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June 29, 2020

Health Home Program
Iowa Department of Human Services
Iowa Medicaid Enterprise
611 Fifth Avenue
Des Moines, IA 50309

RE: SPA IA-20-011 - Medicaid State Plan Amendment Attachment 3.1-H, Integrated Health Homes

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

Dear Director Randol,

UnityPoint Health (UPH) appreciates the opportunity to provide public comment on the proposed 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 more than 400 physician clinics, 21 regional and 19 community network hospitals and home health services throughout our nine regions. In addition, UPH has formal relationships with five Community Mental Health Centers (CMHC) that serve the State of Iowa through IHHs for almost 5,000 adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). 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 the development and growth of the IHH program. 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 (UPH). 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.

GENERAL COMMENTS

In developing this proposed IHH SPA, IME solicited feedback from stakeholders and interested parties in the fall of 2019. In particular, IME indicated its intent 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 stated goals were 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.

Comment: UPH submitted preliminary input through a formal letter[1] as well as our participation in the Health Homes Stakeholders Workgroup and its recommendations contained with the IME report, *Health Home System Review (December 2018)*[2]. ***We wish to acknowledge and thank the State and IME for considering and incorporating many of our recommendations within the proposed IHH SPA***. Of significance are changes related to removing minimum 14-day and 60-day encounter intervals, conforming BSW language to Iowa Code (eliminate reference to licensing), expanding population eligibility criteria, clarifying team roles and health information technology requirements, continuing the PMPM payment methodology, and aligning the SPA to Iowa Administrative Code, Chapter 90, Targeted Case Management. These clarifications will assist IHHs to prioritize direct care services over back office and administrative functions.

INTENT OF THE IHH STATE PLAN AMENDMENT

In the public notice[3], IME states the intent of the IHH SPA is to:

- *Respond to the deficiencies identified in the Office of Inspector General (OIG) 2019 Audit of the Health Home (HH) Programs for the period of State Fiscal Year (SFY) 2013 through SFY 2016;*
- *Add greater clarification around operationalization of the HH programs and overall quality improvement; and*
- *Update the reimbursement rates for the payment tiers assigned to each of the HH programs.*

Comment: Due to time and effort needed for the COVID-19 response, ***we appreciate the State delaying IHH rate adjustments until January 1, 2021, to align with rate adjustment timing for Iowa's Medicaid Managed Care Organizations and other capitated rate contracts***. This will enable our IHHs to concentrate on pandemic response now and provide time to evaluate and prepare our staffing model and program supports to efficiently provide services under the 2021 proposed rate structure. In the future, UPH encourages the State to work towards making the rate-setting process more transparent and to meaningfully engage IHHs in developing payment methodologies. Similar to rate setting for Managed Care Organizations and PACE Organizations, we request that IHHs participate in the Actuarial certification process and that rates be set with sufficient timeframes to promote efficient implementation and minimize service changes to IHH members.

HEALTH HOMES POPULATION AND ENROLLMENT CRITERIA

Among revisions, the SPA includes terminology changes from Serious and Persistent Mental Illness (SPMI) to Serious Mental Illness (SMI) and broadens the scope of qualifying mental health conditions to allow additional members to have access to the IHH program if desired.

Comment: ***UPH supports the expanded SMI definition, as opposed the former approach of listing specific diagnoses.*** The proposed definition recognizes the universe of diagnoses and avoids situations in which individuals in need of IHH services are inadvertently excluded, such as those with Post-Traumatic Stress Disorder.

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[1] Letter from UPH entitled, "Feedback on future Integrated Health Homes State Plan Amendment," dated August 23, 2019, and submitted electronically via Healthhomes@dhs.state.ia.us.

[2] https://dhs.iowa.gov/sites/default/files/2018%20Health%20Homes%20Report_FINAL.pdf?012020190848

[3] Public notice accessed at https://dhs.iowa.gov/public-notices/health-homes

We also support the use of the term "diagnosable" in the definitions of SMI and SED, as opposed to the term "diagnosed", in reference to a specified mental, behavioral or emotional disorder within the past year. "Diagnosable" denotes the ability to be diagnosed, rather than the past act of being diagnosed. This distinction is important and enables IHHs to perform or continue outreach to certain individuals with SMI before diagnosis verification by an experienced and licensed health care professional allowed to diagnosis a mental health condition using the DSM or ICD 10. Since the term "diagnosable" is not synonymous with the term "diagnosed", the SPA's plain language clearly authorizes IHH services without a diagnosed disorder by a health care professional at the time IHH services commence or are continued. While we agree that a diagnosis does need to be reflected within a year of enrollment, we encourage a flexible approach so as not to create an administrative barrier for a population that by definition has a disorder with accompanying episodic, recurrent and continuous functional limitations. With the State's shortage of health care professionals and to promote patient-centered care, IHHs should be able to enroll individuals who are diagnosable with the intent to obtain later diagnosis verification within 12 months. In addition, it is often a challenge for some individuals with SMI to recognize their symptoms and engage with health care professionals, although they are willing to avail themselves of IHH services and supports and, in fact, have benefited from these services. As used in the annual assessment process, the term "diagnosable" also embeds regulatory flexibility to avoid purely administrative IHH disenrollment at calendar day 366 of IHH members whose underlying disorder and functional limitations are unlikely to change. This interpretation aligns with Habilitation rules, which permit continuation of services to members despite their refusal to obtain an annual visit. Since the SPA is intended to be budget neutral and not decrease eligible populations, we urge the State to consider adopting sub-regulatory standards for diagnosis verification, which may include a good faith intent (as demonstrated by notations in the record) to obtain a recurring diagnosis, efforts to secure health care professional appointments, and notes on continued IHH interventions.

While we support the definitional direction for SMI and SED, the language used within the definitions is inconsistent and does not provide clear notice regarding eligibility criteria. We urge that the SPA be revised to clarify:

- Age: At issue is the plain language of the SPA, in which SMI or SED is defined in part as someone over/under the age of 18. For individuals who are 18 years of age, they do not meet either definition of SMI (over 18) or SED (under the age of 18). ***We encourage the State to address this omission within the SPA.***
- Use of "functional impairment" within the definitions of SMI and SED: "Functional impairment" is a defined term but is referenced inconsistently within the definition of SMI and SED. First, for SMI, "functional impairment" is qualified by the term "serious", which does not similarly appear in the definition of SED. With the inclusion of "serious", it is unclear if there is a heightened burden to demonstrate functional impairment for SMI as opposed to SED. Since we do not believe the SPA intends a different standard for SMI, ***we encourage the State to remove "serious" from the definition of SMI***. Second, all language in the sentence after "functional impairment" within the SMI and SED definitions repeat inconsistently a portion of "functional impairment" definition and suggests that functional impairment has a different meaning within those definitions. Since we do not believe the SPA intends a different meaning for functional

impairment within the SMI and SED definitions, ***we encourage the State to remove remaining language in the sentence after the term "functional impairment"***.

HEALTH HOMES PROVIDERS

SPE revisions for health home providers include:

- *Lead entity standards is clarified by adding roles under the provider standards;*
- *IHH standards are changed from milestone standards to standards any IHH must meet;*
- *IHH standards are aligned with the Chronic Care Health Home (CCHH) as they both provide whole person care and include a learning collaborative;*
- *Care Coordinator requirements conform to Iowa Code to not require licensure; and*
- *Health Information Technology description is broadened to support advancing interoperability.*

Comment: A teams-based approach to service delivery is foundational for IHHs. UPH applauds the change that removes reference to an "active Iowa license" for BSWs to assist with 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 and contribute billable hours.*** Peer Support Specialists must be hired to receive training and competency testing; however, training does not occur on a regular basis and any contribution to the team while under supervision but prior to competency testing is not able to be billed.

HEALTH HOMES SERVICE DELIVERY SYSTEMS

The SPA requires the lead entity to offer a performance measures program which may include incentives.

Comment: While UPH supports the concept of a performance measures program, these programs have not been operationalized by the lead entities in a manner that is amenable to success. Simply requiring lead entities to offer these in the SPA without further details or oversight by the State does not provide assurance to IHHs that these will be administered in a transparent and accountable manner. Lead entities to date have been unable to provide performance data to the IHHs in a timely manner or aligned to the benchmarks. Amerigroup provides IHHs quarterly data on a 90-day runout and, since entering the state, Iowa Total Care has not provided any aggregate data to IHHs. Another issue is that performance measures programs vary among lead entities, requiring IHHs to engage in different strategies to resolve/improve similar issues. We are currently halfway through the 2020 performance year and IHHs have received no performance data to gauge current performance. Although five measurement areas[4] have been provided, neither lead entity has specified 2020 thresholds for incentive bonuses nor have 2020 maximum bonus amounts been disclosed. While Iowa Total Care has scheduled a performance measures training for July 8, Amerigroup has not scheduled any trainings/meetings. The lack of program parameters with six months remaining in the performance period is unacceptable and

[4] 1. Ambulatory Care – ED Visits (Adult & Child) (ABM); 2. Adults' Access to Preventive/Ambulatory Health Services (Adult) (AAP); 3. Children and Adolescents' Access to Primary Care Practitioners (Child); 4. Follow-up After Hospitalization for Mental Health – 7 Day (Adult & Child); 5. Inpatient Utilization – Maternity, Surgery, Medical (Adult & Child)

language in the SPA does not address this. ***We request that, for any performance measures program, lead entities provide IHHs with monthly data, including detailed descriptions of the data definitions, and make performance measures and benchmarks available at the start of the performance period.***

Also, we would note that the CMS guidance[5] for the Health Homes Services Delivery Systems response indicated that if "risk-based managed care" is selected and Health Plans will be part of a Team of Health Care Professionals, then the State is to "provide a summary of the contract language imposed on the Health Plans in order to deliver Health Homes services." ***This information was not provided in the public notice or publicly available attachments.***

HEALTH HOMES PAYMENT METHODOLOGIES

The SPA contains several changes, including:

- *Eligibility for IHH members is required to be assessed every 12 months;*
- *Intensive Care Management (ICM) contacts are changed to align with Iowa Code;*
- *Payment tiers definition is clarified;*
- *Information codes are required to be added to the IHH claim to identify which HH service was provided that month; and*
- *Duplication of services with Community-Based Case Manager (CBCM) and Chronic Care Health Homes (CCHH) was addressed.*

Comment: The SPA does not include or define the term "mental health professional". This term is introduced in the Health Home FAQ document[6] in response to the question of whether IHH members must be seen by a licensed professional on an annual basis. The FAQ response indicated an annual assessment must be performed by a provider defined in Iowa Administrative Code Part 441, Chapter 24 and specifically references the definition of "mental health professional". We believe this restriction unduly restricts the plain language of the SPA, which does not limit DSM or ICD 10 diagnoses to be performed by mental health professionals alone, and blatantly disregards patient (IHH member) choice of provider and the sanctity of established relationships between patients and health care professionals. We believe IHH members should continue to have choice in their Primary Care Provider (PCP), other medical specialist or a mental health professional. All these professions are able to diagnosis and bill Medicaid for providing mental health services with mental health ICD 10 codes. This FAQ response appears contrary to the tenets of the IHH program in providing whole person care – if an IHH member elects to continue mental health treatment from their PCP but IHH rules require an annual assessment by a mental health professional, that assessment would be duplicative and we would suggest potentially traumatizing for IHH members to share family social and mental health information without an expectation of an ongoing treatment relationship. ***We urge the SPA to clarify that annual assessment be authorized by an experienced and licensed health care professional allowed to diagnosis a mental health condition using the DSM or ICD 10.***

UPH understands that IHH members need to be eligible to qualify for IHH benefits, and we generally support the annual assessment process. That said, we will reference our comments under HEALTH

[5] CMS, *Consolidated Implementation Guide: Medicaid State Plan – Health Homes*, dated August 21, 22017.

[6] Department of Human Services, *Health Home FAQ*, distributed from the Healthhomes@dhs.state.ia.us address, on June 25, 2020 to a mental health list serv compiled by Pam Lester, IME Program Specialist. UPH was unable to locate this document on the IME website at the time of comment letter submission.

HOMES POPULATION AND ENROLLMENT CRITERIA, in which we expressed support for the use of the term "diagnosable" within the definitions of SMI and SDI. ***IHHs should be able to enroll IHH members and bill for IHH services for members with "diagnosable" disorders.*** While Medicaid eligibility may change due to financial and family circumstances, it is unlikely that an underlying disorder and diagnosis and any accompanying functional limitations will change over time. When placing a bright line, 12-month timeframe on annual reassessments, we urge that SMI or SED assessment timeframes include flexibilities that incorporate the concept that the disorder is "diagnosable" as opposed to diagnosed. While the preference would be to have each IHH member seen by a health care professional within the 12-month timeframe, it is not possible for all IHH members and it is usually those IHH members that are the most challenging and receive the greatest benefit from IHH services.

We are extremely concerned with the level of billing detail being required for a PMPM payment. Specifically, the proposed SPA requires information codes for each core service provided monthly on the IHH claim. By the nature of our team-based delivery model and in response to individual member needs, IHHs often have multiple contacts with the member over the course of a month, including multiple core services, all of which are contained in different notes. This poses a significant challenge for the IHH electronic health records (EHRs) to comprehensively capture and roll up notes into one monthly claim. Presently, our five IHH programs are serviced by four separate EHRs and all will require significant reporting builds to enable a more automated billing function to meet these requirements during a monthly cycle. In the absence of reporting builds, this requirement will significantly increase time devoted to billing activities and divert time away from direct services. ***Alternatively, we would request that the SPA enable IHHs to submit multiple claims during a month, which would provide the requested service level detail but avoid costly reconfiguration of multiple IHH EHR systems to accomplish this.***

HEALTH HOMES SERVICES

The SPA contains additional language intended to clarify IHH services by further describing activities that would fall under each service along with who is responsible for the service.

Comment: There are currently six core health home services. Specific comments for particular core service are as follows:

- **Comprehensive Care Management**: Under the SPA, this core service requires a comprehensive assessment that "includes a physical and behavioral assessment, medication reconciliation, functional limitations, appropriate screenings, completed by a licensed health care professional within 30 days of enrolling". We believe that the 30-day time period incorrectly references enrollment, which is backdated to first of month (i.e. date in the MCO computer for enrollment) and should instead be within 30 days of intake. For example, and without a change in the SPA, an IHH member with an intake date of June 20 is considered to be enrolled on June 1, leaving the IHH with only 10 days to complete the comprehensive assessment. ***We encourage the State to revise the SPA to read "within 30 days of intake" for completion of the comprehensive assessment.***

  The SPA requires an assessment to be conducted at least every 12 months. In the FAQ document, it was clarified that the IHH member would need to be seen by a mental health licensed

professional. Although ideally individuals with SMI would be seen by a mental health professional, this needlessly limits their choice of provider if their PCP manages their mental health diagnosis and/or medications. Additionally, the FAQ does not appear to include Physician Assistants (for either mental health or primary care). ***We recommend the State to permit PCPs to complete the assessment to respect patient choice of provider and to include Advanced Practice Registered Nurses and Physician Assistants to be substituted for physicians.***

The SPA also requires the Nurse Care Manager to be responsible, with assistance from the Care Coordinators, for the delivery of this service. Operationally, Care Coordinators can and should do the bulk of the assessment and care planning work, leaving the Nurse Care Manager ultimately responsible for nursing content, such as medication reconciliation. The time required for the Nurse Care Manager to complete every assessment and care plan leaves very little time for nurses to complete other vital functions that match their unique qualifications. ***As we interpret the SPA, this is a shared responsibility for which the Nurse Care Manager can delegate functions / tasks not related to nursing.*** With the nursing shortage, it is difficult for recruit and retain nurses, so permitting top of licensure practice within a team environment is imperative.

Omitted from the SPA are requirements for non-ICM comprehensive assessments. In the FAQ document, the State indicates there is no required form nor do IHHs need to obtain State approval for IHH-specific comprehensive assessment templates. ***We applaud the absence of a mandated form and further encourage the inclusion of SPA language that if a lead entity develops a form, that the form should be optional.*** This flexibility for IHHs to have our own forms recognizes that IHHs understand their workflows and know how to most efficiently incorporate these forms. While IHHs accept the responsibility of form development, we request guidance as to the State's expectations related to mandated content per assessment category and which assessment category is required to be completed by specific IHH team members (e.g. Care Coordinators, Nurse Care Managers, etc.). In State-sponsored trainings, at least 12 mandated categories were identified for inclusion within the assessment tool. The SPA or sub-regulatory does not expound upon minimum compliance requirements for each category. While the public notice indicates that this SPA was to address OIG Audit concerns, we are concerned that the State has not provided sufficient information related to the documentation required for these assessments.

- **Care Coordination**: Foremost, we are perplexed and frustrated that the SPA provides that "Nurse Care Managers will be responsible for the delivery of this service" and that "Care Coordinators may assist the Nurse Care Manger with Care Coordination." With the nursing shortage, it seems illogical that the State would not enable nurses to practice at the top of licensure and authorize Care Coordinators to lead efforts related to care coordination. Care coordinators should rightful perform tasks related to case management, treatment planning, etc. It is not efficient or effective to have nurse time and effort diverted from nursing functions and resulting in strain on the rest of the IHH team. ***We encourage the State to revise the SPA to read that "Care Coordinators will be responsible for the delivery of this service" and "Nurse Care Managers can assist the Care Coordinators with care coordination."*** Alternatively, we would support the SPA language that mirrors the Individual and Family Support core service, which reads "Nurse Case Managers or Care Coordinators at the IHH will be responsible for the delivery of this service."

In addition, ***we recommend an expanded role for peer support specialists*** to include care coordinator activities and Non-Intensive Care Management assessment and plans.

- **Health Promotion**: This is another core service that the SPA mismatches to the skills and expertise of IHH team members. We are extremely disappointed that Nurse Care Managers will be responsible for the delivery of this service. With the nursing shortage, it seems illogical that the State would not enable nurses to practice at the top of licensure. ***We encourage the State to revise the SPA to read that "Care Coordinators will be responsible for the delivery of this service" and "Nurse Care Managers can assist the Care Coordinators with care coordination."*** Alternatively, we would support the SPA language that mirrors the Individual and Family Support core service, which reads "Nurse Case Managers or Care Coordinators at the IHH will be responsible for the delivery of this service."

  While we are pleased that the SPA references the peer support specialist within the description narrative, we disagree with the narrow scope of responsibilities. The SPA states "*Peer support specials [sic] may assist with this service through peer lead [sic] programs i.e. Wellness Recovery Action Plan (WRAP)*." We are concerned the "peer-led programs" unduly restricts peer support specialists to programmatic functions (as illustrated through the reference to WRAP) and do not recognize the value that peer support specialists contribute to IHH members. The value in peers is more about the conversations that our peers can do as individuals, as far as engaging IHH members, providing a social connection for IHH members, and giving encouragement to IHH members. We also believe that peers could provide value in WHAM training and other health promotion activities. ***We encourage the State to revise the SPA to reference "peer-led activities" to enable peers to use their specialized training in a way that is going to helpful and individualized to the IHH member, and not limited to a specific evidence-based approach.***
- **Comprehensive Transitional Care**: ***We 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).
- **Individual and Family Support**: ***We recommend an expanded role for peer support specialists*** to include assisting with medication and treatment management and adherence.
- **Referral to Community and Social Support Services**: We are pleased that the SPA references the role of the peer support specialist within the description narrative.

FISCAL IMPACT

In the public notice, IME states that there is no fiscal impact related to this proposal. The changes in the PMPM amounts are budget neutral, and the clarification of qualifying mental health diagnoses for IHH eligibility is expected to have minimal impact on overall enrollment.

Comments: ***While the State asserts that this SPA is budget neutral, the State has not provided an analysis in support.*** We are unaware of any actuarial or financial analysis to demonstrate that the update to the reimbursement rates for payment tiers will not result in a fiscal impact, including the methodology used to calculate the new ratio among the tiers. In addition, the eligible population criteria has been expanded beyond a smaller diagnosis list and will potentially enable more individuals with SMI to be enrolled as IHH members.

Although we understand that budget neutrality relates to the State, there is a definite budgetary impact to IHHs who need to maintain sustainable operations. Because PMPMs have been reconfigured, the IHHs will need to review enrollment and evaluate the ICM to non-ICM ratio to assure the business model works. ***If the State is projecting a stable population, that is likely a faulty assumption***. Also crucial in this conversation is the inability of nurses in this SPA to practice at the top of licensure. The SPA needlessly requires nurses to perform administrative functions more appropriately within the wheelhouse of other IHH team members. This elevates IHH costs unnecessarily, causing IHHs to be less efficient and requiring IHHs to revisit their business models for sustainability. ***To promote model efficiency, we reiterate our plea for flexibility to enable nurses to practice at the top of licensure in the IHH team-based model.***

UPH appreciates this opportunity to provide feedback on the SPA and its impact on our IHHs as well as our IHH members and communities. To discuss our comments or for additional information on any of the addressed topics, please contact Ashley Thompson, Director of Government & External Affairs at Ashley.Thompson@unitypoint.org or 515-537-6089.

Sincerely,

Ashley Thompson, MPH
Director, Government & External Affairs

Cathy Simmons, JD, MPP
Executive Director, Regulatory Affairs