

MINUTES

Medical Home System Advisory Council

Wednesday, December 1st, 2010

10:00 am – 2:00 pm

Urbandale Public Library

Members Present

Chris Atchison
 Melissa Bernhardt
 David Carlyle
 Kevin de Regnier
 Bery Engebretsen
 Carrie Fitzgerald
 Ro Foege
 Naomi Guinn-Johnson
 Richard Haas
 Nat Kongtahworn
 Mary Larew
 Tom Newton
 Elayne Sexsmith
 CoraLynn Trewet
 Kurt Wood

Members Absent

Jen Badger
 Libby Coyte
 Tom Evans
 Rep. Wayne Ford
 Jeffery Hoffmann
 Don Klitgaard
 Petra Lamfers
 Jane Reinhold
 Anne Tabor
 Jennifer Vermeer

Others Present

Beth Jones
 Angie Doyle-Scar
 Abby McGill
 Tracy Rodgers
 Michelle Holst
 Nicole Schultz
 Sarah Dixon Gale
 Carlene Russell
 Jodi Tomlonovic
 Leah McWilliams
 Dan Garrett
 Paul James
 Sarah Dixon Gale
 Marni Bussell
 Janelle Nielson
 Becky Blum
 Lary Carl
 Kate Bergner
 Linda Goeldner
 Danielle Donald

* Medical Home System Advisory Council Website (handouts found here):

http://www.idph.state.ia.us/hcr_committees/medical_home.asp

Topic	Discussion
Welcome	<ul style="list-style-type: none"> Council members and others present introduced themselves.
Medical Home Multipayer Collaborative Workgroup <i>David Carlyle</i>	<p><i>Background of Workgroup</i></p> <ul style="list-style-type: none"> On June 2nd, CMS released the solicitation for the Multi-payer Advanced Primary Care Practice Demonstration Project. Under this demonstration, CMS will participate in multi-payer reform initiatives that are currently being conducted by states to make advanced primary care practices more broadly available. The demonstration will evaluate whether advanced primary care practice will reduce unjustified utilization and expenditures, improve the safety, effectiveness, timeliness, and efficiency of health care, increase patient decision-making and increase the availability and delivery of care in underserved areas. A large amount of discussion took place among key medical home stakeholders in Iowa, and the Medical Home System Advisory Council. Iowa decided not to apply for the CMS Demonstration Project for a variety of reasons. Director Tom Newton convened a Medical Home Multipayer Collaborative Workgroup to move forward. It has been agreed that Iowa needs to do something

	<p>within the next 6-12 months. All of the key stakeholders have agreed to be at the table, including Medicaid and Wellmark.</p> <ul style="list-style-type: none"> • At their last meeting, the workgroup came up with shared goals of a transformative initiative. They include: <ul style="list-style-type: none"> • Improve quality of care and reduce costs • Simple methods of measurement and payment • Create synergies on common ground ex. Meaningful use, 90% match for Medicaid, reimbursing for outcomes • Needs to be sustainable- equip people to get to that point • Consumers need to be at the table • Medicaid has developed a proposal including a list of targeted demographics. The following list indicates “special interest groups” for Medicaid to assist with promoting the benefits of the program during the pilot phase. <ul style="list-style-type: none"> • Primary Care Providers with high percentage of Medicaid claims • Ill & Handicap Waivers • Supplemental Security Income (SSI) • Seriously Emotionally Disturbed (SED) • Foster Care • Children with Special Healthcare Needs • Mental/ Behavioral Health Needs • End of Life Scenarios • IME and Wellmark met on November 1st, 2010 to discuss a collaborative Health Home project. A number of shared goals were established: <ul style="list-style-type: none"> • Improve quality of care and reduce costs • Simple methods of measurement and payment • Create synergies on common ground. For example, Meaningful use, 90% match for Medicaid, reimbursing for outcomes • Needs to be sustainable-equip people to get to that point • Consumers need to be at the table • Next steps of the Multipayer Collaborative Workgroup include: <ul style="list-style-type: none"> • Define the payment methodology • Establish core group of providers between the two payers • Establish health home minimum requirements • Report recommendations back to key stakeholders
<p>Primary Care Extension Program- <i>Paul James</i></p>	<ul style="list-style-type: none"> • Background information was provided to the MHSAC regarding the Primary Care Extension Program. • The Affordable Care Act has an opportunity to enable education programs to help practice transform themselves to new models of delivery. The model presented was an extension services model similar to the Iowa State University Extension program. There is an expectation that primary care practices, medical homes, information technology, and improved evidence based guidelines of care deliver will change the way we think about care delivery. The primary care extension program exists because there isn’t a lot of support to enable smaller practices to change. • The pilot opportunity is through the AHRQ and will support and assist providers with dissemination and implementation of innovations and best practices to improve community health. State/ Multi-state Hubs and local extension programs would be created to administer the program. \$120 million is authorized in FY 2011 and FY 2012 and as much as necessary in FY 2013 and FY 2014. Extension Programs would also be

	<p>eligible to apply for AHRQ technical assistance grants and medication management grants in collaboration with eligible entities.</p> <ul style="list-style-type: none"> • The grant requires collaboration with academic, IDPH, Medicaid, and our statewide quality program (IFMC) to implement changes focusing on the medical home. • The scope of the pilot would have to be limited because there is not that much money. 25% of the funding must be spent on disseminating to the other two states awarded. The overall purpose is evaluation. • The grant is due in February. • It was mentioned that the Medical Home Learning Community has a significant number of the practices that are advancing with medical home. This would be an ideal partnership and it has history that would be very valuable. • It was also mentioned that the IowaCare Extension is also ready to do evaluation (the new sites). The pilot can focus on those FQHC's and determine what support is needed for them. • The pilot should focus on providing better prevention services, improved chronic care delivery (implementing the chronic care model) to proactively manage chronic care conditions, and increase access (24/7 access to the primary care team) to reduce emergency room and hospital usage. • States most likely to be awarded the pilot project funding are those with few competing medical schools and primary care systems- predominately rural states with one medical school with a close relationship with the state health department. This is similar to Iowa's environment. • The MHSAC agreed that there is a visceral response to moving forward with this. • Paul James will work with groups within the state- IDPH, IME, IHC, IMS, IHA, IAFF, Colleges of Public Health, etc. and determine what the possibilities are. He is hoping to make the decision to apply within the next three weeks. • Nat Kongtahworn suggested a partnership with the Iowa Chronic Care Consortium and their curriculum around the health coaching competency. • Please send Abby any additional comments or questions regarding the Primary Care Extension Program.
<p>IowaCare Expansion Medicaid Health Care Reform Implementation- <i>Marni Bussell</i></p>	<p>See PowerPoint Presentation</p> <ul style="list-style-type: none"> • The Council continues to collaborate with Medicaid in the development the IowaCare Medical Home Model , established in SF 2356. The expansion will phase in FQHCs to provide primary health care services to the IowaCare population and to comply with certification requirements of a Medical Home. Initially, the FQHC's will be required to meet a set of medical home minimum standards. • On October 1st, FQHC's in Sioux City and Waterloo have begun IowaCare expansion rollout. <ul style="list-style-type: none"> • 23,000 IowaCare members have a medical home. • 37 Counties are now covered by a medical home. • IME is continuing with weekly steering committee meetings to address implementation concerns/policy issues. They also have monthly subcommittee meetings continue to assist with action items assigned from steering and to develop report templates for providers. • A number of challenges at mitigations were discussed and are included in the PowerPoint including: <ul style="list-style-type: none"> ○ Non-covered services ○ Information sharing between facilities ○ Capacity to serve enrolled members

	<ul style="list-style-type: none"> ● IowaCare Next steps include: <ul style="list-style-type: none"> ○ Examine lessons learned from October 1st rollout ○ Analyze quarterly report data ○ Improve process ○ Set schedule for next rollout in 2011 ● A number of impact and opportunities exist for Medicaid in the PPACA: <ul style="list-style-type: none"> ● State Option to Provide Health Homes for Enrollees with Chronic Conditions (2703) ● Grants to Support Medical Homes using Health Teams (3502) ● Grants for Medical Homes through the Primary Care Extension Program (5405 and 1050) ● Proposal for use of HIT in Providing Health Home Services (2703) ● Grants for Prevention of Chronic Diseases (4108) ● Dr. Carlyle suggested getting list of Medical Home Learning Community practices to analyze patient distribution. ● It was suggested that the MHSAC request additional funding for IowaCare statewide expansion in this legislative session. ● IowaCare will phase out in 2014 and will mostly move into Medicaid- looking at it as an experimental time to develop something that will be ready to implement 2014. ● Ro Foege reminded the council that we are in the beginning implementation phase. He reinforced that this is <i>patient-centered</i> and we need to look at the full person. We talk a lot about processes and structures of how we do this, but we need a constant reminder that this is about the patient-centered medical home. ● Chris Atchison mentioned a policy challenge of aligning all of the medical home efforts in Iowa. ● Dr. Carlyle commented that Iowa is in the middle of the 50 states regarding medical home advancement. In 2014, we are going to have a whole other world and practice transformation is key.
<p>Legislative Health Care Coverage Commission- <i>David Carlyle</i></p>	<ul style="list-style-type: none"> ● The Legislative Health Care Coverage Commission is in its second year and was created by 2009 Iowa Acts, Chapter 118, §1 (SF 389) and is charged to develop an Iowa health care reform strategic plan which includes a review and analysis of and recommendations and prioritization of recommendations for various options for health care coverage of Iowa's children, adults, and families, with a particular emphasis on coverage of adults. ● The Commission is made up of 11 citizen (voting) members, 4 legislators, and 3 department heads. They began their work in September 2009 and completed their progress report to the General Assembly which summarizes the Commission's activities from September through December 2009. ● Four workgroups were created to focus on particular aspects of health care coverage. The passage of the Federal Patient Protection and Affordable Care Act has changed the charges of these workgroups to reflect the Commission's new role in assuring that national health reform is implemented in Iowa in an efficient, high-quality, and practical way. The workgroups include: <ul style="list-style-type: none"> ● Workgroup I- IowaCare Expansion, Medicaid Expansion Readiness, and High-Risk Pool will focus on reviewing, analyzing, recommending, and prioritizing options to provide health care coverage to uninsured and underinsured adults. The Workgroup will concentrate on the expansion of the IowaCare program as specified in SF 2356; how to prepare the state for Medicaid expansion set to take place in 2014; and how to maximize the effectiveness of the existing (state) and new (federal) high risk

	<p>pools in providing care to uninsurable individuals between 2010 and 2014.</p> <ul style="list-style-type: none"> ● Workgroup II- Value-based Health Care will focus on how to create opportunities for the most cost-effective use of health care resources throughout Iowa in both the publicly and privately purchased health care. ● Workgroup III- Insurance Information Exchange will work with the Iowa Insurance Commissioner on the development of the new Insurance Information Exchange. ● Workgroup IV- Wellness intends to take testimony from 20-30 organizations from both within and outside the state to discuss cutting edge cost-control efforts, including how to design incentives to change behavior for clients that will bend the curve on health care costs. ● Three out of the four workgroups have a focus on medical homes and it will be a major discussion item at this next legislative session. ● The Commission next meets on December 15th, 2010. Their website with handouts and agendas can be found here: http://www.legis.state.ia.us/asp/Committees/Committee.aspx?id=484
<p>Iowa Collaborative Safety Net Provider Network <i>Sarah Dixon Gale</i></p>	<p>Overview of the Iowa Collaborative Safety Net Provider Network</p> <ul style="list-style-type: none"> ● Almost 700,000 Iowans under age 65, approximately 27% of the total population, do not have health insurance. Thousands more have insurance that only covers catastrophic illnesses and accidents. For these individuals and families, there are limited options available for affordable health care. ● Many of these Iowans turn to Iowa’s safety net providers for affordable primary and preventive health care. Through a unique partnership created in 2005 by the Iowa Legislature, the Iowa Collaborative Safety Net Provider Network (Network), Iowa’s health care safety net providers have united to identify common unmet needs that can be addressed cooperatively. Access to pharmaceuticals, specialty care referrals, and health professionals recruitment were identified as the first three areas for collaboration and medical home was most recently added as a priority issue area. ● In the beginning, the Network was comprised of Community Health Centers, Free Clinics, and Rural Health Clinics, but has grown tremendously in the past few years to include Family Planning Agencies, Local Boards of Health, and Maternal/Child Health Centers. Because the demand for these providers’ services greatly outweighs their resources, there is an ongoing need to coordinate efforts. The recession and dramatic increases in unemployment have amplified the challenges these clinics face of remaining fiscally solvent while providing care for an increasing uninsured population. ● The Network includes a Leadership Group and an Advisory Group (policy direction). Representatives of these groups include: <ul style="list-style-type: none"> ○ Community Health Centers ○ Rural Health Clinics ○ Free Clinics ○ Maternal/Child Health Centers ○ Local Boards of Health ○ Family Planning Agencies ○ Child Health Specialty Clinics ○ State Board of Health ○ Insurers ○ Other Safety Net Providers/Partners <p><u>Safety Net Awards</u></p> <ul style="list-style-type: none"> ● This year’s Safety Net Awards include: Rural Health Clinics, Free Clinics, and Family

Planning. The Grantees include: the Iowa Prescription Drug Corporation, Specialty Care Grantees, and Medical Home Grantees. The grantees collected a variety of data to submit to IA/NEPCA.

- The presentation went into detail about each of the grantees.
- A Pharmacy Oversight Committee is in place to Provide guidance, recommendations, and oversight of Network-supported programs offered through the Iowa Prescription Drug Corporation (IPDC)
- Four Medical Home Grantees four grants to two Local Boards of Health and two Maternal/Child Health centers to work on medical home development in their communities, which are listed below.
 - Local Boards of Health
 - Calhoun County
 - Dallas County
 - Maternal/Child Health Centers
 - Siouxland Community Health Center – Sioux City
- An issue brief was developed by the Network that focused on lessons learned from these projects, which is available [here](#).
- The Community Utility Concept was then discussed. IA/NEPCA hosted a Medical Home/Community Utility Workshop on June 12th, 2009.
- The Community Utility Concept was originally described by Dr. Ed Schor of The Commonwealth Fund
- Medical Home activities that align with community utility approach include
 - Care management/care coordination
 - Some aspects of health information technology
 - Health education and prevention
 - Coordination of existing services in the community
- The concept plays a unique role for safety net providers, small primary care practices, rural providers.
- Below are the Iowa Collaborative Safety Net Provider Network’s Data Reports:
 - [Calendar Year 2007 Data Report](#) 
 - [Calendar Year 2008 Data Report](#) 
 - [July - September 2006 Data Report](#) 
 - [October - December 2006 Data Report](#) 
- Discussion took place regarding mental health services being provided at the primary care level. If a patient has more complex mental health needs, then a referral should be made to a mental health professional.
- Discussion took place on the role of the safety net provider network and free clinics in 2014 when everyone will be required to have health insurance. There will still be a need for this type of health care setting.
- The MHSAC should consider developing a recommendation for the annual report regarding primary care delivery workforce.
- The Health and Long-Term Care Access Advisory Council is exploring the use of community health workers for public health for care coordination. We should keep in mind that many parts of the medical home concept can be directed by a different type of professional.
 - Besides workforce issues related to health care, the baby boomer generation will be retiring and all professional job areas will experience a shortage.

Other Discussion

Prevention and Chronic Care Management Advisory Council- Angie Doyle Scar

Items

- The [Prevention Issue Brief](#) has been finalized.
 - The dramatic growth of chronic diseases is a huge burden to America. An alarming 75 cents of every health care dollar is spent on chronic diseases, and they account for 7 out of every 10 deaths. If this problem is ignored, the cost of treating chronic conditions such as diabetes, cancer, and obesity could overwhelm American health care. But improving preventive care and keeping people healthier is one of the most effective ways to reduce health care costs and is a major focus of health care reform. The issue brief includes:
 - Definitions
 - Health Benefits of Prevention
 - Prevention in Federal Health Care Reform
 - CDC's Six Winnable Battles
 - Return on Investment
 - Obesity Prevention
 - Oral Health
 - Musculoskeletal Health
 - Physical Activity & Health Eating
 - Pediatrics
 - Mental Health
 - Iowa Examples of Successful Prevention Programs
 - Discussion took place at the last meeting of the PCCM Council regarding personal responsibility. It was decided that a section on personal responsibility could be added to the Prevention Issue Brief if the Council agrees to a consistent message.
 - Recommendations are being created for the Legislative Health Care Coverage Commission's Workgroup IV- Wellness. They will be voted on during the December 15th Commission meeting. Check their website for the finalized recommendations.
- Medical Home Rule- Beth Jones***
- IDPH staff are in the process of drafting and adopting rules for medical home certification. The Council voted that Iowa will use NCQA as the method to certify medical homes with the exception that Nurse Practitioners will be able to be certified as well. The internal process to establish rules can be time consuming.
 - They will go to the State Board of Health in January, and should be ready for adoption in February or early March.
- Iowa Health Benefit Exchange- Beth Jones***
- The Health Benefit Exchange website with resources and meeting information can be found here:
http://www.idph.state.ia.us/hcr_committees/health_benefit_exchange.asp
 - IDPH staff from the Medical Home System Advisory Council and the Prevention and Chronic Care Management Advisory Council has been very involved in the writing of the Iowa State Planning & Establishment Grant for the Affordable Care Act's Exchanges. It is a one-year planning grant for \$1 Million dollars. The Notice of Grant Award came on Thursday, September 30th and Iowa was awarded the full \$1 Million.
 - An Interagency Workgroup has been formed with IDPH, Iowa Medicaid Enterprise, Iowa Insurance Division, and the Iowa Department of Revenue to begin the initial planning.
 - *Background of Insurance Exchanges-* Beginning in 2014, tens of millions of Americans will have access to health coverage through newly established Exchanges in each State. Individuals and small businesses can use the Exchanges to purchase affordable health insurance from a choice of products offered by qualified health plans.

	<p>Exchanges will ensure that participating health plans meet certain standards and facilitate competition and choices by rating health plans' quality. Individuals and families purchasing health insurance through Exchanges may qualify for premium tax credits and reduced cost-sharing if their household income is between 133 percent and 400 percent of the Federal poverty level. The Exchanges will coordinate eligibility and enrollment with State Medicaid and Children's Health Insurance Programs to ensure all Americans have affordable health coverage.</p> <ul style="list-style-type: none"> • Iowa will be conducting focus groups for consumers and business, holding regional meetings across the states, and creating a new advisory council to lead this effort. <p>Iowa Health Benefit Exchange Resources:</p> <ul style="list-style-type: none"> • HBE Overview  • HBE Consumer Overview  • HBE Whitepaper- Key Decisions and Activities Table  • HBE Whitepaper- Difference Between Exchanges 
<p>Policy Implications & Collaboration- <i>Chris Atchison</i></p>	<ul style="list-style-type: none"> • Accountable Care Organizations were discussed. The MHSAC should determine a clear state approach to deal with it. • The annual report should provide ideas/recommendations regarding ACO's. • The National Academy for State Health Policy has developed an issue brief which identifies 10 aspects of federal health care reform that states must get right if they are to be successful in implementation: (this issue brief can be found here: http://www.amchp.org/Advocacy/health-reform/Documents/NASHP%20State%20Implementation.pdf) <ol style="list-style-type: none"> 1. Be Strategic with Insurance Exchange 2. Regulate the Commercial Health Insurance Market Effectively 3. Simplify and Integrate Eligibility Systems 4. Expand Provider and Health System Capacity 5. Attend to Benefit Design 6. Focus on the Dually Eligible 7. Use Your Data 8. Pursue Population Health Goals 9. Engage the Public in Policy Development and Implementation 10. Demand Quality and Efficiency from the Health Care System
<p>Determine MHSAC Next Steps</p>	<ul style="list-style-type: none"> • MHSAC Annual Report- a draft will be created and sent out. <ul style="list-style-type: none"> ○ A half hour conference will take place in January 10 to discuss the draft. • Issue Briefs- A SurveyMonkey will be sent out to determine the next issue brief to be written. <ul style="list-style-type: none"> ○ Care coordination ○ Social determinants of health ○ Community utility • MHSAC February 18th Agenda <ul style="list-style-type: none"> ○ Keith Mueller, UI College of Public Health- ACO's and the Medical Home ○ Healthy Iowans ○ Medical Home Rules
<p>The next meeting of the Medical Home System Advisory Council will be held Friday, February 18th, 9:00 – 1:00 at location TBD.</p>	