

MINUTES

National Academy for State Health Policy Site Visit

Thursday, April 8th, 2010
10:00 am – 4:30 pm
West Des Moines Learning Resource Center

Attendees

Neva Kaye - NASHP
 Mary Takach - NASHP
 Jason Buxbaum – NASHP
 Melinda Abrams (on phone) - The Commonwealth Fund
 Beth Jones – Iowa Department of Public Health, MHSAC Coordinator
 Tom Evans – Iowa Healthcare Collaborative, MHSAC Chair
 Bery Engebretsen – Iowa Nebraska Primary Care Association
 David Carlyle – Iowa Academy of Family Physicians
 Chris Atchison (on phone) – University of Iowa College of Public Health
 Jennifer Vermeer – Medicaid Director
 Andi Dykstra - Medicaid
 Denis Janssen - Medicaid
 Sally Nadolsky – Medicaid
 Angie Doyle Scar – Iowa Department of Public Health
 Abby McGill- Iowa Department of Public Health
 Jane Borst – Iowa Department of Public Health
 Deb Waldron – Child Health Specialty Clinics

Background

- Iowa was chosen as one of eight states for the National Academy for State Health Policy (NASHP) Consortium to Advance Medical Homes for Medicaid and Children's Health Insurance Program (CHIP) Participants. NASHP is supported through a grant from The Commonwealth Fund, to develop and implement policies that increase Medicaid and CHIP program participants' access to high performing medical homes.
- Each state will receive a one-year program of technical assistance to support their efforts. The technical assistance program will provide opportunities for consortium members to exchange insights and experience with national experts and their peers, as well as both in-person and distance learning and both group and individual assistance. To view the press release click [here](#).
- Iowa's NASHP team attended the Consortium's kick-off learning session to in Baltimore, Maryland in October. This meeting brought together the newly selected state teams to share information regarding medical home initiatives and policy developments with other teams in a collaborative setting.
- The 8 states — Alabama, Iowa, Kansas, Maryland, Montana, Nebraska, Texas, and Virginia were selected based on specific criteria:
 - The state's documented commitment to improving the quality and availability of medical homes to Medicaid and/or SCHIP participants;
 - The comprehensiveness of the state's plans;
 - The strength of the project team;
 - The likelihood that the state's experience, challenges, and goals for medical home advancement will offer lessons and guidance for other states; and
 - The extent to which a state's work to date offers it potential to realize maximum benefit from Consortium resources.

Topic	Discussion
Overview of Iowa's efforts to advance medical home	<i>MHSAC History</i> - In 2008, the Iowa General Assembly enacted HF 2539 , the Health Care Reform Act, which created the MHSAC, to develop recommendations on implementing a PCMH model. HF 2539 provides a blueprint for the future of a PCMH system in Iowa. The blueprint focuses on the joint principles of a PCMH, defines PCMH, and outlines needs for a statewide structure. It also outlines implementation phases that start with children enrolled in Medicaid.

MHSAC Structure/Workgroups- The MHSAC has face-to-face meetings quarterly throughout the year. Four workgroups have been created to plan and eventually implement a comprehensive Iowa-based PCMH system. They are:

- Certification Workgroup
- Reimbursement Workgroup
- Policy Workgroup
- Education Workgroup

A MHSAC Leadership Team (consisting of the IDPH coordinator, the MHSAC chair, and the chairs of the four workgroups) has been formed to effectively communicate on a bi-weekly basis information and progress of moving the medical home system in Iowa.

- NASHP staff emphasized that the policy workgroup needs to be engaged/informed on the other three workgroups. The policy connection is extremely important in all aspects of PCMH implementation

MHSAC FINAL Progress Report #1- The MHSAC released an initial Progress Report in March 2009 and provided a baseline of where Iowa was at at that time. It was designed to provide background information on development of a PCMH system, describe the current PCMH-building efforts in Iowa, and recommend pertinent building blocks to a PCMH system that meets the needs of all Iowans.

- To build, spread, and sustain the PCMH model to benefit all Iowans, the following building block recommendations are considered top priority by the MHSAC and will continue to be built upon in 2010:
 1. Continue to develop and sustain the MHSAC to promote the PCMH concept as a standard of care for all Iowans.
 2. Encourage and support the identification and implementation of a multi-payer reimbursement model that supports the PCMH.
 3. Support the current efforts to implement and expand the PCMH through existing infrastructures that educate providers and demonstrate best practices.
 4. Support health reform initiatives that address health care workforce needs, health care information technology, prevention, and chronic care management.

2010 Activities

- The MHSAC will be releasing their Progress Report #2 in April.
- Iowa submitted an application for the CHIPRA Grant- unfortunately it was not funded.
- Birth to 5 Pilot Project- IDPH received state funds through an agreement with the Department of Management's Office of Community Empowerment to implement a medical home pilot project. This project seeks to develop of a model for a community based utility that will comprehensively serve children 0-5 to address their specific needs by providing a PCMH.
 - The awarded applicant is Visiting Nurse Services of Iowa (VNS of Iowa) partnering with Iowa Health Physicians Walnut Creek Pediatrics. VNS of Iowa will serve as the community utility and Walnut Creek Pediatrics will serve as the pediatric healthcare provider. The Pilot will show what it takes for a practice to get at the PCMH level.
 - NASHP staff suggested that the pilot have an evaluation component. Ed Shore from the Commonwealth Fund might be a good possibility for the evaluation.

	<p><u>Issue Briefs</u></p> <ul style="list-style-type: none"> • Throughout 2010, the MHSAC will develop issue briefs on a variety of important topics related to the spread of the PCMH in Iowa. The issue briefs will distill the complex information on the topic so that the reader can easily understand the heart of the issue. They will educate stakeholders on Iowa specific information and data and may include recommendations from the Council related to the topic. • The first issue brief will be entitled "<i>Patient Centered- What Does it Look Like?</i>" and will summarize what patient-centered care, including family-centered care, encompasses and how it can be achieved. The concept of patient-centered care is gaining political attention and has become a central aim for our nation's health system. Yet despite growing recognition of the importance of patient-centered care, as well as evidence of its effectiveness, the nation's health care system falls short of achieving it. To dig deeper into this important topic, the issue brief will lay out improvement strategies at a practice and system level to help leverage widespread implementation of patient-centered care. • An issue brief on "<i>Disease Registries</i>" will be released collaboratively by the MHSAC, Prevention and Chronic Care Management Advisory Council, and eHealth Advisory Council. It will summarize the definition of a disease registry, how electronic health records and disease registries interrelate, and provide improvement strategies and recommendations for the development of state level chronic disease registry.
<p>MHSAC Leadership Call</p>	<ul style="list-style-type: none"> • The MHSAC Leadership Team briefly discussed the work of each of the 4 workgroups. • <u>Certification Workgroup</u>- This workgroup has been having many in-depth conversations about how medical homes should be certified in Iowa, especially in relation to the Medicaid IowaCare expansion. • <u>Reimbursement Workgroup</u>- This workgroup is bringing together partners to develop a multi-payer reimbursement model that supports PCMH spread. They have been preparing for Medicare's Advanced Primary Care (APC) Demonstration Project. The workgroup is investigating different reimbursement strategies and is collaborating with Medicaid and Wellmark to prepare for the APC Demonstration Project. • <u>Education Workgroup</u>- This Workgroup is assisting in developing the curriculum for the Medical Home Learning Community (MHLC) for 2010. The MHLC will be held twice a year- the first session on April 21st, and is geared towards primary care providers with the goal of aligning and equipping practices to become a PCMH. Participants in the MHLC work together to share best practice and lessons learned in deploying the nationally recognized PCMH model (NCQA). The Workgroup also plans to build an Iowa-based website to increase understanding of the PCMH and to provide enhanced resources. • <u>Policy Workgroup</u>- This is a newly formed workgroup that will look at policy goals for implementing PCMH in Iowa. They recognize that certifying medical homes for children is different than adults, and are analyzing how to gather those metrics. They are interested in gathering more information about neighboring states, such as Minnesota.
<p>Ideas & Options for advancing PCMH in Iowa</p>	<ul style="list-style-type: none"> • NASHP staff discussed a variety of ideas and options for advancing PCMH's in Iowa. They have done a 50 state scan on PCMH status. 20 of the states they know detailed information about. • After researching and reviewing other states, NASHP has identified five major

strategies states use to advance PCMH:

1. Forming partnerships with key players (including patients, providers and private sector payers) whose practices the state seeks to change.
 2. Defining medical homes to help establish provider expectations and implementing processes to recognize primary care practices that meet those expectations.
 3. Aligning reimbursement and purchasing to support and reward practices that meet performance expectations.
 4. Supporting practices to help advance patient-centered care, and
 5. Measuring results to assess whether their efforts are succeeding not only in changing primary care practices but also containing costs and improving quality, including patient experience.
- NASHP discussed how Iowa's structure and elements look to others from the outside. Iowa has a very strong base with the potential to move PCMH very fast.
 - Legislation ([HF 2539](#)) requires the MHSAC to develop a plan & recommendations for implementing PCMH, starting with children in Medicaid.
 - New legislation ([SF 2356](#)) expands the IowaCare program and mandates that the sites comply with certification requirements of a MH.
 - Iowa has an existing Medicaid Primary Care Case Management Program.
 - Iowa has a very strong provider interested to advance PCMH (Medical Home Learning Community participation).
 - EPSDT Coordinators are locally based and have potential for being a great resource for the pediatric population, especially for care coordination.
 - The issue briefs being produced are great and provide an understanding of what the topics actually mean.
 - Iowa needs to focus on the policy side to continue to build and sustain the movement of PCMH.

Four states were highlighted that relate to where Iowa is currently at: Oklahoma, Rhode Island, Colorado, and Montana.

Oklahoma

- OK is very similar to Iowa.
- OK has a strong primary care case management base.
- They developed a program with a broad, targeted population- everybody on Medicaid).
 - Dr. Carlyle mentioned that one dilemma Iowa faces is that we have a very small percentage of Medicaid patients. Is it enough to do practice transformation for a population of on average 15 percent or less?
 - Melinda Abrams responded that there is no data on critical mass. There is clearly a national movement, therefore all patients eventually will need to be included.
- A Physicians Advisory group was formed.
- They developed their own definition based on the Joint Principles.
- They also developed their own certification process.
 - NCQA was looked at and they decided it was far too expensive and had extensive paperwork- they didn't want that burden for the primary care providers
 - They designed their own with three tiers. It is a provider self-assessment. Medicaid hired a staff person to audit practices. The audit was done to make sure they submitted accurate information, but also to identify things

that the practice needs to change to move to the next tier.

- Reimbursement is determined by the tiers and child/adult.
- OK has ongoing incentives for practices, and transition payments in the first year.

Rhode Island

- RI uses the Joint Principles definition of PCMH.
- They use NCQA as their certification tool.
- Reimbursement is done PMPM of either \$5 or \$10 based on the enhanced services offered. Fee for services is used for some services.
- \$30 PMPM is given to practices with a nurse case manager for members at moderate to high risk. The nurse care manager helps coordinate health care needs and provides a connection to support services in the community.
- Leadership from RI's Health Insurance Commissioner was vital in bringing payers together.
- Also vital was the agreement of metrics among all payers. They are measuring the same thing and measuring them the same way.

Colorado

- Has a large focus on children in Medicaid and CHIP. They had the same legislation as Iowa (starting with children in Medicaid).
- CO developed their own definition and certification process.
 1. They gave practices the option of using NCQA.
- Reimbursement- Qualified practices receive 90% of Medicare for most CPT codes.
- Enhanced visit rates are given for EPSDT screening codes
 1. This is a large incentive to increase EPSDT screenings.
 2. Practices only get this enhanced reimbursement if the screened occurred in a certified medical home.
- CO started with a National Initiative for Children's Healthcare Quality (NICHQ) Learning Collaborative, then established criteria that the practice had to meet.
 1. They took each of the 8 domains from AAP and created measures. The 8 domains are:
 - Accessible
 - Continuous
 - Comprehensive
 - Family-centered
 - Coordinated
 - Compassionate
 - Culturally effective
- NASHP suggested that Iowa considered their technical assistance link with CO's pediatric medical home staff.

Montana

- MT's PCMH system is less developed than others, but they have put a lot of thought and focus into the community utility concept.
- They developed their own definition and are considering NCQA+ (+ for nurse practitioners)
- MT has a primary care case management program and has multi-payer buy-in.
- Community health centers are their source of "shared resources", such as a nutritionist. They also have a nurse advice line.
- There is a FQHC in a 200 mile radius throughout the state that provides

	<p>support to any practice in the area. The CHC's support the private practices to make it easier for them to become a PCMH.</p>
<p>Medicaid Discussion</p>	<p><u>Background</u></p> <ul style="list-style-type: none"> • SF 2356 has been signed by the Governor and includes a section that expands the IowaCare program. IowaCare expands Medicaid to 200% of the FPL for adults who don't otherwise qualify for Medicaid. The coverage includes single adults and childless couples. The IowaCare program has a limited benefit package and a limited provider network (limited to 2 providers – Broadlawns Medical Center in Polk County and the UI Hospitals and Clinics in Iowa City), which provides service statewide. SF2356 expands the provider network under the current IowaCare program to include a regional primary care provider network, beginning with a phased in approach of FQHCs. The bill mandates the FQHC's selected by the DHS to provide primary health care services to the IowaCare population and to <u>comply with certification requirements of a Medical Home</u>. • IowaCare currently serves around 35,000 Iowans, and grows around 1,000 each month. Medicaid is not able to implement a waiting list. • They are going to start with 2 FQHC's in western Iowa, and use a phased in approach. <p><u>Medical Home Certification</u></p> <p>An interim set of minimum standards have been developed for IowaCare that the FQHC's will be required to meet the first year:</p> <p><u>Medical Home minimum standards</u></p> <ol style="list-style-type: none"> 1. Access to care and information; <ul style="list-style-type: none"> ➤ Accessibility-24 hours/day, physician on call 2. Care Management <ul style="list-style-type: none"> ➤ Comprehensive physical exam, and Personal Treatment Plan on annual basis ➤ Disease Management Program ➤ Wellness/Disease Prevention Program 3. Health Information Technology (HIT); <ul style="list-style-type: none"> ➤ 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 <ul style="list-style-type: none"> • NASHP emphasized that these standards are good, but will need to be detail them out further. • These standards will need to be met by the FQHCs the first year. Discussion took place on what certification would be after that. A national model (NCQA) is most ideal. They could easily become NCQA level 1 certified in 1 year. <ul style="list-style-type: none"> ○ Further discussion took place about Minnesota's tiers and payment mechanism. Neva Kaye emphasized that we need to keep in mind that they economist who determined the cost of care coordination etc.
<p>Improving Child Health Quality through Medical Home Implementation in</p>	<ul style="list-style-type: none"> • Deb Waldron with Child Health Specialty Clinics lead this discussion. • HF 2539 determined that the first population Iowa will target to spread the PCMH is children in Medicaid. • Colorado Children's Healthcare Access Program is very similar to Deb Waldron's group and could form a partnership. It is a non-profit organization

<p>Pediatric Primary Care</p>	<p>devoted to ensuring that every child enrolled in Medicaid and Child Health Plan Plus (CHP+) receives comprehensive health care from a primary care provider.</p> <ul style="list-style-type: none">• Four areas of focus of PCMH should be targeted with a pediatric perspective:<ol style="list-style-type: none">1. Family centered partnership-trusting, collaborative, working partnership with families, respecting diversity2. Community based system- (medical neighborhood)- goes beyond the medical home concept by working with the community surrounding the child: family, agency coordinators, the school system, and the social support systems3. Transitions- developmentally appropriate, health services that continue uninterrupted as individual moves along and within system of services and from adolescence through adulthood4. Value- appropriate payment to support and sustain medical homes that promote quality care- optimal health outcomes, family satisfaction, and cost efficiency.• One focus of Dr. Waldron is on late-term preemies and the need to get them appropriate care and screenings. They tend to fall through the cracks and should not be treated the same as full-term babies.• Iowa should support pediatric quality improvement endeavors and quality measures- primary purpose to improve patient care and outcomes (includes health status and patient satisfaction)• Iowa should also utilize resources of newly created IA Child Health Improvement Partnership- incorporate evidence based clinical guidelines, orchestrate learning opportunities, provide tools for screening and assessment, link community resources, help measure progress, share findings with public health and policy makers.
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