

Medical Home System Advisory Council Progress Report #3

April 2011

Background

In 2008, the Iowa General Assembly enacted HF 2539, the Health Care Reform Act¹, which created the Medical Home System Advisory (MHSAC) within the Iowa Department of Public Health (IDPH) to develop recommendations on implementing a patient-centered medical home (PCMH) model. The Health Care Reform Act provides a blueprint for the future of a PCMH system in Iowa. The blueprint focuses on the joint principles of a PCMH (as agreed to by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association), defines PCMH, and outlines needs for a statewide structure.

What is a Patient-Centered Medical Home?

Iowa's medical home definition (HF 2539 and adopted by the MHSAC): "medical home" means a team approach to providing health care that:

- originates in a primary care setting;
- fosters a partnership among the patient, the personal provider, other health care professionals, and the patient's family when appropriate;
- utilizes the partnership to access all medical and non-medical health-related services needed by the patient and family to achieve maximum health potential; and
- maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and
- includes the following characteristics: a personal provider; a provider-directed medical practice; whole person orientation; coordination and integration of care; quality and safety; enhanced access to health care; and payment.

The PCMH system will strive to:

- reduce disparities in health care access, service delivery, and health status;
- improve quality of health care and lower health care costs, thereby creating savings to allow more Iowans to have health care coverage within a sustainable health care system; and
- provide a pragmatic method to document that each Iowan has access to health care.

Progress Reports and Issue Briefs

The MHSAC is legislatively charged to submit annually to the Governor and General Assembly a report regarding the improvements to and the continuation of the PCMH system. The Council has also chosen to develop issue briefs on a variety of important topics related to the spread of the PCMH in Iowa. These progress reports and issue briefs can be found at the MHSAC website under the "Resources" tab: <http://www.idph.state.ia.us/MedicalHome/>

Initial Recommendations

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 2011:

1. Continue to develop and sustain the Iowa 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 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.

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Medical Home Certification in Iowa

It has been established that certification of medical homes in Iowa will be done through the National Committee for Quality Assurance Physician Practice Connections–Patient Centered Medical Home (NCQA PPC-PCMH) tool,ⁱⁱ with the exception that Nurse Practitioners will be able to be certified as well. The MHSAC voted on this decision, and IDPH is in the processes of adopting administrative rules regarding certification. The NCQA tool “takes a systems approach to recognition by assessing practice performance on nine standards: access and communication; patient tracking and registry functions; care management; patient self-management support; electronic prescribing; test tracking; referral tracking; performance reporting and improvement; and advanced electronic communications.” On January 31, 2011, NCQA released new standardsⁱⁱⁱ which call on medical practices to be more patient-centered, and reinforce federal “meaningful use” incentives for primary care practices to adopt health information technology.

Priority Areas

To advance the effort of transforming primary care into a PCMH model, the MHSAC has determined six priority areas with additional recommendations to focus on in 2011.

Primary Care Workforce Shortage

Recommendation: Support state and federal efforts to reverse the decline in primary care workforce and access to dental services in Iowa by addressing the utilization of alternative staffing models including mid-levels.

Evidence shows that expanding access to primary care will significantly improve health outcomes, lower healthcare costs, and benefit the national economy.^{iv} By addressing the primary care workforce shortage, more Iowans will receive effective, regular primary and preventive care in a medical home. This results in reduced hospitalizations, lower use of emergency rooms, and fewer referrals to costly specialists.

Health Professional Shortage Areas (HPSA), established under the US Public Health Service Act (Sections 330 and 332), are federal designations of geographic areas (population groups or facilities) which meet the criteria as needing additional primary health care services. The percentage of Iowans located within a designated Primary Care HPSAs is 36 percent. This equals 214 Primary Care HPSAs throughout Iowa in 54 counties.^v

The shortage of primary care physicians is increasing due to our current payment system. The current fee-for-service reimbursement system pays providers based on the volume of care delivered, providing financial incentives to perform more medical procedures, rather than providing preventative services, education, diagnosis, or prescriptions. Because primary care providers spend relatively less time doing procedures, this reimbursement system results in a large income difference between family physicians and specialists. Graduating medical students faced with repaying loans averaging over \$100,000 are more likely to enter a higher-paying specialty career.^{vi} Many are hoping, however, that the PCMH model will actually attract new medical professionals into primary care with the promise of fundamental improvements in care delivery.

Mid-level providers including physician assistants, nurses, pharmacists, community health workers, and others will be needed to fill the primary care shortage gap. By 2014, 32 million additional Americans are going to have health insurance, and the shortage of primary care

physicians is likely to grow.^{vii} The PCMH concept focuses on a health care team, made up of different types of professionals, who collectively takes responsibility for the ongoing care of patients.^{viii}

Accountable Care Organizations

Recommendation: Continue to monitor and discuss the federal direction of the Accountable Care Organization model and determine implications for Iowa.

The current U.S. health care system uses a fee-for-service reimbursement model, which has been reported to incentivize providers to perform more procedures and provide additional services. Additionally, different providers who see the same patient lack the information or resources to coordinate care, resulting in duplicative or conflicting treatment. Accountable care organizations (ACOs) are a solution to overcoming these challenges in providing high-quality and cost effective care.

ACOs represent a health care model where organized groups of physicians, hospitals or other providers jointly provide care and share accountability for the cost and quality of care for a population of patients. As the model is generally unfolding across the nation, payers contract with ACOs to care for a defined group of patients, using financial incentives to encourage ACOs to produce improved health outcomes and reduce overuse of medical care.^{ix} Because ACO members will share in the savings that results from their cooperation and coordination, they can theoretically act as a reform tool by incentivizing more efficient and effective care. This would help to combat the current fee-for-service incentives of overutilization of health care services.^x

Three important activities related to ACO development must occur to meet the goal of improving the quality and efficiency of care:

- Policy makers and payers must create new payment arrangements, performance measures, reporting processes, and other programmatic features designed to promote provider accountability for improving quality and increasing efficiency.
- A sufficient mix of providers must decide to form an ACO to contract with payers on the basis of the cost and quality of care for a population of patients.
- Providers working together in ACOs adopt practice changes in how care is delivered to patients to improve the quality and efficiency of care.^{xi}

IowaCare Expansion

Recommendation: Support additional resources to advance the IowaCare Medical Home Pilot Project to sustain continued rollout of the Federally Qualified Health Centers.

IowaCare is a limited health care program that covers adults ages 19-64 who are 200% and below the federal poverty level, and who are categorically excluded from Medicaid and do not have comprehensive private insurance. IowaCare covers inpatient and outpatient services, physician and advanced registered nurse practitioner services, limited dental services, routine yearly physicals, tobacco cessation, and a limited prescription drug benefit. IowaCare members have a high incidence of unmanaged chronic conditions, and the IowaCare population continues to grow.

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On October 1, 2010, the IowaCare Medical Home pilot^{xii} was launched under Senate File 2356. The two goals of the expansion are to phase in Federally Qualified Health Centers (FQHCs) to provide primary health care services to the IowaCare population and to comply with certification requirements of a Medical Home. With the first phase-in, approximately 25,000 members (about half of the entire IowaCare population at the time) were assigned to a medical home where they will receive routine care, preventive services, and disease management at four designated clinics:

- Siouxland Community Health Center in Sioux City
- Peoples Community Health Clinic in Waterloo
- Broadlawns Medical Center in Des Moines
- University Hospitals and Clinics in Iowa City

Over the next few years, the program is likely to expand across Iowa using existing FQHCs to effectively assign every IowaCare member to a centrally located medical home.

After the initial rollout of the IowaCare Medical Home pilot, a number of financial impacts raised concern. The original phase-in plan had FQHCs added January 1 and March 1. These rollout dates were delayed due to working through medical home coordination of care issues among providers and assessing the fiscal impacts of adding more FQHCs. Current projects are very close to the federal budget caps, and Medicaid will be facing a budget shortfall in SFY13 due to the growth and elimination of the one-time federal match increase. Enrollment in the IowaCare program is growing faster than expected, especially in the new medical home areas. This growth will continue as more medical homes are added, which has significant fiscal impacts. Additionally, IowaCare members are sicker and have a higher incidence of unmanaged chronic conditions than the Medicaid population. This leads to a larger number of visits per year than expected, which also has fiscal impacts.

Multipayer Collaboration

Recommendation: Continue to develop and sustain the Medical Home Multipayer Collaborative Workgroup to advance the development of a multipayer pilot in Iowa.

In June 2010, a Medical Home Multipayer Collaborative Workgroup was formed which brought together key medical home stakeholders and payers in Iowa to plan for a state multipayer pilot project. This synergy was formed due to in depth conversations being had to determine if Iowa should apply for the Centers for Medicaid Services (CMS) Multipayer Advanced Primary Care Practice Demonstration Project, which was released on June 2nd, 2010.

Under this demonstration project opportunity, CMS agreed to participate in multi-payer reform initiatives that were currently being conducted by states to make advanced primary care practices more broadly available. The demonstration would evaluate whether advanced primary care practice will reduce unjustified utilization and expenditures, improve the safety, effectiveness, timeliness, and efficiency of health care, increase patient decision-making and increase the availability and delivery of care in underserved areas. Iowa currently does not have a developed multi-payer reform initiative. For that reason, along a variety of others, Iowa decided not to apply.

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In order to be prepared for subsequent opportunities from CMS, the MHSAC decided that Iowa needs to bring together providers, payers, and consumers to form a Multipayer Collaborative Workgroup to move forward in developing a multipayer initiative. States that participate in multipayer collaboratives report that they do so to gain provider buy-in. Providers are more likely to invest time and resources if their administrative burden is reduced because of aligned expectations among payers. In addition, public and private payers—including states with Medicaid fee-for-service, and purchasers (employers and states with managed care contracts)—want to spread the costs and risks of medical home investments across all those that benefit.^{xiii}

The Medical Home Multipayer Collaborative Workgroup has established key shared goals:

- *Keep the multipayer pilot patient-centered*
 - Considerable research has been done that shows patient-centered care delivered by primary care physicians in a PCMH is consistently associated with better outcomes, reduced mortality, fewer preventable hospital admissions for patients with chronic diseases, lower utilization, improved patient compliance with recommended care, and lower Medicare spending.^{xiv}
- *Payment should not drive care*
 - The multipayer pilot should reform payment so that providers are reimbursed for delivering quality services that are proven to keep people healthy, reduce errors and help avoid unnecessary care, rather than be reimbursed by the volume of services they provide.
- *Medical Home Learning Community (MHLC) participants should launch the state-wide multipayer pilot*
 - The Iowa Healthcare Collaborative hosts a MHLC^{xv} to equip practices in becoming a PCMH. The MHLC brings practices together to focus on practice transformation and to explore the standards for NCQA recognition of medical home status. Currently, 60 practices in Iowa are participating in the MHLC.
- *The patient population should not be segmented*
 - The PCMH concept emphasizes that patients are treated for with the same high-quality care, no matter their insurance status, age, race, etc.

Prevention and Chronic Disease Management

Recommendation: Collaborate with the Prevention and Chronic Care Management Advisory Council to improve incentives for prevention and chronic disease management by providing support for care through payment systems, organization and delivery of care, and care coordination through a patient-centered medical home.

Providers currently treat their patients in a reactive manor – treating people when they get sick, rather than proactive – focusing on prevention and wellness to keep people healthy. This payment system leads to the dramatic growth of chronic diseases, which are a huge burden to America. An alarming 75 cents of every health care dollar is spent on chronic diseases, and they account for 7 out of every 10 deaths.^{xvi} In 2007, chronic diseases accounted for 68% of all deaths in Iowa.^{xvii}

If this problem is ignored, the cost of treating chronic conditions such as diabetes, cancer, and obesity could overwhelm American health care. The payment system should be reformed to ensure that providers are reimbursed for providing care coordination and delivering quality

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services that are proven to keep people healthy, reduce errors and help avoid unnecessary care, rather than be reimbursed by the volume of services they provide. Keeping people healthier by increasing preventive care and managing chronic conditions are very effective strategies to reduce health care costs and improve the health of Iowans.

The Prevention and Chronic Care Management (PCCM) Advisory Council, also created by HF 2539, is charged with developing a state initiative that integrates evidence-based prevention and chronic care management strategies into public and private health care systems, including the patient-centered medical home system. Strong collaboration with the PCCM Advisory Council will be necessary to improve incentives for prevention and chronic disease management by providing support for care through payment systems, organization and delivery of care, and care coordination through a patient-centered medical home.

Health Information Exchange

Recommendation: Support the implementation of the statewide Health Information Exchange in Iowa.

The Iowa Health Information Exchange (HIE) allows electronic health records data to be securely shared among health care providers (e.g., clinics, hospitals, pharmacies, etc).

Iowa's HIE will allow providers to access vital patient information where and when it's needed. With a connection to the HIE, providers will be able to share patients' health information (e.g., medications, allergies, problem lists, clinical summaries, lab orders and results) with other Iowa providers, and eventually with providers across the nation through the nationwide health information network.

By establishing the statewide HIE infrastructure, Iowa will be more prepared to fully use health information technology to improve quality of health care, assure patient safety, and increase efficiency in patient-centered care and population health in Iowa.

Conclusion

The MHSAC is eager to share this annual report to guide and educate Iowa's stakeholders and policymakers on the implementation of a PCMH system in Iowa. The Council is prepared to play leadership and participant roles in these priority area recommendations to move the PCMH concept forward. Additionally, the MHSAC continues to view and address the initial building blocks recommendations as vital components to a reformed health care system.

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Council Members

Name	City	Position
Chris Atchison	Iowa City	University of Iowa College of Public Health
Melissa Bernhardt, DDS	West Des Moines	Iowa Dental Association
David Carlyle, MD	Ames	Iowa Academy of Family Physicians
Libby Coyte, PA	Redfield	Iowa Physician Assistant Association
Kevin de Regnier, DO	Winterset	Iowa Osteopathic Medical Society
Bery Engebretsen, MD	Urbandale	Iowa Nebraska Primary Care Association
Tom Evans, MD	Des Moines	Iowa Healthcare Collaborative
Carrie Fitzgerald	Des Moines	The Child and Family Policy Center
Ro Foege	Mt. Vernon	Consumer
Rep. Wayne Ford	Des Moines	Urban Dreams
Jeffrey Hoffmann, DO	Guttenberg	Iowa Academy of Family Physicians
Don Klitgaard, MD	Harlan	Iowa Medical Society
Petra Lamfers, ARNP	Belmond	Iowa Nurses Association
Mary Larew, MD	Iowa City	American Academy of Pediatrics, Iowa Chapter
Linda Meyers, RDH	Council Bluffs	Dental Hygienist
Tom Newton	Des Moines	Wellmark Blue Cross Blue Shield
Jane Reinhold	Bettendorf	Consumer
Elayne Sexsmith	Des Moines	Governor's Developmental Disabilities Council
Anne Tabor, MPH, RD/LD	Iowa City	Iowa Dietetic Association
CoraLynn Trewet	Des Moines	Iowa Pharmacy Association
Jennifer Vermeer	Des Moines	Department of Human Services
Kurt Wood, DC	Davenport	Iowa Chiropractic Society

ⁱ <http://coolice.legis.state.ia.us/Cool-ICE/default.asp?Category=billinfo&Service=Billbook&menu=false&qa=82&hbill=HF2539>
accessed January 2009.

ⁱⁱ <http://www.ncqa.org/tabid/631/default.aspx>

ⁱⁱⁱ <http://www.ncqa.org/tabid/1300/Default.aspx>

^{iv} <http://www.nachc.org/client/documents/pressreleases/PrimaryCareAccessRPT.pdf>

^v http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/hltcw_jan08.pdf

^{vi} <http://www.kaiseredu.org/Issue-Modules/Primary-Care-Shortage/Background-Brief.aspx>

^{vii} <http://www.whitehouse.gov/healthreform/relief-for-americans-and-businesses>

^{viii} http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf

^{ix} <http://content.healthaffairs.org/content/26/1/w44.abstract>

^x <http://www.healthreformwatch.com/2010/03/11/a-guide-to-accountable-care-organizations-and-their-role-in-the-senates-health-reform-bill/>

^{xi} <http://www.nihcr.org/Accountable-Care-Organizations.pdf>

^{xii} http://www.idph.state.ia.us/hcr_committees/common/pdf/medical_home/063010_iowacare_model.pdf

^{xiii} <http://www.nashp.org/sites/default/files/MedHomesWebinar.pdf>

^{xiv} Patient-Centered Primary Care Collaborative. The Patient-Centered Medical Home: A Purchasers Guide.

http://www.pcpcc.net/files/PurchasersGuide/PCPCC_Purchaser_Guide.pdf

^{xv} <http://www.ihconline.org/asp/eventsdetail.aspx?eid=67>

Centers for Disease Control and Prevention, http://www.cdc.gov/pcd/issues/2009/apr/08_0236.htm

^{xvii} Healthy Iowans. Iowa Chronic Disease Report. 2009. Available at

http://www.idph.state.ia.us/apl/common/pdf/health_statistics/chronic_disease_report.pdf