Iowa Department of Human Services

Building Health Homes for Iowa Medicaid Members

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Section 2703 of the ACA

- Option to submit State Plan Amendment (SPA) depicting a health home model targeting chronic conditions:
  - Primary Care SPA:
    - Approved June 8, 2012
    - Effective July 1, 2012
  - Specialized Population SPA

    (kids Mental Health focus, but for adults and children):
    - In development
    - TA and CMS consultations Summer 2012
    - Target effective date early 2013
- Draw 90/10 Federal match for 8 Qrts for Health Home Services

What can be achieved in a health home approach?

- For Members

- Better coordination and management of their often complicated and complex care.
- Help navigating multiple systems
- More engagement in their own care
- Access to a wider range of services

- For Providers

- Providers practice more proactive, coordinated care that they want to provide, because of a new reimbursement structure.
- More opportunities to track, coach and engage the patients
- Improved communication and coordination for better patient outcomes
- Improved utilization of health information technology

What is the benefit to the state?

- Improved health for a segment of Iowa Medicaid population with difficult health challenges
- Savings due to reductions in usage of health care services (expect reduced use of ER increased avoidance of hospital admissions)
- Projected savings between $7 million and $15 million in state dollars over three-year period ($4.9M built into Governor's budget)
- Access to enhanced funding (temporary 90% FMAP) under the Affordable Care Act to implement

"Primary Care"
Early Health Home Statistics for Providers

11 Health Home Entities Enrolled:

- 12 counties
- 41 different clinic locations
- 450+ individual practitioners

IME Support of new network:

- Two Implementation TA meetings (1:1)
- Collaborative Learning Network (Monthly)

Primary Care Health Home

Early Statistics for Members

September Member Enrollments:

- 1155 members assigned
  - 44% Tier 1
  - 40% Tier 2
  - 13% Tier 3
  - 3% Tier 4
- Almost half are Duals (Medicare/Medicaid)
- 100 (9%) are under age 19

Primary Care HH
Payment Methodology

In addition to the standard FFS reimbursement…

Patient Management Payment :

- Per Member Per Month (PMPM) targeted only for members with chronic disease
- Tiered payments increase (levels 1 to 4) depending on the number of chronic conditions
- Performance payment tied to achievement of quality/performance benchmarks

Primary Care Payment Rate

Member's Tier	PMPM Rate
Tier 1 (1-3 chronic conditions)	$12.80
Tier 2 (4-6 chronic conditions)	$25.60
Tier 3 (7-9 chronic conditions)	$51.21
Tier 4 (10 or more chronic conditions)	$76.81

- Practice uses Patient Tier Assessment Tool to identify correct tier
- Health Home submits monthly HCFA claim with diagnosis codes that support the tier
- Payments are verified retrospectively through claims data, using the normal IME verification process.

Ensure desired outcomes are achieved

Payment is directed to only practices that commit to providing:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Support Services

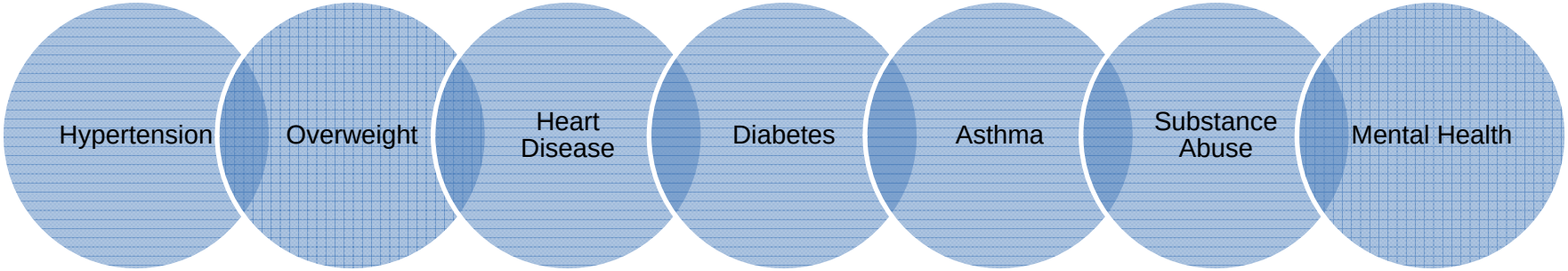
What are the Primary Care Health Home Qualifications?

1. Medicaid enrolled practices including, but are not limited to:
   - Physician Clinic
   - Community Mental Health Centers,
   - Federally Qualified Health Centers
   - Rural Health Clinics
2. Adhere to the Health Home Provider Standards

What are the Primary Care Health Home Qualifications?

3. Fulfill, at a minimum, the following roles:
    - Designated Practitioner
    - Dedicated Care Coordinator
    - Health Coach
    - Clinic support staff
4. Seek NCQA Medical Home recognition or equivalent within 12 months
5. Effectively utilizes population management tools to improve patient outcomes.
6. Use an EHR and registry tool for quality improvements

Primary Care Heath Home Qualifying Members?



Adults and Children with
at least two chronic conditions, or
one chronic condition and at-risk of a second condition
from the above list.

Primary Care Health Home Model

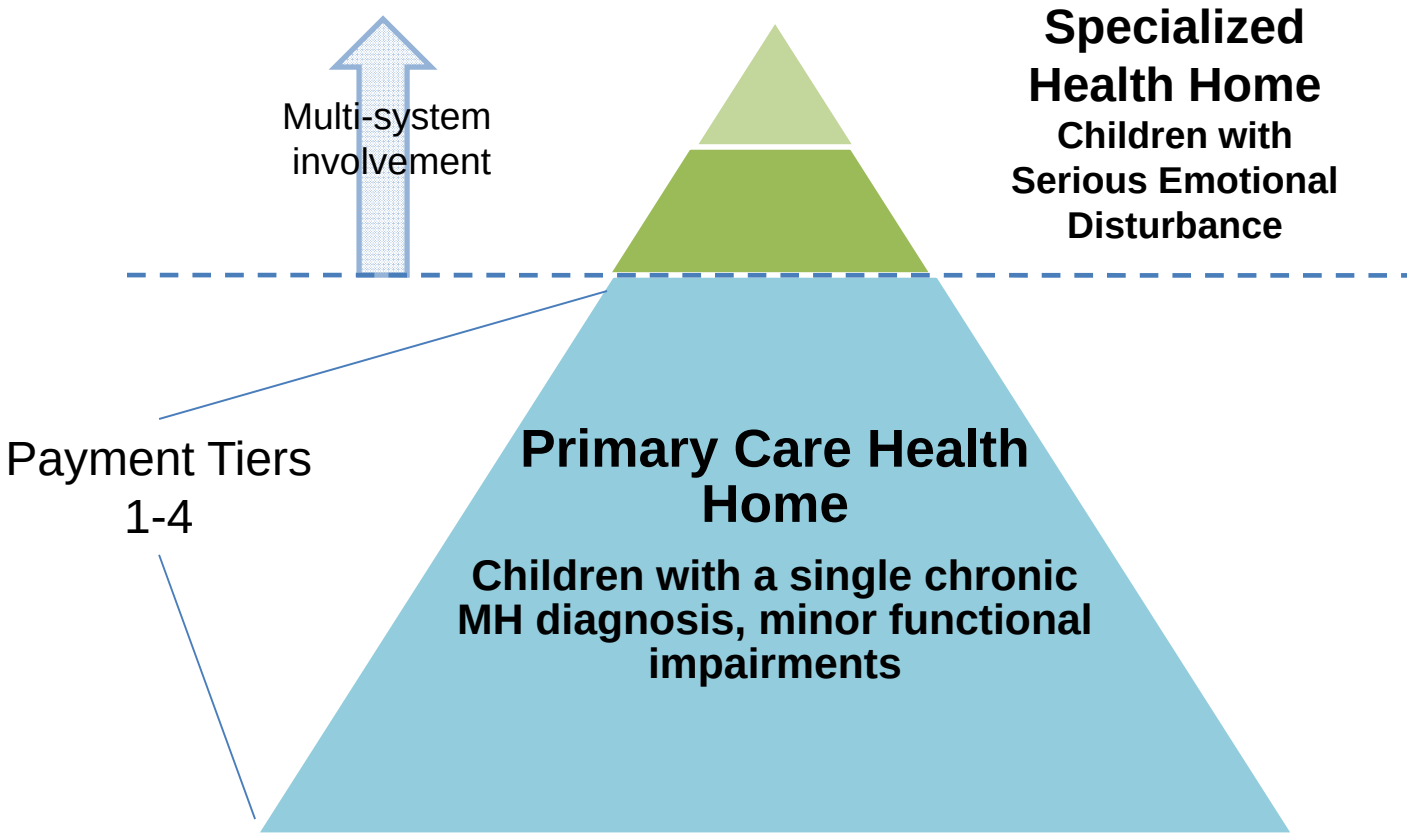
Members opt-in at the provider's office:

- Provider identifies qualified members
- Providers share benefits with Member
- Provider completes a Patient Tier Assessment
- Information is uploaded to IME

"Specialized" Health Home

- Expansion of health home model for adults and children with serious and persistent mental illness
  - Pilots operating for adults
  - Children's concept developed by Children's Disability Workgroup to implement "**Systems of Care model**"
  - Many details yet to be determined, but key details very likely to include:
    - Specialized provider requirements due to special population needs
    - Administered through the Iowa Plan
    - Additional payment tiers above the current 4 tiers due to high need of the population
    - Patient/Family Centered, peer support, team approach

Primary Care and Specialized Health Home Model – example for children with mental health condition



Questions?

Contact

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