

Iowa was one of six states selected to participate in a 15-month “Medicaid-Safety Net Learning Collaborative.” The learning collaborative and this paper was made possible by the Health Resources and Services Administration (HRSA grant number UD3OA22891). The purpose of the learning collaborative was to support partnerships between Medicaid and safety net partners on projects that addressed state priorities. The National Academy for State Health Policy (NASHP) provided state teams with an array of technical assistance, including an in-person group meeting, site visits, facilitated access to federal, state, and national experts, and team calls. The contents of this paper are solely the responsibility of NASHP and do not necessarily represent the official views of HRSA.

Supporting Iowa Rural Provider Capacity Through Community Care Coordination Teams

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Maximizing the participation of eligible safety net primary care providers in both state and federal health reform activities was Iowa’s first priority in its application to participate in NASHP’s Medicaid-Safety Net Learning Collaborative. The Collaborative was funded by a HRSA Cooperative Agreement from May 2012–August 2013. The purpose of this brief is to provide an overview of the steps taken by the Iowa team from planning to launching a “Community Care Coordination Team Pilot.” The path taken by Iowa offers a framework for policy action for states and other organizations considering leading similar efforts to link primary care with comprehensive services in community-based settings. Other states have found community-based care team pilots to be scalable and sustainable through financing from public and private payers.¹

BACKGROUND

Iowa has embarked on a health reform agenda that has gained significant momentum from Affordable Care Act (ACA) funding opportunities. Through the ACA, Iowa received the Centers for Medicare & Medicaid Services (CMS) approval of a Section 2703 health homes state plan amendment in June 2012 to further primary care and behavioral health integration² as well as a State Innovation Model Design award in February 2013 to develop multi-payer accountable care initiatives.³ Iowa policymakers were concerned that primary care providers, especially those in rural areas, would

be challenged to participate in these and other health reform efforts that emphasize patient-centered, comprehensive, team-based care supported by value-based payment models. Rural primary care practices in Iowa and two other states surveyed during 2011 were found to lag behind their urban counterparts in developing patient-centered medical home (PCMH) capacity, likely due to limited access to necessary resources.⁴ Like rural practices, small- and medium-sized practices are similarly challenged. In a study using data from the National Study of Small- and Medium-Sized Practices, these practices used just one-fifth of the patient-centered medical home processes.⁵ Both of these studies point to the need for practices to share resources, including teams of providers.

Over the past several years in Iowa, there has been a growing interest in the concept of developing a “community utility” – a public good in which everyone contributes and everyone benefits – to support key features of a PCMH.⁶ Through participation in the Medicaid-Safety Net Learning Collaborative, the Iowa team learned about ways to operationalize this community utility concept through the implementation of “shared community-based teams.”

Shared community-based teams have been a growing trend among states over the past several years and have enabled providers of varying capacity, especially small and rural practices, to participate in delivery reforms that emphasize team-based care, especially PCMH models.⁷ These shared community-based teams —found in states such as North Carolina,⁸ Vermont,⁹ and Maine¹⁰ —provide an array of targeted services, from care coordination to self-management coaching, and feature frequent in-person contact with patients and integration with primary care providers and community resources. These teams provide services to support many practices in a region. Financing of these teams can be single payer, multi-payer, or grant-based. Over 17 months, the Iowa team took their concept for community-based teams and fully developed and launched their pilot using the following key steps:

1. Assemble a small, nimble team. All state teams participating in the NASHP Medicaid-Safety Net Learning Collaborative were required to include Medicaid

and safety net provider organization leadership, and to develop a common work plan. The Iowa team was comprised of senior staff from Medicaid, the Iowa Primary Care Association, and the University of Iowa Public Policy Center. This team had a strong history of collaboration fostered by groundwork laid by several prior initiatives including a legislatively established Medical Home Systems Advisory Council and Iowa Safety Net Provider Network,¹¹ as well as a Commonwealth Fund Safety Net Network grant, to name a few. The Iowa PCA was well positioned to take the helm of their team and provide momentum for participation in the collaborative.

2. Immerse team in strategies used from other states.

A key feature of learning collaboratives is peer-to-peer education. The Iowa team’s “Aha!” moment came during a July 2012 NASHP Medicaid-Safety Net Learning Collaborative kickoff meeting with five other state teams, during which one of the invited presenters spoke about piloting community care teams for the Maine PCMH Pilot.¹² After the meeting, Iowa requested and received additional information about shared community-based teams and engaged directly with policymakers and program managers from the Maine PCMH Pilot, Vermont Blueprint for Health Community Health Teams, and the Patient Care Networks of Alabama through small group webinars.

3. Define the Concept. After researching other state efforts, the Iowa team put together materials including a concept paper¹³ and webinar¹⁴ that described exactly what the shared community-based teams meant to them.

4. Educate key local constituencies. Using the concept materials developed for this project, the Iowa team began educating and soliciting feedback from state legislators and staff, the Iowa Department of Public Health, the Iowa Safety Net Provider Network,¹⁵ community-based organizations, provider organizations, behavioral health agencies, major commercial payers, and others. The Iowa team leveraged existing grant funds and partnerships and convened in-person meetings including a Community Transformation Grant-supported technical assistance session in August 2012 that featured a speaker from the Community Care of North Carolina to share lessons learned in developing that state’s

network of community-based teams.¹⁶ A “Community Care Coordination Learning Opportunity,” hosted by the Iowa PCA in April 2013 included speakers from NASHP and three states with experience in developing community-based teams: Alabama, Minnesota, and Vermont.¹⁷ The Iowa team also engaged local stakeholders via conference calls, webinars, a webpage,¹⁸ and through the use of a listserv made up of safety net providers from across the state.

5. Seize the moment. The development of the pilot program coincided with the convening of the 2013 Iowa legislative session. This provided an opportunity to gain support from a key legislator to add funding for community-based care coordination teams to an appropriations bill. (Most other states adopting community care teams have public and/or private payer support.¹⁹) After the legislation was introduced, members of the Iowa team convened a meeting with other key Democratic and Republican legislators to build support for the bill. On June 20, 2013, the legislature approved \$1,158,150 for pilot funding.²⁰ Shortly after, the governor signed the legislation into law. In addition, the development of the Iowa’s State Innovation Model (SIM) Design grant provided an opportunity to connect and further this work with the creation of multi-payer accountable care organizations.²¹

6. Gauge community interest. After the legislation was signed into law, the Iowa PCA sprang into action and developed a letter of intent (LOI) released on August 12, 2013 to gauge statewide interest in the pilot and to further hone key pilot criteria. The Iowa PCA used other state examples and incorporated input from key constituencies—including the Safety Net Provider Network—to develop the LOI. The Iowa PCA hosted two informational webinars regarding the pilot in July 2013 and posted information on their webpage, including a “Frequently Asked Questions” document.²² The LOIs were due one month later. Fifteen letters were received and eight communities were invited to the Request for Proposal (RFP) round.

7. Establish essential pilot priorities. Under a tight timeline, the Iowa team found using lessons from trailblazing states useful in developing pilot priorities [see text box] and released the full RFP²³ to selected organizations on September 23, 2013, with the

deadline for submission on October 25, 2013. The two-stage process – LOI, followed by RFP – gave organizations with strong qualifications adequate time to develop full proposals to participate in the pilot. An in-person site visit was conducted with all eight of the communities invited to submit a full RFP. During this time, the Iowa team also established an Independent Review Committee. The committee met and selected two regional pilot sites – a hospital and a public health department – to receive \$300,000 in start-up funds each and made the announcement in November 2013.²⁴

8. Develop state infrastructure to support the pilot.

The Iowa PCA is providing pharmacy and behavioral health technical assistance to the two teams, but also to the applicant organizations and other interested parties. The pharmacy technical assistance will focus on improving medication adherence and patient outcomes and enhancing the role of the pharmacist as an integral member of the Community Care Coordination team. The behavioral health technical assistance will primarily focus on integration of care between primary care and behavioral health providers with emphasis on helping primary care providers understand the role they can play to more appropriately address, triage, and manage behavioral health issues. In addition, the Iowa PCA has met several times with the Iowa Department of Human Services and Iowa Medicaid staff to ensure the project closely aligns with the SIM model and request their assistance in providing data to determine improvement in overall total costs of care. The Iowa PCA has hired a contractor to run the program and will share information from community-based teams formed in other states with the teams.

9. Plan for long-term sustainability. The Iowa team has requested another year of funding for the two existing teams as well as funding for two additional teams for the 2015 state fiscal year (SFY15). Status quo funding for the initiative was included in the Governor’s budget for SFY15. Data regarding the start up and initial impact of the first two Community Care Coordination pilots will be provided to policymakers via an evaluation being conducted by a team from Rural Health Solutions and the University of Iowa Public Policy Center. In addition, the Iowa team is also focused on creating connections between the Community Care Coordination

KEY FEATURES OF IOWA'S COMMUNITY CARE COORDINATION TEAMS

- Offer shared services to multiple primary care practices to expand their capacity to serve as PCMHs
- Provide care coordination, disease and care management support, transitional services, and more
- Focus on high-risk/high-need Medicaid and uninsured populations
- Engage practices in quality improvement initiatives
- Link to existing community resources to address social and behavioral needs
- Align with state efforts to provide pharmacy home and behavioral health integration technical assistance

teams and Iowa's Medicaid Accountable Care regions – both programs debuted January 2014. After receiving numerous strong applications, the Iowa team is already planning for the spread of additional Community Care Coordination teams. Unfunded applicants were encouraged to apply for start-up funding under the HRSA Rural Health Network Development Planning Program²⁵ and the Iowa PCA has also approached foundations in the state to consider funding a team.

Summary

A history of collaboration and cooperation has yielded a trusting partnership among members of the Iowa Medicaid-Safety Net Learning Collaborative team. Strong leadership among team members with a seasoned eye toward capitalizing on policy opportunities enabled the Iowa team to move from concept – community utility – to a pilot project that launched two community care coordination team pilots in rural Iowa.

ENDNOTES

1 For more information on community health teams, see Mary Takach and Jason Buxbaum, "Care Management For Medicaid Enrollees Through Community Health Teams" (New York, NY: The Commonwealth Fund Publication, May 2013).

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