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Mike Randol
Director, Iowa Medicaid Enterprise
611 Fifth Avenue
Des Moines, IA 50309

RE: Feedback on future Integrated Health Homes State Plan Amendment

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

Dear Director Randol,

UnityPoint Health (UPH) welcomes the opportunity to offer feedback for consideration in a future Medicaid State Plan Amendment related to Integrated Health Homes (IHH). UPH is one of the nation's most integrated healthcare systems and provides care to patients across Iowa, Illinois and Wisconsin through 310 clinics, 39 hospitals and 19 home care locations. In addition, UPH has formal relationships with five Community Mental Health Centers (CMHC) that serve the State of Iowa through IHHs for over 7,400 adults with serious mental illness (SMI) and children with serious emotional disturbance (SED), which accounts for approximately one-fourth of the state's total IHH population. Our CMHCs and their respective IHH programs include the Abbe Center for Community Mental Health, UnityPoint Health – Berryhill Center, UnityPoint Health – Black Hawk-Grundy Mental Health Center, UnityPoint Health – Eyerly Ball Community Mental Health Services and UnityPoint Health – Robert Young Center.

Since the inception of IHHs in the state, UPH has participated in its development and growth. Most recently, UPH has had three representatives selected to serve on the Health Homes Stakeholder Workgroup: Kristine Karminski (Abbe Center), Aaron McHone (Berryhill Center) and Ashley Thompson (UnityPoint Health). UPH appreciates the time and effort of Iowa Medicaid Enterprise (IME) in developing and ultimately proposing a State Plan Amendment (SPA). We respectfully offer the following comments based upon the current Health Home SPA, *Attachment 3.1-H (IA-16-013)*, effective April 1, 2016.

FUTURE REVISION OF IA SPMI HEALTH HOME STATE PLAN AMENDMENT

Iowa Medicaid Enterprise (IME) has indicated that it intends to revise the *IA SPMI Health Home – Managed Care Implementation SPA*, *Attachment 3.1-H (IA-16-013)*, to better align with the *Chronic Conditions Health Home – Managed Care Implementation SPA*, *Attachment 3.1-H (IA-16-012)*, as well as the overall transition to Managed Care Organizations (MCO). The goals of the revision are to: (1) increase behavioral and physical health care in promoting whole-person health; (2) clarify roles of IME, MCOs, and Health Home providers; and (3) align expectations of both MCOs and Health Home providers between the SPAs.

Based on prior forums for stakeholder feedback, topics being considered for inclusion by IME in this SPA include:

- Qualifying conditions for enrollment;
- Overlap with IHH core service definitions;
- Potential service duplication with other Medicaid benefits;
- IHHs services for individuals with Substance Use Disorders (SUD);
- Expansion of outcomes-based measures;
- IHH reimbursement model, including incentive structures (bonus versus withhold) and cost savings models; and
- Further specificity within the SPA related to roles and responsibilities and program implementation.

IME encouraged stakeholders to forward comments on these and other topics related to the SPA. Additionally, feedback from the Health Homes Stakeholders Workgroup, *Health Home System Review (December 2018),* will be incorporated into the SPA as warranted.

Comment: Our specific feedback on language within the IA SPMI Health Home State Plan Amendment is addressed in the following sections. In this section, ***we want to express the need, and our support, for health homes generally as well as the need for a separate health home program for adults with SMI and children with SED***. We urge IME to maintain the following when revising the SPAs:

- ***Program Eligibility***: While we welcome the opportunity to clarify roles within the SPA, *population eligibility and the ability to cease health home enrollment should remain with IME and be dictated by the SPA*. We would oppose any SPA language that shifts this authority to the discretion of the MCOs to alter. While MCOs as the lead entity have been specifically delegated program implementation functions, these currently do not include the discretion to change program eligibility. The current SPA arrangement should be maintained as its enables Health Home providers to clearly understand which individuals may be enrolled and billed for accordingly. It also provides that there will be no service duplication as assured by IME, which prohibits MCOs from diverting eligible enrollees to alternative programs outside Health Home program constructs.
- ***Specialized Needs for IHH Patients***: Although we recognize that some provisions of the IA SPMI Health Home SPA could be aligned with the Chronic Conditions Health Home SPA, we urge caution and deliberation. *These two SPAs address distinct populations and do require some divergence in program structure and outcomes.* The IHH program provides behavioral health-led care coordination for individuals with SMI and SED and functional limitations. IHH patients are primarily cared for by CMHCs, which most appropriately coordinate their care, including community wrap-around services and medical care. Primary care providers and their Patient Centered Medical Home (PCMH) teams do not have the capacity nor the mental health expertise to perform the care coordination activities or other core services for the IHH population. We would oppose any SPA language that permits lead agencies to reassign IHH core services to primary care PCMHs. We encourage any efforts to streamline these SPAs to fully vet the impact on the IHH population and vice versa for the chronic conditions population.

- ***Payment and Value-Based Arrangements***: Delivering IHH services is not well suited to fee-for-service reimbursement. Health home services are currently reimbursed under a per-member, per-month (PMPM) payment. There are also performance measures associated with Health Home participation. The PMPM permits IHH providers to focus on individualized patient care and services, including more intensive time and effort required to provide equivalent service to "hard-to-reach" IHH patients such as individuals who are homeless. *UPH supports the PMPM payment platform and urge IME to maintain this structure within the SPA.* Also, we believe that value-based arrangements outside the PMPM structure should be voluntary for IHH providers, and UPH would be supportive of collaborating with the State and MCOs on potential value-based arrangement opportunities. For IHH core services, UPH would oppose any SPA language that permits lead agencies to deconstruct the PMPM payment and mandatorily reassign any or all core services (including care coordination) to shared savings agreements.

IA SPMI SPA: HEALTH HOMES POPULATION CRITERIA AND ENROLLMENT

Comment:

- **Population Criteria**: Serious mental illness (SMI) is defined as Psychotic Disorders, Schizophrenia, Schizoaffective disorder, Major Depression, Bipolar Disorder, Delusional Disorder, or Obsessive-Compulsive Disorder. *UPH would encourage the addition of Post-Traumatic Stress Disorder (PTSD) to the SMI definition.* The diagnostic criteria for PTSD is included within the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; 1) under the category Trauma- and Stressor-Related Disorders.
- **Enrollment of Participants**: The SPA currently uses an opt-in model. Enrollment may occur during initial engagement with a Health Home provider or through attribution by the State or MCO. Health Home disenrollment, or opting out, can occur at any time. There is not a real-time system to verify enrollment – *UPH would recommend a real-time roster by required in the SPA*. *UPH would also recommend that the SPA be revised to clarify enrollment transition periods to understand when services and billing can commerce and terminate*: (1) whether IHH enrollment (and service provision) can continue when Community-Based Case Management (CBCM) and/or Home- and Community-Based Services (HCBS) waivers are being assessed and then granted; and (2) what level of IHH services may be billed to assure a warm hand off for individuals moving to Non-Intensive Care Management or Intensive Care Management services from CBCM and/or HCBS waivers. At issue are those situations when IHH enrollment is submitted and IHH services are provided, but IHH enrollment is not timely approved (i.e. approval occurs several months post enrollment submission). Presently, while IHH approvals are granted retroactively, IHH providers are not permitted to bill retroactively for services provided.

IA SPMI SPA: HEALTH HOMES PROVIDERS

Comment:

- **Types of Health Home Provider - Teams of Health Care Professionals**: We agree with this team-based approach. For social workers, *we would suggest that requirement for an "BSW with an active Iowa license" be changed to a BSW without reference to licensing due to workforce*

shortages. In the "other" category, Peer Support Specialist / Family Support Specialist is defined and includes training and competency testing requirements. *We would suggest that, while Peer Support Specialists are undergoing training (up to a period of six months), they may serve on the team while under supervision.*

- **Supports for Health Home Providers**: In the description, the SPA states that the "State will support Health Homes in achieving the 11 components . . . by designing a program that aligns provider standards and a payment method that . . . [includes in part] an appropriate reimbursement structure to ensure sustainability for the providers." *UPH is concerned that a flat PMPM does not promote sustainability for providers and would recommend that periodic payment updates to the PMPM be authorized by the State*.

  To assist with clarifying roles of MCOs and State oversight, UPH would recommend that description language contain more detail. For the State, we would recommend that the SPA specifically provide access to the Iowa Medicaid Portal Access by IHHs. For lead agencies, we would recommend a general reference to the need for portal access and usability, access to timely and accurate rosters and timely prior authorization and level of care decisions. IME can then regulate with more specific standards.
- **Provider Standards**: The section sets forth numerous requirements for IHH providers. We would anticipate that IME will condense the requirements in Initial IHH Provider Standards and Ongoing IHH Provider Standards. We would recommend that:
  - *Staff requirements remain as is without stated staffing ratios* to enable flexibility for IHHs based on the acuity of their population and to account for diverse geographies. Staffing caseloads will be and are different among IHHs with rural service areas due to added travel time to serve individuals in place;
  - Capacity to complete status reports to document member's housing, legal, employment status, education, custody, etc. be retained, but that the *State, and not lead agencies, dictate a consistent reporting format and associated reporting timeframes*;
  - *Technology infrastructure requirements be streamlined*, removing bullets related to specific platforms; and
  - *Requirement for letters of support be eliminated*.

IA SPMI SPA: HEALTH HOMES SERVICE DELIVERY SYSTEMS

Comment:

- **Risk-based Managed Care**: Aligned with our input on Supports for Health Home Providers, we would suggest that IME clarify in rules how it is providing "an annual assessments to determine if payments delivered were sufficient".

IA SPMI SPA: HEALTH HOMES PAYMENT METHODOLOGIES

Comment:

- **PMPM rates**: *UPH would recommend that the minimum criteria in Subsection F for Intensive Care Management members, reference the underlying rules or statutes* instead of making specific reference to the 14-day and 60-day intervals and restrictions on site of services (home or location

of service). We believe these timeframes and site of service restrictions are contrary to the IHH model of care. While we understand that these references are based on statutes/regulations, specific references within the SPA unduly hamstrings the IHH program.

The SPA states that "IME shall pay the health home based on the member needs. Adults and children shall be grouped into two categories. Category one is for those members needing IHH services who are actively engaged in the IHH program. Category two is for those actively engaged members needing IHH with more intense community service case management (CM)." While UPH supports PMPM payment for this model, we believe that the current tiers are flawed in that they are based not on acuity but on whether individuals are participating in HCBS. This shift (from acuity to service use) alters how the IHH was originally envisioned under Magellan. *UPH recommends that the SPA revert payment back to acuity and away from touchpoints or clicks.* The current approach contradicts holistic care based on value.

- **Non-duplication of Payment**: See narrative above under "Enrollment of Participants." We are concerned that IHHs are not being reimbursed for services while waiver eligibility is assessed and made effectively retroactively.

IA SPMI SPA: HEALTH HOMES SERVICES

Comment: There are currently six core health home services. While UPH is offering suggestions to clarify these services, *UPH does support the inclusion of a menu of core services under a flexible PMPM reimbursement methodology.* This methodology allows services to be provided as needed by the individual and most efficiently by providers to meet program outcomes. Particularly for SMI adults and SED children, this flexibility and tailored approach facilitates whole-person care and transitions away from needless Fee-For-Service touchpoints. Specific comments for each core service is as follows:

- **Comprehensive Care Management**: The description indicates that the nurse manager serves as a "communications hub" for this core service. Under a team approach, all team members accept this responsibility and *we would suggest that this reference to communication hub be removed. We would also recommend that the nurse case manager responsible for delivery of this service reside solely with the IHH to clarify roles between IHH and MCOs.*
- **Care Coordination**: While the social worker is listed as a Care Coordinator, social worker is not referenced in the description narrative. To clarify that social workers should continue performing this function, *we would recommend that the narrative description be revised to state that nurse care coordinators or social workers at the IHH will perform care coordination*. *We would recommend an expanded role for peer support specialists* to include care coordinator activities and Non-Intensive Care Management assessment and plans. *We would also recommend that the nurse case manager and social worker responsible for delivery of this service reside solely with the IHH to clarify roles between IHH and MCOs.*
- **Health Promotion**: While the peer support specialist is listed as a provider type, peer support specialist is not referenced in the description narrative. *We would recommend that the description narrative be revised to include peer support specialists and that their role include WHAM training and other health promotion activities. We would also recommend that the nurse case manager*

and social worker responsible for delivery of this service reside solely with the IHH to clarify roles between IHH and MCOs.

- **Comprehensive Transitional Care**: *We would recommend an expanded role for peer support specialists* to include participation in hospital discharge process and facilitation of crisis plan development (such as WRAP plans). *We would also recommend that the nurse case manager and social worker responsible for delivery of this service reside solely with the IHH to clarify roles between IHH and MCOs.*
- **Individual and Family Support**: *We would recommend an expanded role for peer support specialists* to include assisting with medication and treatment management and adherence. *We would also recommend that the nurse case manager and social worker responsible for delivery of this service reside solely with the IHH to clarify roles between IHH and MCOs.*
- **Referral to Community and Social Support Services**: While we understand that this category is within the federal definition of health home services, we would support the elimination of this as a core service. Referrals are not a direct service and are not uniformly needed or available. If referrals are retained as a core service, *we would recommend that the description narrative be revised to include the role of peer support specialists. We would also recommend that the nurse case manager and social worker responsible for delivery of this service reside solely with the IHH to clarify roles between IHH and MCOs.*

IA SPMI SPA: HEALTH HOMES MONITORING, QUALITY MEASUREMENT AND EVALUATION

Comments:

- **Minimum HIT Infrastructure Requirements for Providers**: *UPH would recommend that the specific list of items under this second bullet be removed* from the SPA to allow the State more flexibility to reflect current technology trends.
- **Evaluations and Data Collection**: The narrative indicates that the State will be collecting and monitoring this data. *UPH would recommend that the SPA specifically indicate who is providing this information to the State* – the IHH or the lead agency.

We appreciate this opportunity to provide feedback and its impact on our IHHs as well as our Medicaid patients and communities. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President of Government & External Affairs at Sabra.Rosener@unitypoint.org or 515-205-1206.

Sincerely,

Sabra Rosener, JD
VP, Government & External Affairs