Iowa Department of Human Services

Building a Health Home for Iowa Medicaid Members

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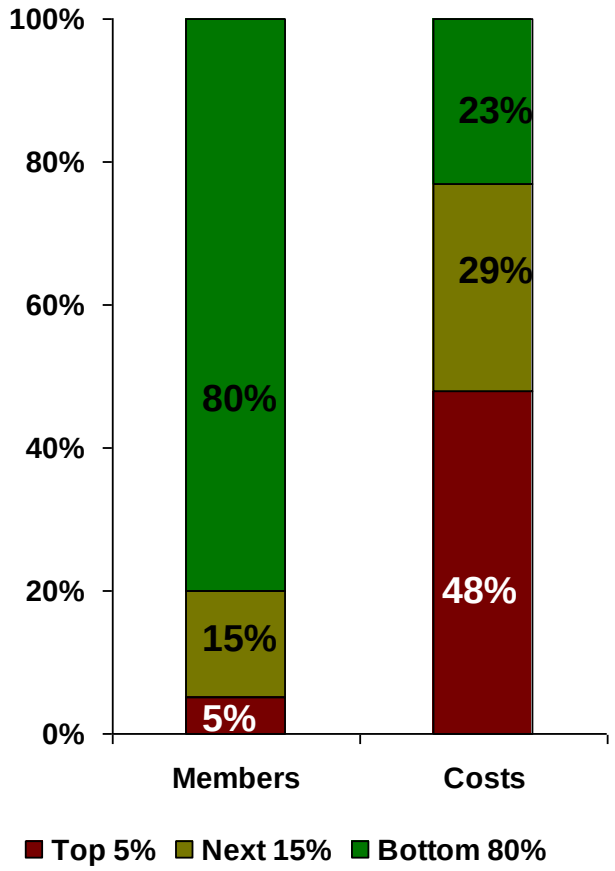
July 25, 2012



- Individuals with chronic disease drive a significant share of cost in the Medicaid Program
- 5% of members account for 48% of acute care costs*

*Excludes Long Term Care, IowaCare, Dual Eligibles, and maternity

Top 5% High Cost/High Risk Members* Accounted for:

- 90% of hospital readmissions within 30 days
- 75% of total inpatient cost
- Have an average of 4.2 conditions, 5 physicians, and 5.6 prescribers
- 50% of prescription drug cost
- 42% of the members in the top 5% in 2010, were also in the top 5% in 2009

*Excludes Long Term Care, IowaCare, Dual Eligibles, and maternity

Section 2703 of the ACA

- Option to submit a State Plan Amendment (SPA) depicting a health home model of care – ***Approved June 8, 2012!***
- Draw down a 90/10 Federal match rate for eight quarters. ***Effective July 1, 2012***
- <u>Targets members with specific Chronic Conditions (including duals)</u>

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 can practice more proactive, coordinated care that they want to provide, because of a new reimbursement structure.
- More opportunities to track, coach and engage the patient's.
- 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

IME's Proposed HH Model
Payment Methodology

In addition to the standard FFS reimbursement…

Patient Management Payment :

- Per Member Per Month (PMPM) targeted <u>only</u> 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

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 the normal IME verification process.

IME's Proposed HH Model

Quality Measures

- Preventive (pneumococcal vaccines, flu shots and BMI)
- Diabetes or Asthma
- Hypertension or Systemic Antimicrobials
- Mental Health (discharge follow-up or depression screening)
- Total Cost of Care Measure

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

Current Health Home Statistics

9 Health Home Entities Enrolled

- 10 counties
- 39 different clinic locations
- 330+ individual practitioners

IME Support of new network

- Conducting 2 Implementation TA meetings
- Collaborative Learning Network Monthly

Current Health Home Statistics

July Member Enrollments

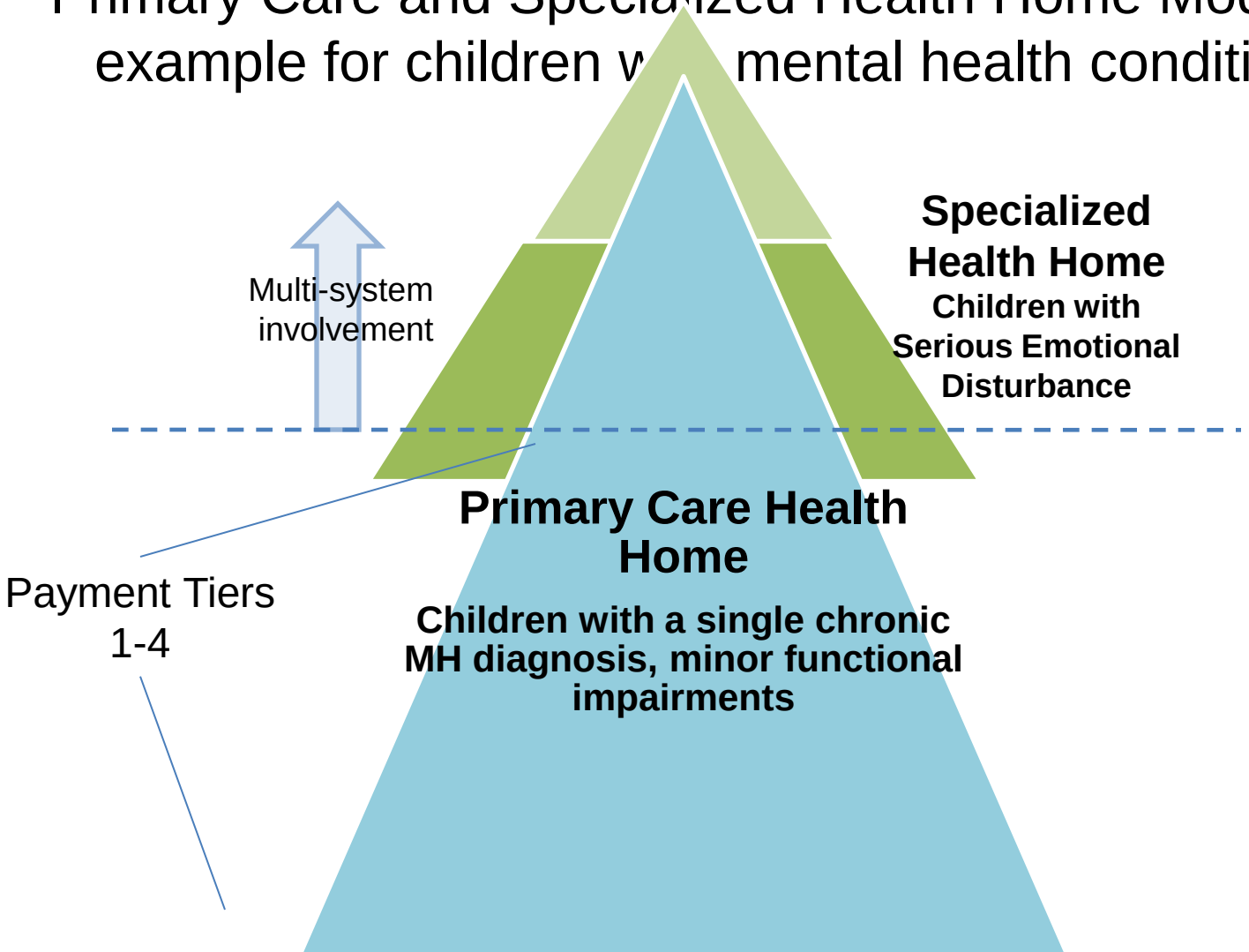
- 308 members assigned
  - 58% Tier 1
  - 38% Tier 2
  - 4% Tier 3

August enrollment number projected to approach 1000 members assigned

"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"
  - Developing separate State Plan Amendment – 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 w mental health condition



Questions?

Contact

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