up-to-date care plans. Health Homes should create a *Continuity Care Document (CCD)* for members, as outlined by the State Plan Amendment. Amerigroup does not have a standard format for assessments or care plans with the exception of required templates for Integrated Health Home (IHH) Intensive Case Management (ICM) members. For copies of example templates including the comprehensive assessment and social history, care plan and Continuity of Care Document, Health Homes may email IA-HealthHome@amerigroup.com. For more information on documentation for members with Intensive Case Management, see the **HCBS: Habilitation and CMH Waiver Requirements** chapter of this manual.

Services Provided

Health Homes are required to follow State Plan Amendment(s), the Amerigroup Provider Manual, and Iowa Administrative Code for documentation requirements regarding services provided.

CHAPTER 4: COLLABORATION

Overview

Health Homes participate in ongoing collaboration with other providers, hospitals, community groups, schools, residential and psychiatric treatment facilities, Mental Health and Disability Services (MHDS) regions, Iowa HHS, Iowa Medicaid (IM), managed care organizations (MCOs), member supports, member families, other Health Homes, Long-Term Services and Supports (LTSS) Community Based Case Managers (CBCM), Department of Corrections, Iowa Vocation Rehabilitation Services, and other providers, supports, and entities.

Amerigroup Teams

Amerigroup Integrated Case Management staff members include outreach specialists, wellness and recovery specialists, and licensed case managers. Case Management staff are available for case consultation, to attend joint treatment planning and person-centered planning meetings, and to provide information on benefits and support for members. For more information on Amerigroup Case Management program, email IA-HealthHome@amerigroup.com.

Members may be enrolled in a Health Home and Amerigroup Case Management program as appropriate. If a member is enrolled in both case management entities, the Health Home assumes the lead case manager role.

Additional Amerigroup staff specialize in employment, foster care youth, and peer support services. For assistance with these topics at any time, Health Home providers may email IA-HealthHome@amerigroup.com.

Hospitals

Health Homes should work closely with emergency room and hospital staff to prevent gaps in care for members and to assist with transitions of care. See the **State Plan Amendments** for additional information.

Psychiatric Medical Institutes for Children (PMIC) and Residential Treatment/Foster Group Care

In the event a child or youth meets clinical criteria for PMIC/residential treatment, the Health Home should work closely with the PMIC or residential treatment center and remain involved with youth and families. Health Homes should participate in ongoing staffing and assist with transitions in care as a member prepares to return to the community.

For IHHs, when a youth is on the CMH Waiver and/or Habilitation program and is placed in a PMIC or group care facility, the IHH and the PMIC will notify the Iowa HHS income maintenance worker as soon as possible. The IHH should continue to remain involved and may bill a PMPM if, at minimum, gaps for care are monitored and a Health Home service is provided. See Appendix D for additional guidance on billing the PMPM.

Other Health Homes

Health Homes should work closely with each other during member referral and transfers. Amerigroup Health Homes can locate other Amerigroup Health Home contact information on the Amerigroup Provider website at **https://provider.amerigroup.com/ia**.

Members cannot be enrolled in an IHH and a Chronic Condition Health Home (CCHH) at the same time. Members can only be enrolled in one Health Home at any given time.

Members cannot be enrolled in a CCHH and CareMore at the same time. CareMore is a provider that currently serves the Des Moines metro and surrounding communities.

Health Homes can view Patient 360 through Availity Essentials to determine if a member is enrolled in another Health Home as indicated in the alert box.

Services at a State Mental Health Institute and other Institutions for Mental Disease

The Institutions for Mental Health Disease (IMD) exclusion, as a part of the **Medicaid and CHIP Managed Care Final Rule**, allows Medicaid to pay for short-term stays (in other words, 15 days or less) for adults ages 21-64 in psychiatric hospitals and facilities. During the first 15 days a member is inpatient at a State Mental Health Institute/IMD, Amerigroup/Medicaid will reimburse all covered services for the member. However, if a member stays longer than 15 days services provided, including HH services, are not eligible for Medicaid reimbursement. Once discharged from the State Mental Health Institute/IMD, services provided to the member can again be eligible for Medicaid reimbursement.

CHAPTER 5: REPORTS

Health Homes have access to a member listing and member-specific reports on the Amerigroup secure provider website. Amerigroup recommends that Health Homes reconcile their member lists, at minimum, on a monthly basis and review reports on a daily/monthly basis, depending on the report. If there are discrepancies in Amerigroup reports compared to what the Health Home has on file, Health Homes should contact the Amerigroup Health Home team at IA-HealthHome@amerigroup.com.

The three member-specific reports are located at **https://www.availity.com** > Provider Online Reporting. Below are descriptions of each report and how Health Homes can use these reports to their maximum benefit:*

Report Name and Frequency	Report Description	How to use this report
Inpatient Daily	Displays HH assigned members who have been recently inpatient for behavioral health or medical needs. Report information includes: • Plan type • Iowa county • Date of inpatient • Location of inpatient • Admitting diagnosis A report will only be generated if an HH assigned member is inpatient. This report will not show members with primary insurance when the primary insurance is the payer (for example, Medicare).	Use this report to identify members who are inpatient. HHs should be in contact with hospitals when a member is inpatient.
IA HH Specific Membership with HIP Data Weekly	Displays HH assigned members, including currently enrolled and disenrolled members. Disenrolled members will remain on this report for 60 days. Report information includes: • Plan type • Iowa county • PRPR ID (Amerigroup/HH specific) • HH start date • HH end date • PTAT date off of HIP (CCHH) • Care plan date off of HIP (IHH) • Medicaid renewal date • Hab/CMH notice of decision (NOD) (IHH) • Start date NOD (IHH) • End date NOD (IHH) • LTSS Waiver (Yes/No) • Medicaid eligibility (Yes/No) • CI3 score[1] 1 The Chronic Illness Intensity Index (CI3) is the Amerigroup predictive model that compares the complexity of the conditions of all members in the Amerigroup diverse population. The CI3 is based on the John Hopkins ACG Predictive Risk Scoring Model. To yield a CI3 score, Amerigroup re-indexes the member's score so the average Amerigroup member has a score of 1.	This report can be used to monitor the following: • HH enrollment and disenrollment dates • If a Health Information Plan (HIP) has been submitted • If a member's Medicaid is up for renewal soon • If a member's Habilitation or CMH Waiver eligibility will end soon • If a member is on a waiver • If a member is Medicaid-eligible/eligible with Amerigroup • CI3 scores A CI3 score of 6.79 or higher indicates clinically complex, high clinical complexity, or most complex needs.

Report Name and Frequency	Report Description	How to use this report
HAB CMH Monthly	Displays HH assigned members who have expired eligibility or an NOD for Habilitation or CMH Waiver in the past 60 days. Report information includes: • Plan type • Iowa county • PRPR ID (Amerigroup/HH specific) • HAB/CMH NOD • Start date NOD • End date NOD	This report is for IHHs only. IHHs can monitor expired NODs to ensure Amerigroup has been notified of NODs that will not be renewed and double-check there are no lapses in care for members.
IHH Service Tracking **Weekly**	Displays current Habilitation and Children's Mental Health Waiver eligibility and provider service authorizations as of the day the report was run.	This report is for IHHs only. This report will help IHHs track eligibility and HCBS service authorization dates and information.
HHQIP Report Card Quarterly	Displays performance measure rates for time period indicated.	This report will help Health Homes determine if they are on track with meeting annual performance measures.
Gap in Care Reports Monthly to Quarterly	Displays current Health Plan Provider HEDIS measures and indicates gaps in care.	Health Homes should collaborate with the member's PCP / Specialist and the member to assist in - identifying and resolving potential barriers for follow up - exploring thoughts and steps on changing behavior with the member through motivational interviewing - providing additional health education to the member - ensuring medication reconciliation when appropriate - completing other activities and collaboration to assist with closing gaps

* Reports are for informational purposes only. If information appears inaccurate, please contact Amerigroup at IA-HealthHome@amerigroup.com. Member updates may lead to duplicate entries on reports. Please review report fully before utilizing. Health Homes may choose to use their own reports for monitoring purposes.

CHAPTER 6: QUALITY REPORTING AND MONITORING

Reporting

Health Home providers have significant reporting requirements, as established by the Affordable Care Act, State Plan Amendments, Federal Waivers and the Amerigroup contract.

CMS has outlined reporting requirements for Health Home providers for high-risk Medicaid members involving tracking and reporting on specific data elements (see **Health Home Quality Reporting** at **https://www.medicaid.gov**). Additionally, Health Homes should have the capacity to complete Health Home member status reports that document members' housing, legal, employment, education and other requirements as determined by Amerigroup to meet Iowa HHS reporting requirements for MCOs. This may include submitting reports and/or completing data entry by the dates due and in specified formats. State reports that require HCBS Habilitation and CMHW reporting include:

- Bi-annual
    - E-10 Employment
- Quarterly
    - A1 A5 D1 E1 E4 Care Coordination
    - A13 Revised Assessments
    - A14 Revised Care Plans
    - E17 CMS NEW 1915c and 1915i
    - E2 E6 E9 Waivers
    - E8 LTSS
- Monthly
    - A15 Service Plan Reductions
    - A16 Planned Coordination

Additional information on these reports including technical specifications and reporting manual can be found on the Iowa HHS website at **https://dhs.iowa.gov/RFP_MED-18-029_reporting_and_manual_templates.**

The Health Information Portal on Availity Essentials (www.availity.com) allows Health Home providers to submit reporting information on enrolled members to Amerigroup (see **Appendix B**). HIPs should be completed upon enrollment and annually for all enrolled members. Additional information may be gathered through chart reviews.

Monitoring

The Health Home model utilizes population health management strategies to understand the population being served in a more efficient and effective way. Population health management is effective by using a comprehensive health assessment and evidence-based decision support tools, which are based on complete patient information and clinical data, to manage and monitor the health of its entire Health Home population. This information should be used to create a service or care plan.

The following lists are examples (not all-inclusive) of data Amerigroup recommends should be monitored through electronic health records:

- Member information
    - Date of birth
    - Sex
    - Race

    - Ethnicity
    - Preferred language
    - Telephone numbers
    - Email address
    - Occupation
    - Date of previous clinical visits
    - Legal guardian/health care proxy
    - Primary caregiver
    - Presence of advance directives
    - Health insurance information
    - Name and contact information of other health care professionals involved in patient's care
- Clinical data
    - Problem list with current and active diagnoses
    - Allergies, including medication allergies and adverse reactions
    - Blood pressure, with last date taken
    - Height
    - Weight
    - BMI
    - Tobacco / Nicotine use
    - Prescription medications, with prescribed dates and prescriber
    - Family history
    - Progress notes signed by eligible professional

Health Home Quality Incentive Program

Quality incentive measures are quantifiable and are used to establish acceptable levels of Health Home performance, including a baseline measure, measurable goal and measurement at least annually through the Health Home Quality Incentive Program (HHQIP).

Quality outcome measures are structured each year and are based on the performance benchmarks the Health Home achieves. They are paid in a lump sum on a scheduled basis (for example, annually). Health Home bonus payments are tied to a percentage of the per-member-per-month (PMPM) payments made to each individual Health Home provider during the performance year.

Amerigroup will inform Health Home providers of the target measures, benchmarks and other measurement specifications for the specific year (see **Appendix C** for additional ;information on the HHQIP).

Health Homes and Amerigroup will track activities and outcomes and provide feedback utilizing various reporting tools. Health Home providers will also track core processes for ongoing improvement activities.

CHAPTER 7: QUALITY MANAGEMENT

The Health Home is responsible for establishing a continuous quality improvement program as well as collecting and reporting on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Quality Management Activities

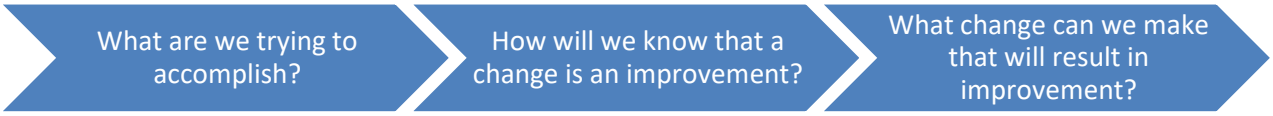
Quality management is the act of overseeing all activities and tasks needed to maintain a desired level of excellence. This includes creating and implementing quality planning, assurance, control, and improvement. The Health Home is responsible for promoting objective and systematic measurement, monitoring and evaluation of services. The Health Home also implements quality improvement (QI) activities such as:

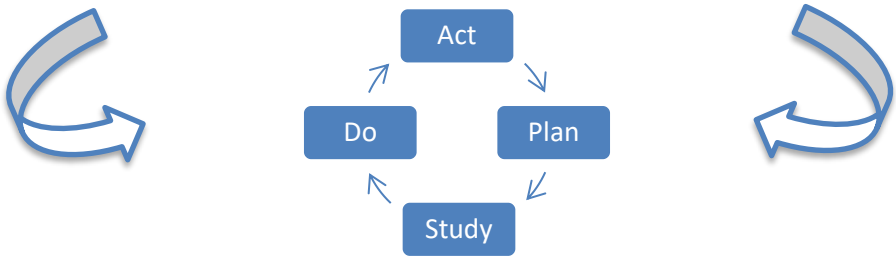
- Establishing a consistent framework for measuring and reporting Health Home outcomes at the individual Health Home performance level, the overall program level and at the member level in relation to engagement, health status changes and service utilization.
- Ongoing monitoring and evaluation of the effectiveness of Health Home services via quality measures.
- Assisting in monitoring compliance with program requirements.
- Maintaining compliance with program standards as well as local, state and federal regulatory requirements.

The quality management structure of a Health Home should also include the establishment of quality improvement teams. Staff members should be trained to utilize the Institute for Healthcare Improvement's "Model for Improvement," a framework for accelerating improvement, in their everyday work.

Health Homes should use quality improvement teams and methodology to develop processes and protocols that result in improved care outcomes in various settings and within diverse constraints. This will help to ensure Health Homes meet the "Quadruple Aim": decreased costs, improved quality outcomes, increased patient satisfaction, and increased provider satisfaction. Placing an emphasis on the importance of establishing a culture of continuous improvement within the Health Home is a foundational element of the organization's success in meeting defined quality performance measures.

Figure 7.1 Model for Improvement





Amerigroup Review Process

As part of the Health Home quality improvement process, Amerigroup, in conjunction with Iowa Medicaid and other Managed Care Organization(s) completes an annual review of each Health Home including policy and procedures and member charts. Results of this review process are shared with each Health Home with an opportunity for further discussion and guidance on modification to existing procedures. For a current copy of the Amerigroup Chart Review Workbook and process, Health Homes may email IA-HealthHome@amerigroup.com.

CHAPTER 8: HEALTH HOME EDUCATION AND SUPPORT

Practice Transformation

Transformation assistance is hands-on guidance for providers in making meaningful changes to improve outcomes. Amerigroup practice transformation consultants collaborate closely with providers to make improvements in areas such as timely patient access, quality of chronic and preventive care, effective use of electronic medical records, patient-centeredness, cultural competence, and team-based service delivery. Consultants assist providers with addressing the physical health, mental health, substance use and social service needs of members in a coordinated, integrated manner. Additionally, consultants help clinicians and staff members develop the capacity for sustained change and improvement.

Learning Collaborative

The Health Home teams are encouraged to participate in a learning collaborative series that may include webinars, listening to educational recordings, and completing virtual training sessions designed to assist in practice transformation and maintenance. Attendance will be tracked and assessed to monitor ongoing participation and performance of Health Home activities. A transformation education series will help support provider success in improving quality of care, reducing costs and managing high-risk members.

Learning collaborative events may involve a variety of virtual learning opportunities, including monthly webinars, local virtual office hours that provide extended access for care teams who have questions and community-based forums for sharing best practices. Examples of learning collaborative topics include how to reduce unnecessary hospital readmissions and emergency room visits and how to increase access to care. This includes care coordination for complex conditions like diabetes, chronic obstructive pulmonary disease (COPD), asthma, coronary artery disease (CAD), hypertension (HTN), congestive heart failure (CHF) and behavioral health conditions, including serious mental illness (SMI), severe emotional disorder (SED) and substance use disorder (SUD). In building the Health Home network, new community-based organizations are recruited through directed outreach efforts.

Additional activities dedicated to enhancing the network of Health Homes include the following:

- Practice consultants and liaisons
- Regional provider meetings that offer clinical and administrative information on program components, vision, goals and objectives
- Distribution of a Health Homes manual
- Webinars and conference calls that address program implementation issues
- Support for multipayer learning collaborations
- Encouraging and notifying IHH providers of opportunities to evolve their clinical model
    - The National Council for Behavioral Health calls for organizations to participate in a national learning collaboration for behavioral health organizations to build integrated care capacity. This opportunity addresses topics such as:
        - Developing high-functioning primary care teams.
        - Integrating behavioral health in the primary care setting.
        - Integrating chronic care/disease self-management in behavioral health settings.
        - Integrating population health management in behavioral health settings.
        - Identifying who is responsible for care coordination.
- Encouraging and notifying (CCHH) providers of opportunities to evolve their clinical model
    - The Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC), in partnership with the Institute for Health Care Improvement, developed technical assistance that has three main components:

- A learning model
- A chronic care model
- An improvement model

Transformation consultants are also available to assist Heath Homes with practice transformation. They can:

- Help prepare the organizational infrastructure for quality improvement implementation by providing direction on teambuilding, improving communication, facilitating meetings and developing leadership skills.
- Communicate the vision for change by presenting best-practice approaches and share what other organizations have done to transform their work.
- Help providers understand how to transform their practice by observing and delineating practice operations, assessing needs, gathering baseline data and guiding discussions of the current practice and opportunities for change.
- Assist IHHs in developing processes and procedures to address member's physical health conditions, including screening, coordination and documentation.
- Assist CCHHs in developing processes and procedures to address member's behavioral health conditions including screening, coordination and documentation.
- Help practitioners with the change process by encouraging goal development, providing options of possible strategies or innovations, and helping to create a plan.
- Enable practitioners to execute changes by providing tools, guiding them through rapid-cycle tests of change and assisting when obstacles arise.
- Aid practices in customizing processes to fit their own situation and incorporating the changes into their day-to-day routines, so as to increase the likelihood the changes will be sustained.
- Provide direct technical assistance with health information technology (HIT) implementation and development of registries and reminder systems.
- Help practitioners collect and use measurement data, assess the effectiveness of changes, and occasionally undertake activities such as plan, do, study and act (PDSA) projects as a means to facilitate rapid-cycle improvements.

Motivational consulting drives the effort that group members collectively put into a task, specifically by enhancing group members' conviction and confidence through encouraging, nudging, reassuring and providing program expertise. Motivation, education and consultation are at the core of coaching and transformation.

Consultative coaching fosters use of performance strategies that are well-aligned with and appropriate to the task. Consultative coaching may include rapid response to needs and requests, interactive problem solving, and suggestions for change concepts or resources.

Most coaching activities involve a mix of these functions, but the emphasis placed on any one function changes over the course of the process. A motivational focus, for example, may be needed before education or consultation can be effective. Amerigroup offers Practice Transformation consultation to all Health Home providers on a biannual basis. To request Practice Transformation assistance at any time, email IA-HealthHome@amerigroup.com.

Training and Technical Support

Amerigroup offers several tools and methods to track, monitor, and intervene with Health Home members. The Amerigroup Health Home team contacts Health Homes on a biannual basis to determine training needs

for ongoing use of these tools. To request technical support at any time, email IA-HealthHome@amerigroup.com.

Monitoring

Availity Essentials offers several monitoring tools including Patient 360 and Provider Online Reporting. Patient 360 is a real-time member dashboard that provides a robust picture of a member's health and treatment history. Patient 360 includes specific member details including: demographic information, care summaries, Health Home status, claims details, authorization details, pharmacy information, primary care physician and other provider information, and care management activities. Provider Online Reporting houses several reports available to Health Homes (see Reports for more information and guidance on best practice).

Amerigroup clinical guidelines and best practice recommendations can be accessed on the Amerigroup provider website at **https://provider.amerigroup.com/ia** under the heading "Provider Policies, Guidelines and Manuals." For guidance or training on clinical practice guidelines, see "Practice Transformation."

Amerigroup Resources for Members

Amerigroup offers extra benefits, a website, and a portal specifically for members. Members can access their Amerigroup handbook and additional information about these resources at **www.myamerigroup.com/ia**.

Extra benefits include an exercise kit, comfort item, dental hygiene kit, and many others as outlined in the Amerigroup member handbook on the member website. Amerigroup also has the Healthy Rewards program in which members can earn dollars for completing predetermined healthy activities including preventative care visits. To learn more, members can find information in the Amerigroup member handbook or they can log in to the member portal at **www.myamerigroup.com/ia**.

The Amerigroup member website also has a Common Ground Library that includes information about recovery, Health A to Z, wellness resources, manage your condition, and a local resources search option that is monitored and updated continuously by The Community Resources Link group. The member website also includes a provider search and information on getting care 24/7 including the 24-hour Amerigroup Nurse Helpline and LiveHealth Online.*

The Amerigroup member portal, also found on the Amerigroup member website, allows members to complete the Health Risk Assessment electronically, print off their Amerigroup ID card, manage their prescriptions, change their primary care physician, and access extra benefits.

For questions about the member website, portal, or additional resources, Health Home providers may email IA-HealthHome@amerigroup.com.

Health Home Guidance and Updates

Amerigroup offers one to two times per month Health Home Open Office Hours to provide timely information on updates, changes, training and for discussions, questions and answers. To request an invite, Health Home staff may email IA-HealthHome@amerigroup.com.

The Amerigroup provider website at **https://provider.amerigroup.com/ia** houses the Amerigroup Provider manual, Screenings, provider newsletters, HEDIS Guidelines and coding booklet, Amerigroup training programs, tutorials, and much more. For additional assistance with resources on the Amerigroup provider website, Health Home providers may email IA-HealthHome@amerigroup.com.

New Health Homes receive onboarding training including a review of the State Plan Amendment and this supplemental provider manual. Providers who are interested in becoming a Health Home should first contact Iowa Medicaid Provider Services. Existing Health Homes may request a refresher training by emailing IA-HealthHome@amerigroup.com.

CHAPTER 9: PAYMENT

Health Homes are compensated on a per-member-per-month (PMPM) basis **for enrolled members** with active Medicaid benefits. Health Homes are required to complete the enrollment process for members (see the **Membership** chapter). Providers who are contracted as Health Homes will be configured to bill for Health Homes services using the specified billing codes and modifiers.

This reimbursement model is designed to only fund Health Home services not covered by any of the currently available Medicaid funding mechanisms. These Health Home payments:

- Are contingent upon the Health Home provider delivering the minimum service requirement, described as care management monitoring for treatment gaps defined as Health Home Services in the State Plan Amendment. The Health Home must document Health Home Services that were provided for the member.
- May or may not require face-to-face interaction with the member.
- Are in addition to the existing fee-for-service, capitated or managed care plan payments for direct services.

For additional billing information, see **Appendix D**.

Claims

Providers can check claim status at **https://www.availity.com**. Health Homes claim requirements include:

- Member identification — the member and member identification number
- Provider information — the provider who is administering the Health Home service
    - If there is a registration for monthly PMPM payment, a member of the Health Home service team/organization is included.
- Date of service — the actual date of service for one of the core Health Home services provided
    - For registration, use the first business day of the month to indicate member enrollment in the Health Home for the month.
- Procedure code — CCHHs use SO280 and IHHs use code 99490
    - Both should also include the modifier related to the tiers.
- Informational code(s) --- CCHHs and IHHs use the following information codes to indicate the Health Home service(s) provided to the member that month:
    - G0506 – Comprehensive Care Management
    - G9008 – Care Coordination
    - 99439 – Health Promotion
    - 99426 – Comprehensive Transitional Care
    - H0038 – Individual and Family support Services
    - S0281 – Referral to Community and Social Support Services
- Diagnosis — the member's diagnosis
- Amount — the charge for Health Home service tier
- Place of service — out-patient service

Providers can submit corrected claims with additional information as needed.

For additional information about claims reconsiderations, submissions and guidelines, please see *Amerigroup Provider Manual* (**https://provider.amerigroup.com/ia** > Provider Policies, Guidelines and Manuals).

In addition to the PMPM payment structure, Health Home providers are eligible to earn incentive payments when meeting quality outcome measures. See **Appendix C** for additional information.

CHAPTER 10: HCBS — HABILITATION AND CMH WAIVER REQUIREMENTS

Overview

The 1915(i) Habilitation and 1915(c) Children's Mental Health (CMH) Waiver programs provide care coordination and services that meet member's individual needs while supporting resiliency and recovery. Effective case management and care coordination recognizes that:

- An effective program embraces principles that reflect hope, voice and choice, and empowers relationships with the expectation that resilience and recovery lead to meaningful participation and an active role in society.
- Effective coordination of CMH services is child- and family-focused. Children with a serious emotional disturbance (SED) and their families need intensively coordinated in-home and wraparound services to support successes at home and in school and the community.
- Adults with serious mental illness who have a history of homelessness, unemployment, and poor social functioning benefit from intensively coordinated, community-based service options to reside successfully in home- and community-based settings.
- Ongoing mental health treatment provider education and training in evidence-based practices and developments are essential elements of a high-quality program.
- Stigma and discrimination take many forms, including children being bullied by other children and youth. Working with schools and community groups is an important aspect of waiver programs and services.
- Evolving and emerging technologies, such as telehealth and web-based communications, are used to increase access to services and help maintain members in their homes and communities.
- Systematic tracking of progress and outcomes informs shared decision-making and is an important aspect in the implementation of evidence-based treatment programs and services.

Case management and coordination activities for Habilitation and CMH Waiver services include:

- Assessment of needs-based eligibility.
- Person-centered service planning.
- Routine monitoring of services.

For additional information on Home-and Community-Based Services, see the Federal Code of Regulations, Iowa Administrative Code, the *Iowa HHS HCBS Provider Manual* and the *Iowa HHS Habilitation Provider Manual*.

CMH Waiver Slot Releases — Amerigroup Process

Amerigroup receives notification from Iowa Medicaid (IM) when members have slot releases for the CMH Waiver. Once Amerigroup notifies an IHH of a slot release for a member, the IHH should make every effort to ensure the member and family has an opportunity to consider the CMH Waiver.

If the IHH is unable to reach the member or family, the IHH should make at least two call attempts and one mailed letter that includes a deadline to contact the IHH. If these attempts do not result in member contact, the IHH must make contact with the Iowa HHS Income Maintenance Worker (IMW) for possible updated or new contact information. If new contact information is available, an additional two phone calls and a mailed letter must be completed. If the member or family indicates that they do not want a particular waiver or slot award, the IHH should consider having the member sign a statement to be emailed to the IMW to close the slot.

Once the family returns the acceptance letter to Iowa HHS, accepting the slot on the CMH Waiver, the IHH has 45 calendar days to complete and submit the interRAI, comprehensive assessment and social history, and diagnosis as established by a mental health practitioner to Amerigroup. See **Appendix E** for CMH Waiver process workflow.

Habilitation Program Referrals

Once a member has been referred for the Habilitation program, required paperwork for IHH and Habilitation program eligibility should be completed and appropriate paperwork submitted to Amerigroup for review within 30 calendar days of the referral. There may be exceptions to this 30-day timeframe including member scheduling conflicts.

Assessment

Iowa HHS has **designated an assessment** that, in combination with the member's comprehensive assessment and social history, will be used to determine the level of care, functional eligibility and supports needed for the member. The assessment will also be used to identify the member's needs and goals for specific services and will include an assessment of the individual's ability to have his or her needs met safely and effectively in the community.

For Children's Mental Health Waiver, initial interRAI manuals are supplied by Amerigroup for Amerigroup members. Annual license to print interRAI assessment forms will be sent out by email to IHH providers. The IHH is responsible for implementing a quality assurance system to ensure the accuracy of assessments. For more information, see page 2 of the *interRAI Assessment Form and User's Manual.* To purchase additional manuals, please visit **www.interrai.com**.

Assessments should also be signed and dated by the member (or member's guardian if applicable) to indicate the member was part of the assessment process.

IHHs should document who the member chose to have present during the assessment meeting. For renewal assessments, members should be contacted to schedule a renewal assessment no less than 14 days prior to the current assessment end date. IHHs should document that the member and chosen team members were sent a copy of the completed assessment within three (3) business days of the assessment.

Requesting Eligibility and Services

For initial eligibility requests, the IHH will submit the *interRAI* (if applicable) and comprehensive assessment and social history to Amerigroup, and Amerigroup will submit materials to the Iowa Medicaid for eligibility and level of care determination.

Amerigroup is responsible for issuing concurrent/continued stay notice of decisions (NOD). If it appears the member no longer meets criteria for CMH Waiver or the Habilitation program, Amerigroup will send the review to IME for final determination. See **Appendix E** for specifics regarding the Amerigroup CMH Waiver and Habilitation workflow.

IHHs will ensure service plan development for members enrolled in the Habilitation program or CMH Waiver, following the person-centered planning process and home-and community-based service requirements as outlined in the, **Habilitation Services 1915(i) HCBS State Plan**, 1915(c) Children's Mental Health Waiver State Plan, Federal Code of Regulations, **Iowa Administrative Code**, Iowa **Department of Health and Human Services Provider Manuals**, the Amerigroup Provider Manual, and contracts. Person-

centered service plans should be completed in a timely manner following the assessment. Amerigroup has required templates for Habilitation and CMH Waiver planning including a comprehensive assessment, person-centered service plan, additional required documentation, and a policy and procedure. To request a copy of these templates, IHHs may email IA-HealthHome@amerigroup.com.

Once the level of care or program eligibility is confirmed, the IHH submits the service plan and service request via fax or Interactive Care Reviewer through Availity Essentials (www.availity.com). Upon authorization of services, providers may access the authorization at **https://www.availity.com**. The IHH care manager is also notified of service authorizations.

When a member switches his or her MCO to Amerigroup, the IHH will ensure Amerigroup has the proper documentation and, if applicable, prior authorization(s) from the previous MCO. See the *Amerigroup Provider Manual* (**https://provider.amerigroup.com/ia** > Provider Policies, Guidelines and Manuals) for information about services approved before a member's coverage began with Amerigroup.

After the initiation of services identified in the member's service plan, the IHH should implement strategies to monitor the provision of services and confirm services have been initiated and are being provided on an ongoing basis, as authorized in the service plan. At minimum, the care coordinator should contact 1915(i) Habilitation Program and 1915(c) Children's Mental Health Waiver members within five business days of scheduled initiation of services to confirm services are being provided and that members' needs are being met. This initial contact may be conducted via phone.

IHHs must track the assessment renewal dates, service plan renewal dates, and service authorization(s) dates for members. IHHs must plan ahead to ensure there is not a disruption in care due to a preventable lapse in authorization(s). IHHs may use Availity Essentials Interactive Care Reviewer (ICR) dashboard, Availity Essentials Provider Online Reporting (POR) Service Tracking Reports available under the drop down Habilitation / CMH Waiver, or their own method to track assessment and authorization dates and information.

Eligibility Renewals

IHHs are responsible for ensuring members do not experience gaps in care wherever possible. IHHs should plan ahead with eligibility renewals and service plans. IHHs can submit concurrent/continued stay eligibility requests 4-6 weeks prior to the end date. Service plans should be submitted after eligibility is approved.

Ineligibility

During the assessment and social history review process, if the IHH care coordinator determines the member may not meet criteria for Habilitation or CMH Waiver eligibility, the care coordinator will advise the member and/or family. The care coordinator will also inform the member and/or family of the member's right to pursue eligibility regardless of this determination. The member and/or family may elect to terminate the assessment at that time or at any time during the assessment. If they make the decision to terminate the assessment, the care coordinator will document the decision in the member's record and obtain the member's or representative's signature.

Wait List for CMH Waiver

Iowa Medicaid (IM) manages a wait list for the CMH Waiver. During the time the family is applying for the CMH Waiver, the IHH care coordinator will advise the member, family member or representative of other support services and ensure the member is receiving additional non-Waiver services and supports, including

state plan behavioral health services and community-based supports. If a member is in a facility and qualifies for a reserved capacity slot, the IHH will work with Iowa HHS to determine when the member may access CMH Waiver services and inform the member, family or representative, if applicable, of the timeline and process for enrollment into the CMH Waiver.

Refusal to Sign

In the event the member, family member or representative declines to sign the service plan, the team lead will discuss alternative supports, services or service settings that can meet the member's needs and assure the member's well-being. In addition, if agreeable to the member, the service plan will be revised. If the member is unwilling to accept the alternatives offered, the team will develop a risk mitigation plan with the member. The risk mitigation plan identifies the services and supports that will be available, documents a plan to mitigate any identified risks that could arise, and captures the refusal to sign in the care coordination and management system.

Disenrollment

Reasons for Habilitation program or CMH Waiver disenrollment may include: the member is hospitalized or in PMIC placement beyond 30 days, the member fails to receive the minimum billable unit of service (CMH Waiver), the member is care coordinating on his/her own, or the member appears to have a change in functional or medical status that could make him or her ineligible. Additional reasons for CMH Waiver or Habilitation disenrollment can be found in Iowa Administrative Code 441-78 and 441-83.

Iowa HHS will have sole authority for determining if the member will continue to be eligible under the 1915(i) Habilitation program and 1915(c) CMH Waiver.

IHHs should notify Amerigroup when a member is disenrolled from Habilitation or the CMH Waiver. See the **Tier Changes** section for more information.

Monitoring Receipt of Services

IHHs should follow Iowa Administrative Code 441-90.5(1)(d)(1) to (5) for monitoring activities. Additionally, the IHH care coordinator will routinely review Patient 360 for Habilitation or CMH Waiver claims. During the monthly contact with the member or at any time the IHH care coordinator or Amerigroup identifies a service gap, the IHH care coordinator will review, identify the cause and determine if intervention is needed for the gap. For example, if a member misses scheduled days of service due to illness that would have otherwise been provided, these missed services might not constitute a service gap that requires intervention. Reasons that service gaps may require specific intervention include:

- The provider failed to show up as scheduled, and the member did not notify the IHH care coordinator.
- The member or family declined authorized services.
- The provider is no longer available, and the member has not selected a new provider.
- The provider is unable to meet the member's needs because of a change in the member's needs, and the IHH care manager was not notified of the change in needs.
- The authorized services are not meeting the member's needs, addressing the members individually identified goals or helping the member achieve desired outcomes.

The Health Home will gather information from the member/family and provider to determine reasons for the service gap and develop solutions, including ways to avoid the situation in the future. Interventions may include:

- Completing a member reassessment to confirm the member's needs, individually identified goals and desired outcome and to identify any changes.
- Revising the member's service plan to address changes in a member's needs, individually identified goals and desired outcomes.
- Working with the provider to initiate a plan to provide services appropriately if the provider failed to deliver services as outlined in the service plan.
- Offering the member/family the choice of a different provider.
- Updating the member's risk assessment and agreement to prevent a recurrence of the service gap.

Incident Reporting

Integrated Health Home (IHH) providers, HCBS providers and other designated intensive/targeted case management (ICM/TCM) providers are required to report critical incidents as outlined in Iowa Administrative Code.

Providers can complete the critical incident form on **www.availity.com** for Amerigroup members. If a member is enrolled in a Health Home, HCBS providers completing the critical incident form should also notify the member's Health Home care coordinator of the incident. For reporting purposes, the provider with first-hand knowledge of the incident should submit the critical incident form to Amerigroup. For additional information on critical incident reporting with Amerigroup, refer to the *Amerigroup Provider Manual*, located at **https://provider.amerigroup.com/ia** > Resources > Provider Policies, Guidelines and Manuals.

National Committee for Quality Assurance- Delegation

The Amerigroup Long-term Services and Support Program adheres to NCQAs LTSS Distinction Standards. As part of this process, Amerigroup delegates case management for the Habilitation program (non-Waiver) and Children's Mental Health Waiver to IHHs. Amerigroup provides technical assistance and training to IHHs on the NCQA LTSS Distinction Standards and reviews these standards for compliance as part of the Health Home review process (see Quality Improvement for more information).

APPENDIX A: TOOLS AND RESOURCES

The Amerigroup provider website (**https://provider.amerigroup.com/ia**) contains:

- Provider resources such as manuals, trainings, forms and documents.
    - Health Home Notification Form
    - Health Home Contact Information
    - Health Home Brochure
- Availity Essentials, which can be accessed at **https://www.availity.com**, to:
    - File and check the status of medical claims.
    - Verify eligibility.
    - Request precertification.
    - Access member reports.
    - View Patient360.

For additional details on documentation, refer to the Amerigroup Provider Manual at **https://provider.amerigroup.com/ia** > Provider Policies, Guidelines and Manuals.

Informational Links

Iowa Administrative Rules
www.dhs.iowa.gov/administrative-rules

Iowa Administrative Code 441-78.27(249A): Home- and Community-Based Habilitation Services
Iowa Administrative Code 441-83: Medicaid Waiver Services
Iowa Administrative Code 441-90: Case Management Services (Habilitation and CMH Waiver)
https://www.legis.iowa.gov/law/administrativeRules

Iowa Department of Human Services Habilitation Services Provider Manual
https://dhs.iowa.gov/policy-manuals/medicaid-provider

Habilitation Services website
www.dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/habilitation

Iowa HHS Medicaid Provider Manual
www.dhs.iowa.gov/policy-manuals/medicaid-provider

Iowa Department of Human Services informational letters:
www.dhs.iowa.gov/ime/providers/rulesandpolicies/bulletins

Patient Tier Assessment Tool (*PTAT*)
www.dhs.iowa.gov/ime/providers/enrollment/healthhome

Iowa HHS Integrated Health Home Provider Manual
https://dhs.iowa.gov/sites/default/files/IHH.pdf

APPENDIX B: HEALTH INFORMATION PORTAL

Health Homes use the Health Information Portal (HIP) (**https://www.availity.com** > Payer Spaces Amerigroup > Resources > Iowa Health Information Portal) to enter necessary patient information for quality patient monitoring as well as the information required by CMS and Iowa HHS, as outlined in the State Plan Amendment. The HIP should be completed within 90 days of enrollment for new members and then yearly for enrolled Health Home members. The following table displays questions in the HIP:

Health Information Portal (HIP) Questions	Information Needed (1)	Information Needed (2)
Does member have an advanced directive?	Yes/No	N/A
Last PCP visit	Provider	Date
Height (inches)	Numeric	N/A
Weight (pounds)	Numeric	Date
Blood pressure(systolic/diastolic)	Numeric	Date
Diabetes: A1c	Numeric	Date
LDL	Numeric	Date
BMI	Numeric	Date
Mammogram	Provider	Date
Pap smear/HPV testing	Provider	Date
Dental	Provider	Date
Vision	Provider	Date
Flu Vaccine	Provider	Date
Depression screening	Referred (Y/N)	Date
Depression follow-up	Provider	Date
Substance abuse screening	Referred (Y/N)	Date
Substance abuse follow-up	Provider	Date
Psychiatrist	Provider	N/A
Counselor	Provider	N/A
Peer	Name	N/A
Other	Name	N/A
CCHHs: • ***PTAT* date** • ***PTAT* tier** • ***PTAT* diagnosis (10 fill-in blanks provided)**	Numeric; open-ended	N/A
IHHs: • ***IHH care plan date*** • ***IHH diagnosis (3 fill-in blanks provided)*** • ***IHH functional impairments as defined by the SPA (Yes / No)*** • ***Annual Assessment Completed by Mental Health Practitioner date*** • ***Comprehensive Assessment* date**	Date	N/A
Habilitation NOD start date/end date	Date	Date

Health Information Portal (HIP) Questions	Information Needed (1)	Information Needed (2)
CMH Waiver NOD start date/end date	Date	Date
Living situation of the member (several options)	• Living with four or more unrelated people in a community-based setting • Living independently or with a spouse (adult only) • Living with family members • Living in residential care facility • Living in a shelter setting • Homeless	N/A
Community tenure (in months)	Numeric	N/A
Tobacco use (several options)	• Occasional cigarette smoker • Light cigarette smoker (1-9/day) • Moderate cigarette smoker (10-19/day) • Heavy cigarette smoker (20-39/day) • Very heavy cigarette smoker (40+/day) • Chews products containing tobacco • Pipe smoker • Nonsmoker • Previous smoker	N/A
Member accesses the community and has ongoing involvement in activities	Yes/No	N/A
Member reports he or she feels like a part of the community	Yes/No	N/A
Member reports he or she feels safe where he or she lives	Yes/No	N/A
Member reports he or she receives services when needed	Yes/No	N/A
Member reports he or she is treated with dignity and respect	Yes/No	N/A
Member reports needs are being met	Yes/No	N/A
Member reports assigned case manager provides assistance when needed	Yes/No	N/A
Member reports he or she is satisfied with their relationships	Yes/No	N/A
Member reports he or she participated in treatment planning	Yes/No	N/A
Member is competitively employed	Yes/No	N/A
Member reports he or she is involved in meaningful day activities	Yes/No	N/A
Child is attending school regularly – no identified truancy issues (children only)	Yes/No/N/A	N/A

APPENDIX C: HEALTH HOME QUALITY MEASURES

Health Homes are evaluated by the Center for Medicare and Medicaid Services (CMS) on the Health Home Core Set of Measures and by quality incentive measures selected by Amerigroup and approved by the Department of Health Human Services (Iowa HHS).

Health Home Core Set of Measures

The Core Set of Health Care Quality Measures and Utilization Measures provided by CMS for Health Homes can be accessed at this **link**: **https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting/index.html**.

Health Home Quality Incentive Program

The Health Home Quality Incentive Program (HHQIP) includes measures approved by Iowa HHS and outlined in contractual collaterals. Health Homes are eligible to earn incentive points and dollars based on performance on the approved measures. Health Homes receive quarterly report cards to monitor progress and have access to Practice Transformation coaching to assist in improving on these measures. To access Practice Transformation coaching or additional information on the HHQIP program including program description, Health Homes can email a request to IA-HealthHomes@amerigroup.com.

APPENDIX D: BILLING GUIDE

1. The Health Home (HH) submits the **HH Managed Care Organizations (MCOs) Notification Form** within 30 days of enrollment. If the enrollment is approved, payment becomes effective the first day of the month the HH begins working with the member.
    a. MCO/Iowa Medicaid Fee-For-Service (FFS) transfer enrollment forms are honored up to 90 days and begin the month the member became active with Amerigroup.
    b. For HH-to-HH transfers, the enrollment becomes effective the first day of the month after disenrollment from the prior HH.

2. The HH billing is allowed if the member remains eligible for the HH program, is enrolled in an HH and has received HH services per contract expectations.
Monthly billing procedural codes (required):

Chronic Condition Health Home (CCHH) Billing Codes A CCHH service must be provided monthly.			
Tier 1	1-3 chronic health conditions	Code S0280	Modifier U1
Tier 2	4-6 chronic health conditions	Code S0280	Modifier TF
Tier 3	7-9 chronic health conditions	Code S0280	Modifier U2
Tier 4	10+ chronic health conditions	Code S0280	Modifier TG

Integrated Health Home (IHH) Billing Codes An IHH service must be provided monthly.			
Tier 5	Adult IHH	Code 99490	Modifier TF
Tier 6	Child (< 18 years old) IHH	Code 99490	Modifier TG

Habilitation and Children's Mental Health (CMH) Waiver— IHH members Active *Notice of Decision (NOD)* authorization required.			
Tier 7	Habilitation / intensive case management (ICM)	Code 99490	Modifier U1
Tier 8	CMH Waiver (ICM)	Code 99490	Modifier U2

Monthly billing informational codes (required):

CCHH and IHH Informational Service Codes	
Comprehensive Care Management	Code G0506
Care Coordination	Code G9008
Health Promotion	Code 99439
Comprehensive Transitional Care	Code 99426
Individual and Family Support Services	Code H0038
Referral to Community and Social Support Services	Code S0281

3. The IHH is eligible to be reimbursed according to the member's tier for any month in which any of the six core services has been provided. Adults and children are grouped into four tiers: Tier 5 is an adult that qualifies for an IHH but without approved HCBS Habilitation Services, Tier 6 is a child that qualifies for an IHH but without approved HCBS Children's Mental Health Waiver (CMHW), Tier 7 is a member with approved HCBS Habilitation Services, Tier 8 is a child approved for the HCBS CMHW.
    a. CMH Waiver and Habilitation members requires meeting minimum requirements outlined in Iowa Administrative Code 441--90 as related to frequency and type of contact.

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i. Contact with the ICM member shall occur at least monthly either in person or by telephone.
ii. A face-to-face ICM contact in the member's residence must be provided quarterly at minimum.
iii. The secondary modifier U3 needs to be billed to document ICM face-to-face contact was provided that month.

4. Health Homes should submit claims using the credentialed NPI location and date of service as the first of the month. It is recommended that claims are submitted the following month to avoid eligibility concerns.

5. Procedural and informational codes may only be billed by the NPI of the facility where the member is enrolled during the month.

6. Claims should include ICD-10 codes that qualify the member for the identified HH tier.

7. Disenrollments become effective the last day of the month. HH may bill in that month of disenrollment if the member received HH services per contract expectations.

8. Member enrollment is based upon the HH effective dates within the Amerigroup system — not by the months the HH submits a bill.

9. Timely submission of claims, claim denials and rejections will follow the normal claim process per the Amerigroup provider manual.

Examples:

1. CCHH has a member approved for enrollment effective April 16, 2020, for tier 2. The CCHH will submit a claim with the following parameters:
    a. Use procedural code S0280UF with four or more chronic condition ICD-10 codes.
    b. Include informational code(s) to indicate what service was done during the month.
    c. The first available billing month is April.

2. IHH has a member approved for enrollment effective April 16, 2020, and the member's age is 18. The IHH will submit a claims with the following parameters:
    a. Use procedural code 99490TF.
    b. Include informational code(s) to indicate which IHH service(s) was done during the month.
    c. The first available billing month is April.

3. IHH has a member approved for enrollment effective April 16, 2020, the Habilitation *NOD* is effective April 16, 2020. The member is over 18 years old. The IHH will submit a claim with the following parameters:
    a. Use procedural code 99490 with modifier U1.
    b. Include informational code(s) to indicate which IHH service(s) was done during the month.
    c. Include modifier U3 if an IHH face-to-face contact was done during the month.
    d. The first available billing month is April.

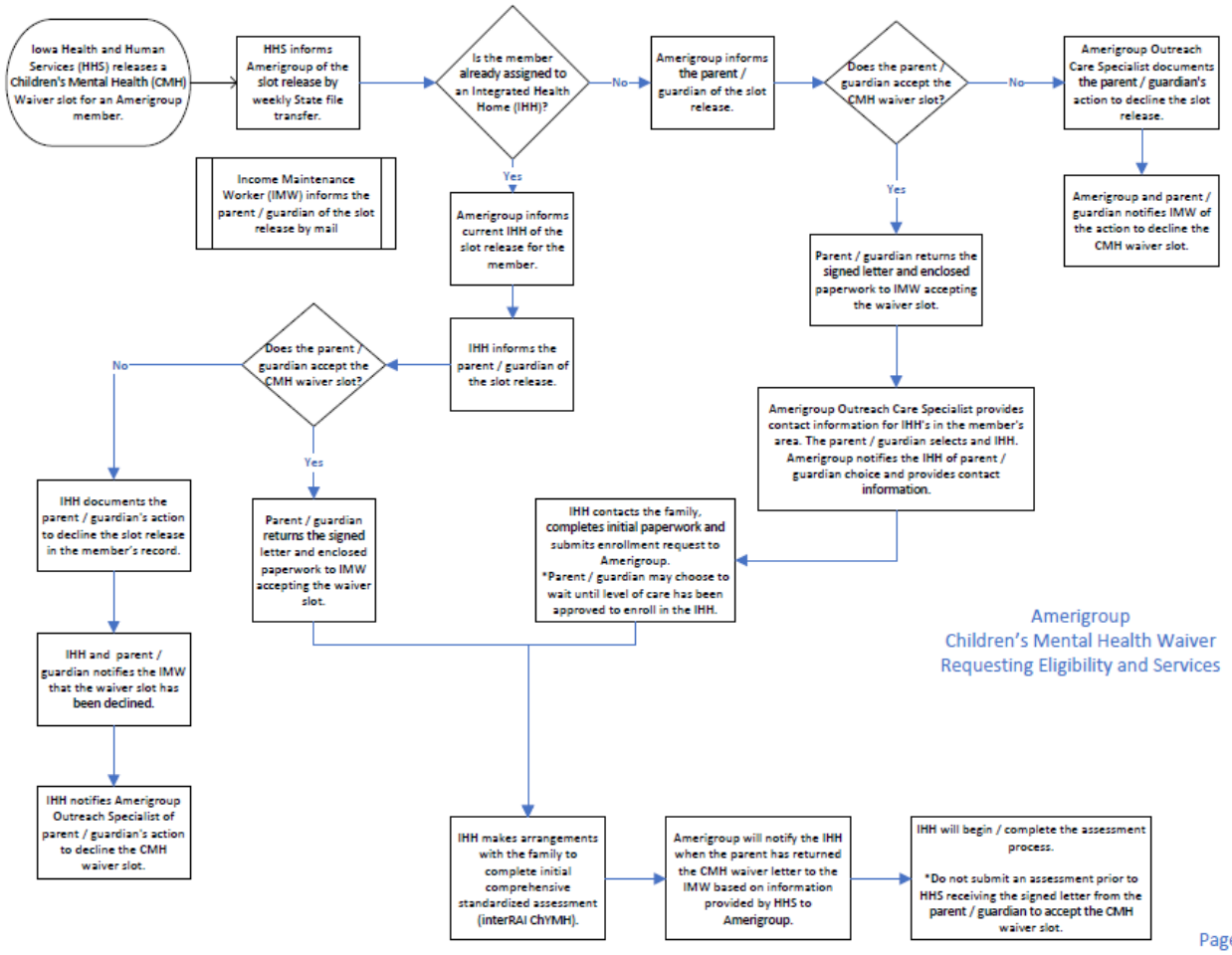
4. A member transfers on June 16, 2020, from HH A to HH B:
    a. HH A can submit a claim for June 2020 if a HH service was done during the month.

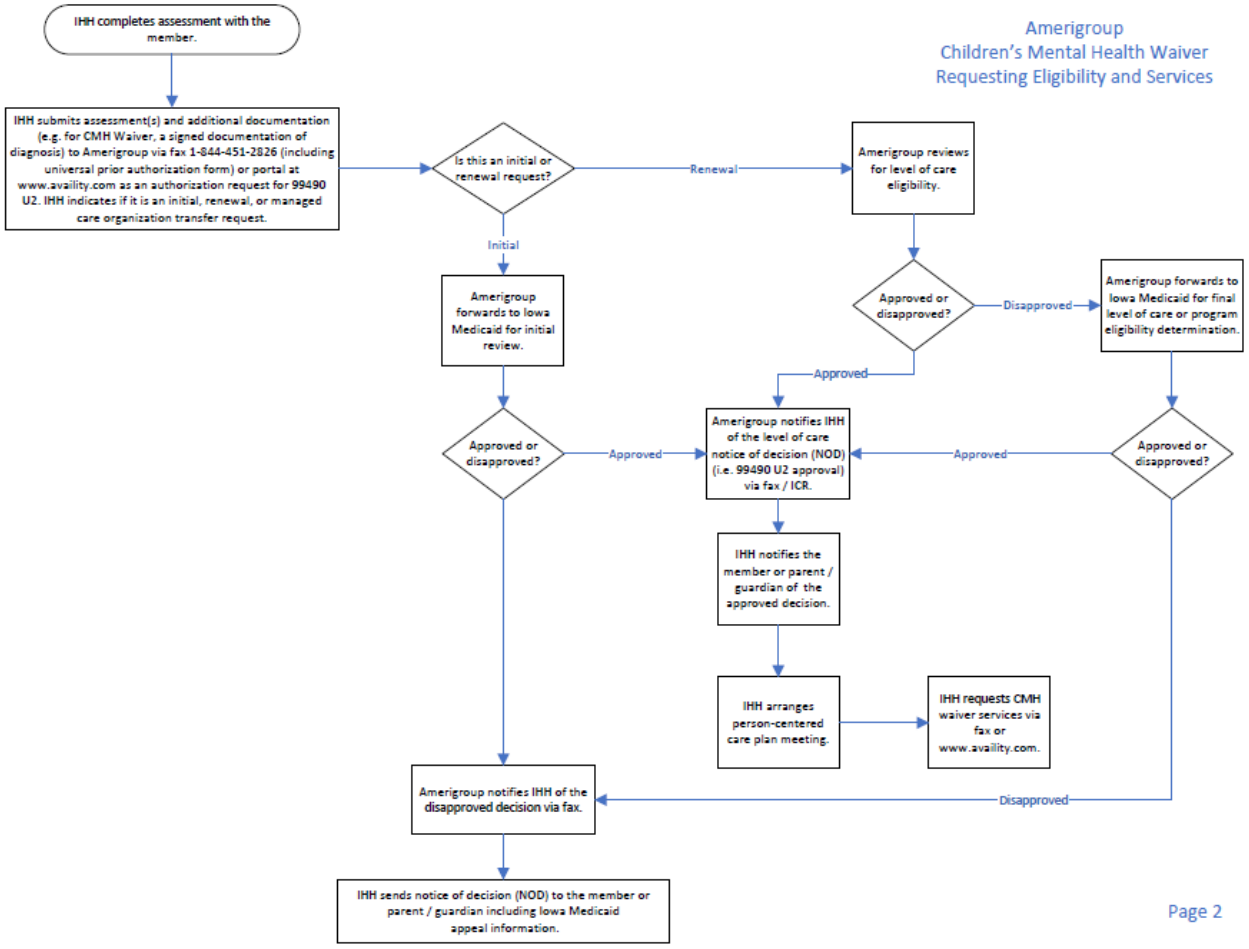
b. HH B can submit a claim for July 2020 if a HH service was done during the month.

5. CCHH/IHH has disenrollment processed by Amerigroup on June 12, 2020. Disenrollment effective date will be June 30, 2020:
    a. The HH will submit a claim with the appropriate procedural and informational codes for June 2020 if a HH service was done during the month.

Note: This guide is intended solely for informational purposes. Under no circumstances should this be construed as a guarantee of benefits or payment.

APPENDIX E: CHILDREN'S MENTAL HEALTH WAIVER AND HABILITATION WORKFLOW




Amerigroup
Children's Mental Health Waiver
Requesting Eligibility and Services
IHH completes assessment with the member.
IHH submits assessment(s) and additional documentation (e.g. for CMH Waiver, a signed documentation of diagnosis) to Amerigroup via fax 1-844-451-2826 (including universal prior authorization form) or portal at www.availity.com as an authorization request for 99490 U2. IHH indicates if it is an initial, renewal, or managed care organization transfer request.
Is this an initial or renewal request?
Renewal
Amerigroup reviews for level of care eligibility.
Initial
Amerigroup forwards to Iowa Medicaid for initial review.
Approved or disapproved?
Disapproved
Amerigroup forwards to Iowa Medicaid for final level of care or program eligibility determination.
Approved
Approved or disapproved?
Approved
Amerigroup notifies IHH of the level of care notice of decision (NOD) (i.e. 99490 U2 approval) via fax / ICR.
Approved
Approved or disapproved?
IHH notifies the member or parent / guardian of the approved decision.
IHH arranges person-centered care plan meeting.
IHH requests CMH waiver services via fax or www.availity.com.
Amerigroup notifies IHH of the disapproved decision via fax.
Disapproved
IHH sends notice of decision (NOD) to the member or parent / guardian including Iowa Medicaid appeal information.
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* LiveHealth Online is the trade name of Health Management Corporation, an independent company, providing telehealth services on behalf of Amerigroup Iowa, Inc.

* Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup Iowa, Inc.