Proposed Chronic Condition Health Home Program

- Section 2703 of ACA
- Health Home Concept
- IME's Proposed Strategy
- Medicare-Medicaid Members ("Duals")

Section 2703 of the ACA

- Option to submit a State Plan Amendment (SPA) depicting a health home model of care
- Draw down a 90/10 Federal match rate for eight quarters for the specific health home services
- The State is required to consult with SAMSHA/ensuring integration of mental and behavioral health services
- <u>Targets members with specific Chronic Conditions (including duals)</u>

Health Home Concept

What is a health home?

- Whole Person, Patient Centered, Coordinated Care for all stages of life and transitions of care

- Following the 7 principles of a Patient Centered Medical Home (PCMH) with added flexibility around the location which care coordination is provided

Health Home Concept

The value added for comprehensive care coordination expects:

- Initial increases in office visits, and prescription drugs utilizations
- Savings in ER, Inpatient and avoidable hospital admissions

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 does a Health Home do differently?

- Embeds population health management into their workflow and demonstrates use of data to drive quality improvements.
- Use evidenced-based guidelines to improve quality and consistently among their providers.
- Focuses on communication and coordination between referring providers to ensure comprehensive patient-centered care.
- Engages members in their own care plans
- Has an ongoing performance measurement system in place that allows the practice to measure current performance to evidence based guidelines.
- Identifies gaps in care delivered compared to clinical guidelines and deploy interventions designed to increase guideline compliance

What are the 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 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

Core Health Home Services

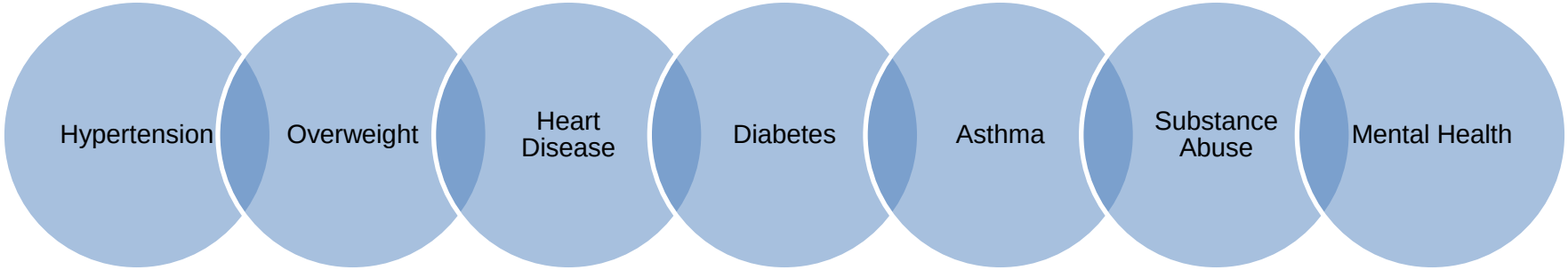
- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Support Services

IME's Proposed HH Model

Health Home Services promote a <u>TEAM</u> environment

- For example, physicians, physician assistances , nurses, care coordinators, nutritionists, social workers, behavioral health professionals, dental professionals, and chiropractors.
- Those services may or may not occur at the physical location of the health home.
- The designated provider coordinates, directs, and ensure results are relayed back to the health home.
- The use of HIT and connection to Iowa's HIN are essential

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.

IME's proposed HH 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

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
- Providers submit monthly PMPM claim / retrospectively verified through claims data

IME's Proposed HH Model

Payment Methodology

Performance payment tied to achievement of quality/performance benchmarks:

- Using the State HIN to collect measure data
- Annually, starting in year 2 correlating with state fiscal year
- Payment tied to achievement of quality/outcome measures for the health home
- Measures align with meaningful use, national quality programs and other payer initiatives

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

Anticipated program start?

April 2012
Provider Enrollment Starts

→

June 2012
Member Enrollment Starts

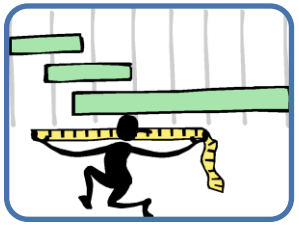
→

July 2012
PMPM Payments to Providers Start

Next Steps?

Identify Practices to enroll in April

- Review HH Provider Standards and Qualifications
- Assess Volume of Medicaid patients



Start PCMH Recognition Process

- NCQA, Joint Commission
- Identify gaps and Action Plans

Identify Qualifying Members

- Outreach to qualifying members
- Perform Tier Assessments
- Explain HH to members/Opt-in

Medicare-Medicaid Members

- "Dual Eligibles" proposal needs public input.
- IME is in the process of implementing a comprehensive approach aimed at integrating care and improving the population health of Medicare-Medicaid members.
- Please review the proposal. It will be on the IME Website by April 13th.
- Comments can be forwarded to Marni Bussell at mbussel@dhs.state.ia.us Deadline for comments is May 14, 2012.

Questions?

Contact

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