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March 15, 2022

Nancy Freudenberg
Iowa Department of Human Services
Hoover State Office Building, Fifth Floor
1305 East Walnut Street
Des Moines, Iowa 50319-0114

RE: **ARC 6211C**: Notice, Community Mental Health Centers, amendments to ch 24; and **ARC 6202C** Notice, Integrated Health Homes; Chronic Health Homes, amendments to ch 77 to 79; published in Vol. XLIV, No. 17 Iowa Administrative Bulletin 2218-2241 on February 23, 2022

Submitted electronically via appeals@dhs.state.ia.us

Dear Ms. Freudenberg,

UnityPoint Health appreciates this opportunity to provide comments on proposed rules relating to Community Mental Health Center accreditation and Integrated Health Home services. UnityPoint Health is one of the nation's most integrated health care systems. Through more than 34,000 employees and our relationships with more than 480 physician clinics, 40 hospitals in urban and rural communities, and 14 home health agencies throughout our 9 regions, UnityPoint Health provides care throughout Iowa, central Illinois and southern Wisconsin. In Iowa, UnityPoint Health has four accredited Community Mental Health Centers located within five facilities that provide Integrated Health Home services.

UnityPoint Health appreciates the time and effort of the Human Services Department in developing these proposed rules. We respectfully offer the following input on specific areas outlined below:

ARC 6211C: PROPOSING RULE MAKING RELATED TO COMMUNITY MENTAL HEALTH CENTERS

The purpose of these proposed amendments is to establish a set of standards to be met by all designated community mental health centers (CMHCs). These amendments also define the process that the Department will use to designate at least one CMHC for addressing the mental health needs of the county or counties comprising a catchment area in accordance with Iowa Code chapter 230A, identify the target populations and core services to be served by CMHCs, and identify a formal accreditation review process for CMHCs. These proposed amendments update language in Division I to reflect current practices and add a new Division III specific to CMHCs.

Comment: UnityPoint Health urges your strong consideration of the following revisions:

- Service Plan Documentation**. For performance indicators in IAC 441-24.4(14)"b", stricken subparagraph (14)"b"(5) should be reinstated clarifying that a distinct service plan document is optional as service plan documentation**. This subparagraph stated, "A distinct service plan document

is not required." We agree the CMHCs must meet all the requirements of a treatment plan, but reinserting the stricken language enables flexibility as to where the contents are located / documented and its form (e.g. whether a distinct separate document or incorporated otherwise). This flexibility would be particularly helpful for outpatient psychotherapy and counseling services for which this is a new requirement.

- Accreditation Clarification. **For CMHC designation in IAC 441-24.51(3), applicants should not be restricted to those CMHCs with a three-year accreditation and as such subparagraph (3)"a"(2) should be stricken.** Under this subparagraph as proposed, applicants are required to submit "Evidence of active three-year accreditation for outpatient and evaluation services under this chapter." It is unclear if the Department intends to exclude CMHC designation for organizations on an initial 270-day accreditation, One-year accreditation, and Probational 180-day accreditation as found in IAC 441-24.5(5). We would encourage the department to not limit this designation to those who have a three-year accreditation as this would cause major disruption to the State's Community Mental Health Center infrastructure.

- Standards for Core Services and Supports. IAC 441-24.54(5) sets forth requirements for community support services (CSS) and requires clarifications. In particular:
  - Functional impairments determination. Paragraph (5) contains an undefined term, "functional impairments," which creates uncertainty in interpretation. The paragraph states: "Community support services (CSS). The purpose of CSS is to support individuals as they live and work in the community and address mental health symptoms and functional impairments that negatively affect integration and stability in the community." **In the rule, we would recommend that functional impairments referenced in IAC 441.24.54(5) either be defined or included within a clarifying statement to authorize trained CSS staff to make this determination** as opposed to requiring an assessment done by another provider which may limit services available to the community.
  - CSS educational requirements. Subparagraph (5)"b"(1)3 requires that qualifications for CSS staff include "a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field, including but not limited to psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy." This educational requirement was not present for Supportive Community Living Providers, and it is unclear why CSS providers would have this heightened educational requirement. **We request that this new subparagraph, IAC 441-24.54(5)"b"(1)3, setting forth heightened educational attainment for CSS staff be stricken from the rules.** In an environment plagued by workforce shortages, we question the Department's need to artificially increase minimum requirements for staff, which will undoubtedly exacerbate the current workforce shortages and further limit services available to the community.
  - Admission screening requirements. IAC 441-24.54(4) requires "admission screening for voluntary patients to a state mental health institute." This includes both screening and evaluation to individuals requesting admission as well as the adoption of policies and procedures that define

this process and include referrals to other services pending placement if not immediately available. **While we agree these admission screening activities in IAC 441.24.54(4) are prudent, we urge the Department to develop accompanying payment mechanisms for the provision of such services under the Iowa Medicaid Fee Schedule**. Without reimbursement, these represent unfunded mandates that would be impossible to implement and contribute to the unsustainability of CMHCs as a whole.

- Consultation services. IAC 441-24.54(6) requires that "consultation services shall be provided in accordance with Iowa Code section 230A.106(2)"f". **While we agree these consultation services activities in IAC 441-24.54(6) are prudent, we urge the Department to develop accompanying payment mechanisms for the provision of such services under the Iowa Medicaid Fee Schedule**. Without reimbursement, these represent unfunded mandates that would be impossible to implement and contribute to the unsustainability of CMHCs as a whole.
- Education services. IAC 441-24.54(7) requires that "education services shall be provided in accordance with Iowa Code section 230A.106(2)"g". **While we agree these education services activities in IAC 441-24.54(7) are prudent, we urge the Department to develop accompanying payment mechanisms for the provision of such services under the Iowa Medicaid Fee Schedule**. Without reimbursement, these represent unfunded mandates that would be impossible to implement and contribute to the unsustainability of CMHCs as a whole.
- Coordination with unaffiliated agencies. IAC 441-24.54(8) requires that "coordination shall be provided in accordance with Iowa Code section 230A.106(3)." **While we agree these coordination activities IAC 441-24.54(8) in are prudent, we urge the Department to develop accompanying payment mechanisms for the provision of such services under the Iowa Medicaid Fee Schedule**. Without reimbursement, these represent unfunded mandates that would be impossible to implement and contribute to the unsustainability of CMHCs as a whole.

ARC 6206C: PROPOSED RULE MAKING RELATED TO INTEGRATED AND CHRONIC HEALTH HOMES

The Department is proposing to update rules for Integrated Health Homes and for Chronic Health Homes based on the deficiencies identified in the audit completed in 2019 by the Office of Inspector General (OIG) for the Health Home (HH) programs for the state fiscal years 2013 through 2016. The proposed amendments clarify the standards and requirements for the delivery of Health Home services. The audit recommended the Department improve its monitoring of the HH programs to ensure that HH providers comply with federal and state requirements for maintaining documentation to support the services for which the providers billed and received payments. The audit also recommended the Department revise the state plan to define the documentation requirements that HH providers must follow to bill and receive higher in-home health payments for intensive services and educate providers on these requirements. Recommendations were also made that the state plan be revised to define the documentation requirements the HH providers must follow to bill and receive payments for outreach services and also educate providers on these requirements.

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

Comment: UnityPoint Health limits our comments to the Integrated Health Home (IHH) program and these provisions:

- Whole person orientation. IAC 441-77.47(5)"a" contains eight requirements for health home programs, including IHH programs, to demonstrate the provision of whole person care. UnityPoint Health urges the Department to align these regulatory requirements more closely with those contained in the State Plan Amendment (SPA). In particular:
  - Letters of support. IAC 441-77.47(5)"a"(6) states, "The health home must initially and annually provide letters of support from at least one area hospital and two area primary care practices that agree to collaborate with the health home on care coordination and hospital and emergency department notification." The current IHH SPA references "provide letters of support from at least one area hospital and two area primary care practices that agree to collaborate with the IHH on care coordination and hospital/ER notification." The proposed regulation adds a frequency requirement – "initially and annually". While we agree with the requirement of initial support letters, obtaining letters on an annual basis would be overly burdensome to the area hospitals, primary care clinics and health homes. The federal government requires initial letters of support for federally qualified health centers (FQHCs) but does not require these to be resubmitted annually. **We request that the Department strike "and annually" from IAC 441-77.47(5)"a"(6) to conform with the SPA**. Alternatively, a less burdensome approach may be for the Department to consider permitting IHHs to attest that the collaborations in the initial letters are ongoing or to require that IHHs notify the Department should any of these collaborations terminate.

    Although the proposed rule aligns with the SPA in requiring "two" area primary care practices to agree to collaborate with the IHH, many rural communities do not have two primary care practices located in the community. In effect, requiring multiple primary care collaborations, including with providers outside a rural community, may create access barriers by embedding additional travel time. **We encourage the Department to either amend the SPA to reference a support letter from "at least one" area primary care practice or revise subparagraph (6) to contain an exception from the requirement of two area primary care practices for rural communities.**
  - Service duplication. IAC 441-77.47(5)"a"(8) states, "The health home must be responsible for preventing fragmentation or duplication of provided services to members." Fragmentation is a new term that is not included within the SPA and is undefined. It is unclear what additional responsibilities this term may entail and how surveyors will interpret. **We request that the Department strike "fragmentation and" from IAC 441-77.47(5)"a"(8) to better align with the IHH SPA**, which focuses on the prevention of service duplication to members.

- Coordinated integrated care. IAC 441-77.47(5)"b" contains ten requirements for health home programs, including IHH programs, to demonstrate the provision of coordinated integrated care. The first requirements (IAC 441-77.47(5)"b"(1)) states, "The health home must ensure that the nurse care manager is responsible for assisting members with medication adherence, appointments, referral

scheduling, tracking follow up results from referrals understanding health insurance coverage, reminders, transitions of care, wellness education, health support or lifestyle modification, and behavior changes." This requirement lists the "nurse care manager" as the sole responsible party, which is too restrictive and does not conform to the IHH SPA. As provided in the IHH SPA, the nurse care manager, care coordinator, and peer support or family support specialist all have core service care coordination roles, which includes the items listed in IAC 441-47.47(5)"b"(1). **We request that the Department revise IAC 441-47.47(5)"b"(1) to state "The health home must assist members with medication adherence…….and behavior changes".** By a more generic reference to health home as opposed to a particular position, this enables role flexibility envisioned within the SPA.

- Enhanced access. IAC 441-77.47(5)"c" provides that "The health home must provide enhanced access for members and member caregivers, including access to health home services 24 hours per day, seven days per week. The health home must use email, text messaging, patient portals and other technology to communicate with members." Our concern is with the second sentence related to use of technology for communication. As written, this omits a key concept from the SPA and requires, instead of encourages, specific modes of communication. Specifically, the current IHH SPA states "use of email, text messaging, patient portals and other technology to communicate with members *is encouraged*." **We request that the Department revise the second sentence of IAC 441-77.47(5)"c" to strike "must" and insert "is encouraged to" to conform with the intent of the IHH SPA.** This sentence would read "The health home *is encouraged to* use email, text messaging, patient portals and other technology to communicate with members." In the absence of this change, IHHs are required to use all the specified modes of technology listed in this provision which is unduly burdensome and may not reflect changes in technology.

- Emphasis on quality and safety. IAC 441-77.47(5)"d" contains twelve requirements for health home programs, including IHH programs, to demonstrate an emphasis on quality and safety in the delivery of health home services. The fifth requirement involves practice transformation meetings – "The health home must participate in or convene ad hoc or scheduled meetings with lead entities and the department to plan and discuss implementation of goals and objectives for practice transformation, with ongoing consideration of the unique practice needs for adult members with a serious emotional disturbance and child members with a serious emotional disturbance and those members' families." We agree and support this provision; however, a technical correction is needed to accurately reference a defined term. **We request that the reference to "adult members with a serious emotional disturbance" in IAC 441-77.47(5)"d" be revised to "adult members with a serious mental illness."**

- Definition of patient-centered care plan. IAC 441-78.53(1) defines "patient-centered care plan" instead of "person-centered care plan." Both the CMS Health Home guidance and the Department's IHH SPA do not use the term "patient-centered care plan". To conform with these documents, **we request that the Department revise the definition of "patient-centered care plan" in IAC 441-78.53(1) to reference "person-centered care plan".**

- Member identification and enrollment. IAC 441-78.53(4)(a) states that "Eligible members are identified through a referral from the department, lead entity, primary care provider, hospital, other providers or the member." The referral sources listed in this provision exclude family or other natural supports and unduly restricts referral for IHH services. **We request that the Department strike the proposed language from IAC 441-78.53(4)(a) in its entirety and instead insert, "Eligible members are identified through a referral. Referrals may come from the department, lead entity, primary care provider, hospital, other providers, the member, natural supports or others as applicable."** This language not only recognizes that family and/or caregivers are important sources of referrals for IHH members, but it allows referral flexibility instead of an absolute laundry list of sources that will undoubtedly in the future require revisions to reflect one-off cases.

- Health home documentation. IAC 441-78.53(5) specifies seven services that at a minimum must be documented and sets forth requirements for that documentation. UnityPoint Health seeks clarity and suggests revisions related to the documentation requirements for eligibility, comprehensive assessment, person-centered service plan and patient-centered care plan, and core services.
  - Eligibility documentation. IAC 441-78.53(5)"a" requires that minimum documentation must include the following nine items in quotations:
    - "(1) How the member presented to the health home, including the referral." In the IHH SPA, eligibility does not include how the member was referred, and generally referral methods or sources should not impact eligibility. **We recommend that the Department strike this provision (IAC 441-78.53(5)"a"(1)) in its entirety from eligibility documentation.**
    - "(2) Identified needs and plan to assess for eligibility." In the IHH SPA, eligibility does not include identified needs and plans to assess for eligibility. **We recommend that the Department strike this provision (IAC 441-78.53(5)"a"(2)) in its entirety from eligibility documentation.**
    - "(3) Documentation that the member is eligible for health home services. If a member is not eligible, the health home must document the plan to support the member." **We recommend that the Department combined this provision (IAC 441-78.53(5)"a"(3)) with IAC 441-78.53(5)"a"(4) to streamline documentation.** We would suggest that the combined provision read as follows: "Documentation of a Qualifying diagnosis/condition per 78.53(3) that makes the member eligible for health home services. If a member is not eligible, the health home must document other services/support options discussed with the member."
    - "(4) Qualifying diagnosis that makes the member eligible for health home services." **See immediately preceding bulleted comment.**
    - "(5) Member agreement and understanding of the program." **We support as proposed.**
    - "(6) Enrollment request." **We seek clarification from the Department as to whether this is an enrollment request to the managed care organization (MCO), Iowa Medicaid, or both.** An affirmative statement as to request entity within this provision (IAC 441-78.53(5)"a"(6)) would be helpful.
    - "(7) Enrollment with the health home." **We seek clarification from the Department as to**

whether this referring to approval of enrollment with the health home by the MCO, Iowa Medicaid, or both. An affirmative statement as to approval entity contained within this provision (IAC 441-78.53(5)"a"(7)) would be helpful.

- "(8) Plan to complete the comprehensive assessment." As IAC 441-78.53(5)"b" sets forth requirements for the comprehensive assessment, documentation of a plan to complete such assessment according to these requirements is burdensome with questionable added value. **We recommend that the Department strike this provision (IAC 441-78.53(5)"a"(8)) in its entirety from eligibility documentation.**
- "(9) Documentation of eligibility and member's agreement to continue participation in the program, obtained on an annual basis." As written, it is unclear what documentation will satisfy this annual requirement, and we request the Department revise this provision accordingly. First, **we recommend that the Department specify the eligibility documentation with more granularity**. To accomplish this alone, consider replacing IAC 441-78.53(5)"a"(8) with "Annual documentation of a qualifying diagnosis/condition per 78.53(3) that makes the member eligible for health home services." Second, since IHH members can opt out of the program at any time, we assume that member's agreements do not need to reference an annual commitment. That said, it is confusing to have "obtained on an annual basis" at the end of this provision. **We seek clarification/confirmation from the Department that a member's agreement to continue participation in the program is not an annual commitment**. For the member's agreement alone, we recommend that the Department revise IAC 441-78.53(5)"a"(8) to "Annual documentation of a member's agreement to continue participation."

- <u>Comprehensive assessment documentation</u>. IAC 441-78.53(5)"b" details completion timeframes and minimal content requirements. UnityPoint Health's comments relate specifically to subparagraph (3) that addresses comprehensive assessments for members enrolled in intensive care management. This provision states: "(3) The comprehensive assessment for members enrolled to receive intensive care management must be in a format designated by the department and must include:

  1. The member's relevant history, including the findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to complete the comprehensive assessment.
  2. The member's physical, cognitive, and behavioral health care and support needs; strengths and preferences; available service and housing options; and if unpaid caregivers will be relied upon to implement any elements of the person-centered service plan, a caregiver assessment.
  3. Documentation that no state plan HCBS is provided that would otherwise be available to the member through other Medicaid services or other federally funded programs.
  4. For members receiving state plan HCBS and HCBS approved under 441—Chapter 83, documentation that HCBS provided through the state plan and waiver are not duplicative."

  While we support the documentation requirements overall, we disagree with the Department's characterization of (3)3 and (3)4 above as assessment documentation and believe they are more

appropriately characterized as plan documentation. Based on this, **we recommend that the Department consider moving both IAC 441-78.53(5)"b"(3)3 and IAC 441-78.53(5)"b"(3)4 under documentation for person-centered service plan and patient-centered care plan in IAC 441-78.53(5)"c".** More specifically, we would suggest that IAC 441-78.53(5)"b"(3)3 be moved to IAC 441-78.53(5)"c"(2)1, and IAC 441-78.53(5)"b"(3)4 be moved to IAC 441-78.53(5)"c"(2)2.

- o Person-centered service plan and patient-centered care plan documentation. IAC 441-78.53(5)"c" sets for documentation requirements for these plans. **UnityPoint Health reiterates its recommendations for revisions from earlier in this comment letter**. First, as described in the "Definition of patient-centered care plan" narrative, occurrences of "patient-centered care plan" in the "c" and "c"(1) should be changed to "person-centered care plan". Second, as described in the "Comprehensive assessment" narrative, two comprehensive assessment documentation provisions are better characterized and placed under "c"(2) referencing intensive care management plan documentation.
- o Core services documentation. IAC 441-78.53(5)"d" states "Documentation must reflect monthly provision of one of the six core health home services as outlined in subrule 78.53(2), based on the members' identified needs in the member's patient-centered care plan or person-centered service plan." **We recommend that the Department strike the language, "based on the members' identified needs in the member's patient-centered care plan or person-centered service plan."** The IHH SPA references the need to document the monthly provision of one of the six core health home services; however, it does not reference it being in the care plan or service plan. Often health homes provide interventions based on immediate and/or new needs. Restricting IHH billing to items listed/services listed in the care plan/service plan prevents IHHs from adapting quickly to meet member needs and may have the unintended consequence of initiating barriers to services/care for members.

- Payment. IAC 441-78.53(6)(a) conditions monthly payment for health home services on three requirements: (1) Medicaid eligibility and health home enrollment; (2) provision of at least six core health home services; and (3) maintenance of documentation outlined in paragraph 78.53(5)"e." This third requirement reference intensive health home services. As currently proposed, all three requirements must be met to receive payment, as an "and" appears at the end of first and second requirement. This construction is confusing, as the third requirement should only be applicable if and when payment is being requested in that month for intensive health home services. We do not believe it is the intent of the Department to make payment for services non-intensive health home services dependent upon documentation for intensive health home services. To clarify the applicability of subparagraph (3) to overall payment, **we request that the Department insert at the end of IAC 441-78.53(6)(a)(3), the following: "if intensive health home services were provided."**

- Department rules for documentation of services and audit procedures. IAC 441-79.3(2)"d"(40) sets for the maintenance of records to demonstrate the basis for service requirements for health home providers. Categories of IHH records to be maintained doubled from five to ten. Overall, we request that the Department consider reorganizing and rewording this health home maintenance of records

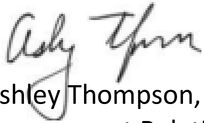
rule to make consistent with core services descriptions in the IHH SPA and CMS guidance. IAC 441-79.3(2)"d"(40) as proposed appears bulleted below, with Department requirements in numbered quotations and UnityPoint Health comments and suggestions following each requirement:

- "1. Member's eligibility." **We support as proposed.**
- "2. Comprehensive assessment." Comprehensive assessment are a component of the core service, Comprehensive Care Management. Based on this**, we recommend that the Department strike this provision and include it within the #3 requirement below.**
- "3. Comprehensive care management plan for members receiving chronic condition health home services, or comprehensive person-centered care plan or service plan for members receiving integrated health home services." In addition to including a reference to comprehensive assessments, **we recommend that the Department strike the word "plan" after "Comprehensive care management"** as the description of the core service encompasses more than a "plan". "Documentation" is more accurate than "plan" to describe the records being maintained. **We also recommend that the Department strike the word "comprehensive" before "person-centered care plan"** as being redundant. With renumbering, this provision would read, "2. Comprehensive care management <u>documentation including comprehensive assessments and</u> for members receiving chronic condition health home services a <u>person-centered care plan</u>, or person-centered care plan or service plan for members receiving integrated health home services."
- "4. Care coordination and health promotion plan." Care coordination and health promotion are two separate and distinct core services, so **we recommend that the Department divided this provision into two distinct provisions**. For both provisions, **we recommend that the Department strike the word "plan" and insert "documentation"** to reflect a broader core service. Lastly, **we recommend that the Department insert the clause, ", if relevant" at the end of each provision** as documentation of core services is dependent on member needs to determine if those services are documented or the frequency by which they are documented. With renumbering, these provisions would read, "3. Care coordination <u>documentation, if relevant</u>**.** 4. Health promotion <u>documentation, if relevant</u>.".
- "5. Comprehensive transitional care plan, including appropriate follow up." **We recommend that the Department strike the word "plan" and insert "documentation"** to reflect a broader core service. **We also recommend that the Department insert the clause, ", if relevant" at the end of this provision** as documentation of a core service is dependent on member needs to determine if that service is documented or the frequency by which it is documented. With suggestions, this provision would read, "5. Comprehensive transitional care <u>documentation</u>, including appropriate follow up, <u>if relevant</u>.".
- "6. Continuity of care document." **We support as proposed.**
- "7. Documentation of member and family support (including authorized representatives)." **We recommend that the Department insert the clause, ", if relevant" at the end of this provision** as documentation of a core service is dependent on member needs to determine if that service is documented or the frequency by which it is documented. With suggestion, this provision would read, "7. Documentation of member and family support (including authorized representatives), if relevant.".

- “8. Documentation of referral to community and social support services, if relevant.” **We support as proposed.**
- “9. Service notes or narratives.” **We support as proposed.**
- “10. Other documentation as applicable, including as outlined in 441-subrule 78.53(5).” **We support as proposed.**

UnityPoint Health is pleased to provide input on these proposed rules and their impact on our CMHCs, IHHs, patients and communities served. To discuss our comments or for additional information on any of the addressed topics, please contact Ashley Thompson, Government Relations Director at ashley.thompson@unitypoint.org or 515-537-6089.

Sincerely,



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