IowaCare Medical Home Model

I. Background

a. IowaCare is an 1115 demonstration waiver that expanded Medicaid to 200% of the Federal Poverty Level for adults (age 19-64) who don't otherwise qualify for Medicaid. The coverage includes single adults and childless couples. The IowaCare program has a limited benefit package (inpatient/outpatient hospital, physician, limited dental and transportation), and a limited provider network. The provider network has been limited to two providers – Broadlawns Medical Center in Polk County and the University of Iowa Hospitals and Clinics in Iowa City, which provides service statewide.

b. SF2356 as amended and passed by the Senate, expands the provider network under the current IowaCare program to include a regional primary care provider network, beginning with a phased in approach of Federally Qualified Health Centers (FQHC). The bill mandates the FQHC's selected by the Department of Human Services to provide primary health care services to the IowaCare population and to comply with certification requirements of a Medical Home.

II. Establishment of 3-4 Medical home sites beginning with phased in approach;

a. 1-2 FQHC's on western side of state
b. Broadlawns Medical Center
c. University of Iowa Hospitals and Clinics

III. Medical Home Certification

a. Sign agreement and memorandum of understanding to three year commitment in Medical Home Pilot

b. Meet Interim minimum standards for IowaCare Medical Home. Practices must demonstrate a patient-centered approach and have implemented processes that, at a minimum, are consistent with must-pass elements outlines in the NCQA PPC-PCMH standards.

- Practices must be able to meet NCQA Level 1 certification or equivalent measurement in Year one, transitioning to permanent certification process (if there is not an Iowa certification process we are looking at NCQA).
- Complete Transformed Baseline Assessment or other comparable measurement tool to demonstrate practice readiness
- On quarterly basis progress report toward obtaining Level one certification

c. Medical Home minimum standards;

1. Provider Directed Care Coordination Services aimed at managing all aspects of a members care, ensuring quality of care and safety.

- Comprehensive physical exam at time of enrollment and an age and gender appropriate physical exam on an annual basis thereafter. Each exam should include a personal treatment plan (PTP).
- Assessment of a member's health status, including risk factors, past medical diagnosis, current medical diagnosis, self management skills, and adherence to treatment plan
- Development of an individualized PTP, detailing all aspects of members medical needs

- PTP must be submitted prior to each referral

- Provide access to care and information;
  - Maintain system and written standards/protocols for tracking patient referrals, patient access and patient communication
  - Accessibility-24 hours/day, physician on call
  - Opening scheduling to allow walk ins
  - On quarterly basis report on patient access and specialty referrals

2. Care Management

- Designate a Dedicated Care Coordinator
  - Provide member with community resources, information and support to assist member with adhering to PTP, including;
    - Assisting member with medication adherence
    - Assisting with appointment and referral scheduling and reminders
    - Assisting with member wellness education, health support, and or lifestyle modification and behavior changes

- Disease Management Program
  - Improving health outcomes using evidence based guidelines and protocols
  - On quarterly basis report data on clinic outcomes

- Wellness/Disease Prevention Program
    - Promoting behavior modification aimed at supporting health management
    - Screening; Identify health risks
    - Coaching; Assisting members to both understand and mitigate identified risks

3. Health Information Technology (HIT);

    - Demonstrate evidence of acquisition, installation and adoption of an electronic health record (EHR) system
    - Established plan for meaningful use of health information exchange (HIE) in accordance with the Federal Register requirement
    - Registry Function/Immunization Registry
        - Report data from the patient registry and other records/sources for evaluation purposes

4. Performance Reporting and Quality Improvement
    - Create and follow evidence-based medical guidelines
    - Participation in Learning collaborative Meeting's on Medical Home
    - Quarterly reports to Department on member outcomes including data from Disease Registry

IV. Payment System Methodology

a. A monthly care coordination payment PMPM up front at time of member enrollment in Medical Home. Then a possible performance-

based component PMPM at end of each year based on evidenced based quality measures and member outcomes

Level of Certification/Year	Monthly Care Coordination PMPM	Performance Based Reimbursement	Possible total Reimbursement PMPM
Year 1	$3.00	$1.00	$4.00
Year 2 -Level 1	$1.50	$1.50	$3.00
Level 2	$2.50	$1.50	$4.00
Level 3	$3.50	$1.50	$5.00

b. Peer to peer conferencing reimbursement
(UIHC and BLMC reimbursement for providing specialty care consultation to FQHC's).
   - Reimbursement based on telephone evaluation and management (E/M)codes

c. Possible Federal and State assistance for HIE development, registry expansion, and meaningful use of HIT

V. Goals

a. Increase patient satisfaction with healthcare
b. Reduce percentage of IowaCare members receiving specialty services
c. Reduce duplication of services
d. Enhance communication among providers/family and community partners
e. Increase member access to healthcare
f. Meet NCQA Level 1 certification or equivalent measurement in Year one

g. Document at least one chronic disease in registry
h. Demonstrate evidence of acquisition, installation and adoption of an electronic health record (EHR) system
i. Establish plan for meaningful use of health information exchange (HIE) in accordance with the Federal Register requirement

VI. Performance Reporting and Outcome Measurement

a. Every member enrolled in the pilot, over the age of 50, should have a colon cancer screen on an annual basis via one of the below methods.
    1. Fecal occult blood test
    2. Flexible sigmoidoscopy
    3. Double contrast barium enema
    4. Colonoscopy

b. Every member enrolled in the pilot should have their BMI measured or calculated recorded in their chart, and reported to the Department on an annual basis.

c. All educational and informational printed material, provided to the enrolled members, should be culturally and linguistically appropriate

d. 100% of all members referred to the UIHC for secondary and tertiary care should be tracked via a referral tracking system (either manually (paper based) or electronically maintained).

e. At least 75% of all member will have a Medication Review at each visit to insure accurate and appropriate utilization and compliance of prescribed medications

f. At least 75% of the members enrolled in the Medical Home Pilot

are entered into the registry according to their chronic condition

g. At least 75% of all members enrolled in pilot have had their smoking status documented

h. At least 75% of all members enrolled in the pilot have annual immunizations or there is documentation that immunizations were offered, education provided to member, and member refused

i. At least 75% of all eligible women enrolled should have an age appropriate cervical screen or documentation of need for exam

j. At least 75% of all enrolled members with a diagnosis of Diabetes have had at least one HgbA1C annually

k. Each network provider in the pilot has or is in the process of developing a reminder service to inform members of appropriate preventative services

l. Each network provider in the pilot has developed an effective system of sharing clinical information with the UIHC, and will develop an efficient process for referrals to the UIHC for specialty care

VI. Provider integration/system of care approach

a. Concentration of care in Medical Home – avoidance of need for specialty visits/hospital care.
b. Development of referral protocols between providers and UIHC
c. Peer to peer consultation between medical home and UIHC specialty providers to avoid need for traveling to UIHC and higher level of care
d. Exploration of telemedicine for specialty care at Medical Home site. Options- G0406-G0408 Telehealth

PPC-PCMH Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 - 100	10 of 10
Level 2	50 – 74	10 of 10
Level 1	25 – 49	5 of 10
Not Recognized	0 – 24	< 5

Levels: If there is a difference in Level achieved between the number of points and "Must Pass", the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 "Must Pass" Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 "Must Pass" Elements are not Recognized.

PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts
A. Has written standards for patient access and communication**	**4**
B. Uses data to show it meets its standards for patient access and communication**	**5**
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	**6**
E. Uses data to identify important diagnoses and conditions in practice**	**4**
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	**3**
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	**4**
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	**7**
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	**4**
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	**3**
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician **	**3**
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

****Must Pass Elements**