IowaCare Medical Homes and ACA Health Homes

June 16th 2011

Presentation to:
Prevention and Chronic Care Management Advisory Council

Iowans Working Together... Doing What Works

Iowa Department of Human Services

Presentation Overview

1. IowaCare Progress Report
2. ACA Health Home Development

IowaCare Progress Report

Overall, the IowaCare medical homes are managing diabetes patients better than the general Medicaid population.

- 2,351 Diabetes Patients are in an IowaCare Medical Home
- 85% of medical home members have had an A1c in the last twelve months, compared to 44% of Medicaid patients

Disease Management Diabetes:

2010 Q4

Diabetes Disease Management	A	B	C	D	Overall
# in Registry					2211
# with A1c in last 12 months	90%	26%	93%	79%	83%
A1c less than 7 (ideal)	38%	5%	44%	45%	42%
A1c between 7 - 9 (moderate control)	36%	12%	29%	27%	29%
A1c greater than 9 (not in control)	16%	10%	20%	8%	12%
Dilated eye exam	20%	19%	10%	3%	9%
LDL-C checked	72%	24%	55%	67%	67%
LDL-c<100 mg/dL	58%	80%	59%	56%	63%
microalbumin	70%	5%	61%	49%	56%

2011 Q1

Diabetes Disease Management	A	B	C	D	Overall
# in Registry					2351
# with A1c in last 12 months	94%	74%	89%	79%	85%
A1c less than 7 (ideal)	38%	45%	40%	43%	41%
A1c between 7 - 9 (moderate control)	36%	19%	28%	27%	30%
A1c greater than 9 (not in control)	20%	10%	20%	9%	14%
Dilated eye exam	18%	8%	13%	2%	9%
LDL-C checked	71%	40%	58%	67%	66%
LDL-c<100 mg/dL	56%	66%	49%	55%	56%
microalbumin	73%	3%	58%	46%	55%

IowaCare Progress Report

- Access has increased for IowaCare patients in a medical home

- In the last 6 months
  - 18,717 same day visits for emergent care needs through a primary care office
  - 49,137 patient encounters have occurred at a primary care office
  - Average .91 encounters per member

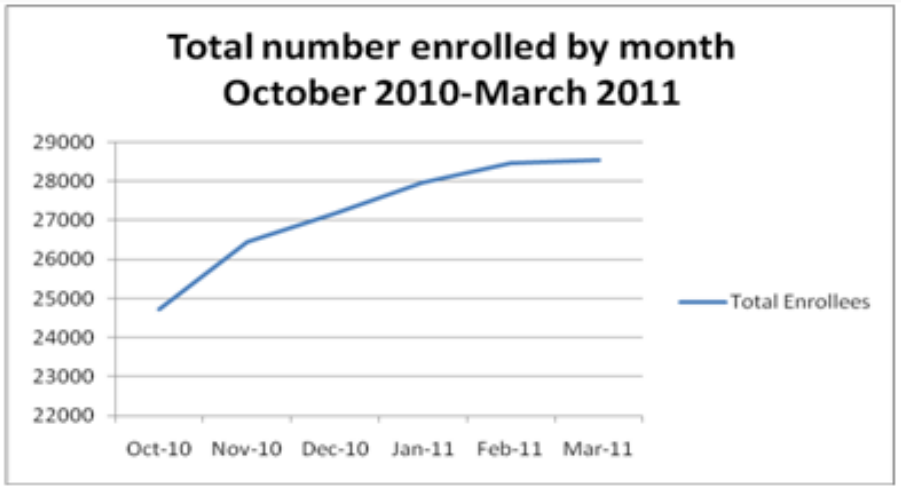
IowaCare Progress Report

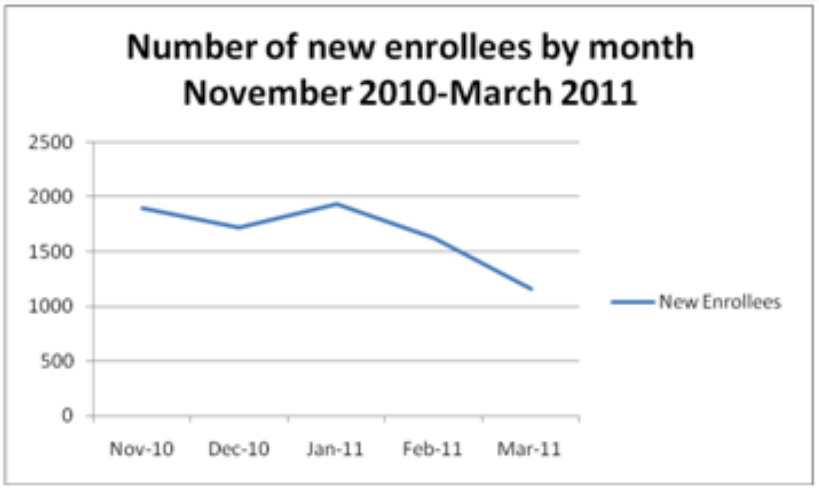
- Non-emergent care wait times vary from medical home to medical home, using the standard measurement of the 3rd next available appointment, wait times varies from 1 week to 11 weeks.

- Referral tracking continues to be a problem within the Medical Home network. Access to referral data has been challenging.
  - Interpretations of HIPPA regulations
  - The lack of stable or well established HIT connections between the medical homes and UIHC hinders communication for referrals, discharges and transfers of care data

IowaCare Progress Report

- As of 3/31/2011, there are 28,539 members in a medical home, a 3,814 increase since October 2010
- Over 8,300 members are new to IowaCare since October 2011



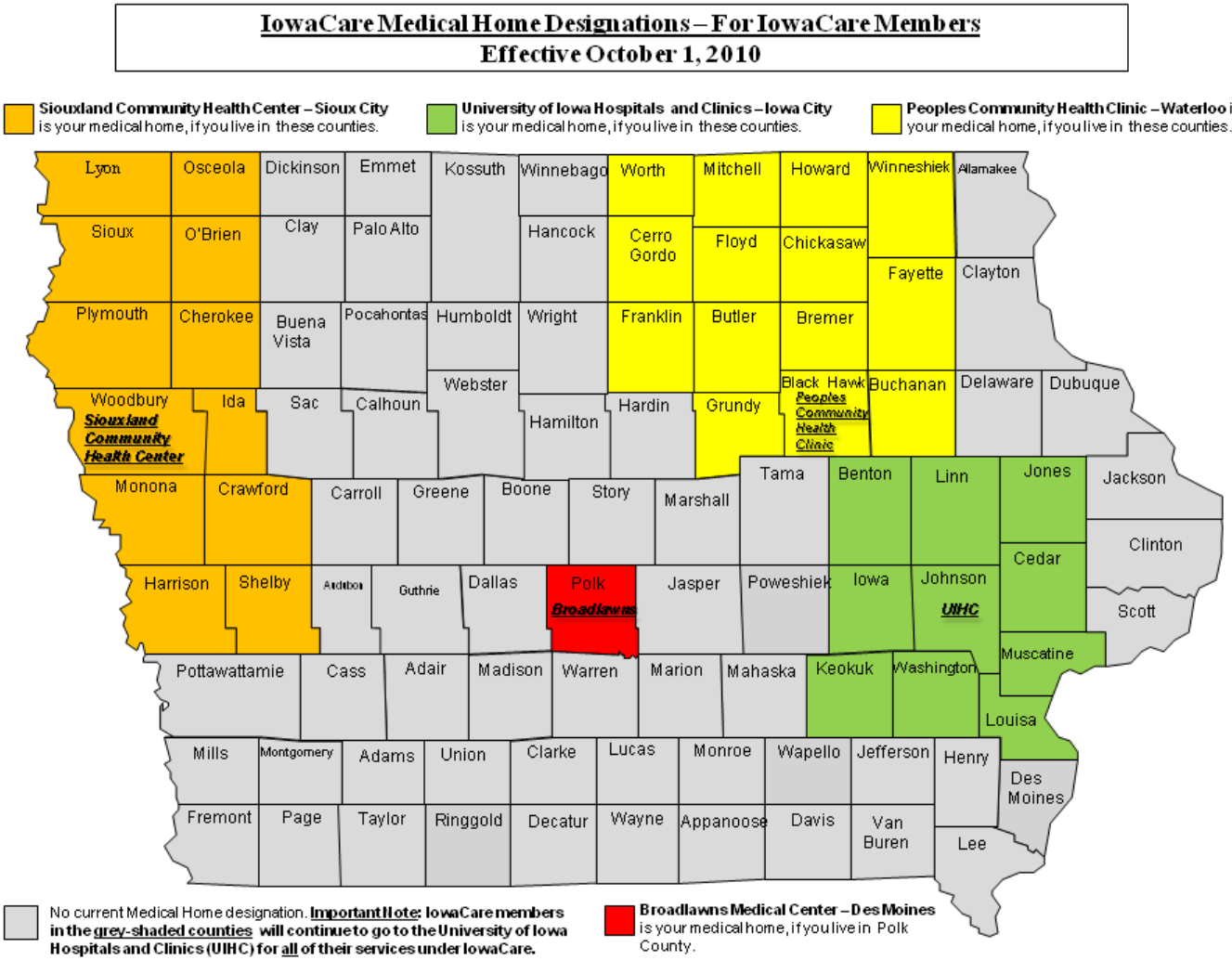


IowaCare Progress Report

Other Lessons:

- More work needs to be done to ready a practice for an assigned mass of members needing care all on the same day
- Attention is needed to understand the higher medical needs of this population before rolling out to other practices
- Referral protocols and communication lines should be pre-established and understood

IowaCare Progress Report

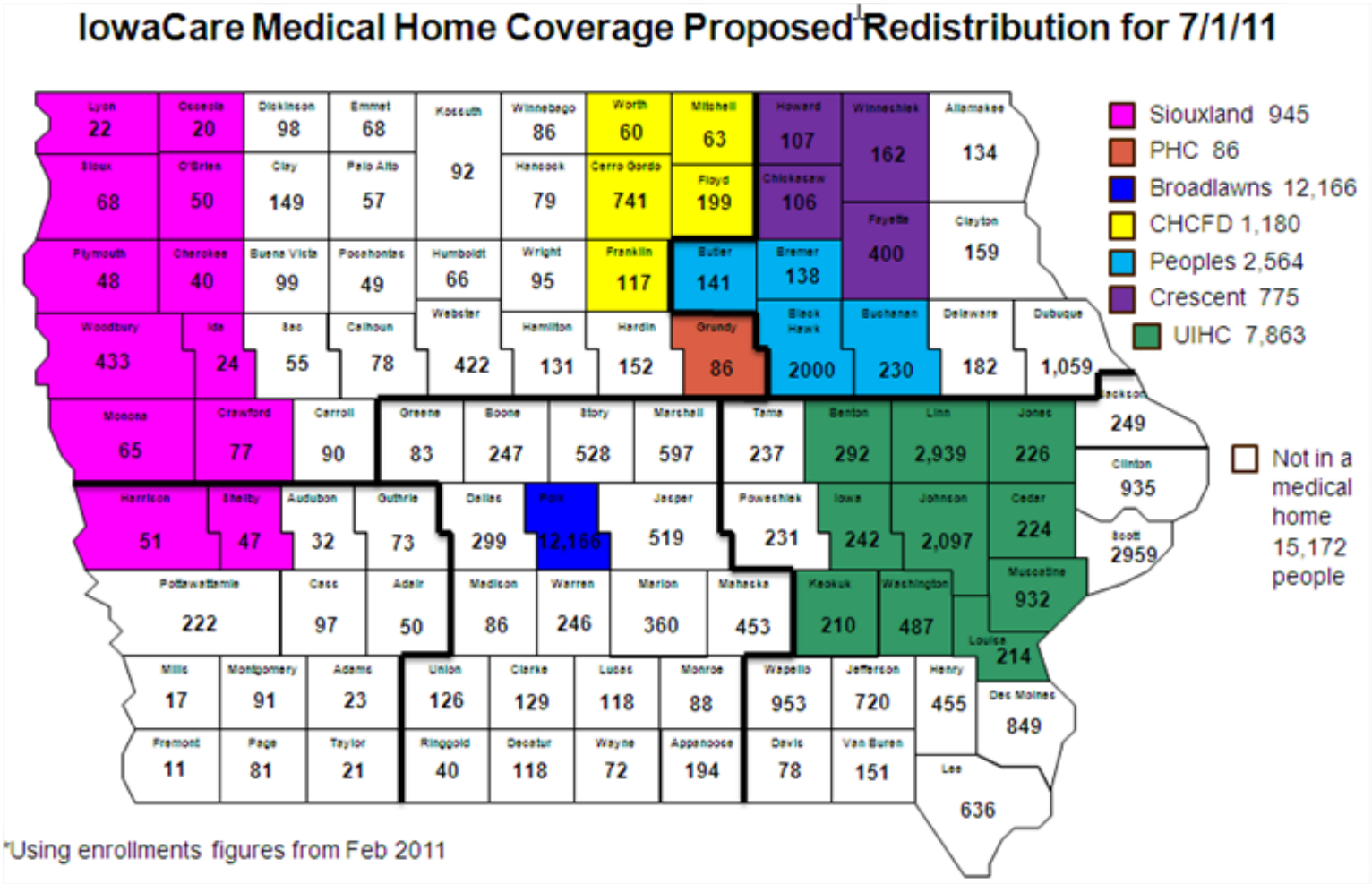


IowaCare Progress Report

North Eastern Redistribution

- Three new FQHC's are joining July 1, 2011 to redistribute existing counties currently assigned to Peoples:
  - Grundy county to Marshalltown (86 members)
  - Worth, Mitchell, Floyd Cerro Gordo, Franklin counties to Fort Dodge (1,180 members)
  - Howard, Chickasaw, Winneshiesk, Fayette counties to Dubuque (775 members)

IowaCare Progress Report



IowaCare Progress Report

- Communication: IME is working directly with FQHCs to discuss readiness:
  - Readiness surveys completed
  - Face-to-face meetings conducted
  - Contracts reviewed and signed
  - Member re-assignment letters will be staggered
  - New FQHCs will be added to subcommittee meetings
  - Establish communication line for reporting of issues as they arise

IowaCare Progress Report

- Proposed plan for remaining expansion is being discussed. Will likely involve:
- Less medical homes in the program
  - Members in outlying counties will have a longer drive than originally planned, but still much shorter than the current drive to Iowa City
- Use Broadlawns as a secondary care hospital for western and central regions of the state

ACA Section 2703 Health Homes

- Following the 7 principles of a Patient Centered Medical Home (PCMH)
- The IME is forming a Chronic Condition Health Home program for Medicaid members
- Starting early 2012

ACA Section 2703 Health Homes

- Limited to practices with at least one of the following provider types:
  - MD/DO
  - ARNP
- May include, not limited to entities enrolled as:
  - Physician Clinic
  - Community Mental Health Centers
  - Federally Qualified Health Centers
  - Rural Health Centers

ACA Section 2703 Health Homes

- Certification/Recognition:
  - Health Homes will have to meet the standards specified in IDPH rules. Those rules require NCQA or other national accreditation.
  - Providers may enroll as a health home by:
    - Completing a TransforMed self-assessment (if not already NCQA recognized),
    - Achieve NCQA or other national accreditation within first year of operation
    - Sign Contract delineating responsibilities of a health home

ACA Section 2703 Health Homes

Payment Methodology

- Per-member-per-month (PMPM) care coordination health home payment:
  - Targeted only for persons with defined chronic disease
  - PMPM Tiered payment Levels 0 to 4 –
  - Depending on the acuity/risk of the enrollee the PMPM increases by the tier assignment.

ACA Section 2703 Health Home

Payment Methodology

- Performance payment tied to achievement of quality/performance benchmarks:
  - Annually, starting in year two correlating with state fiscal year
  - Measures align with Wellmark COQ, meaningful use, and other national quality initiatives

ACA Section 2703 Health Homes

Eligible Individuals

- Diagnosed with at **least one serious and persistent mental health condition**, or;
- Has at least **two chronic conditions** or ;
- Has **one chronic condition and is at risk for a second** chronic condition from the following list of categories:
  - Mental Health Condition
  - Substance Use Disorder
  - Asthma
  - Diabetes
  - Heart Disease
  - Obesity (overweight, as evidenced by a BMI over 25)
  - Hypertension
- Individual Opts –in to the program through the engagement of the provider