MINUTES

Medical Home System – Prevention and Chronic Care Management Advisory Council

YMCA Healthy Living Center
Thursday, April 12th, 2012
9:30 am – 3:00 pm

Members Present
Chris Atchison (Sara Imhof)
Melissa Bernhardt (Larry Carl)
Charles Bruner
David Carlyle
Marsha Collins
Ana Coppola
Chris Espersen
Tom Evans
Jason Kessler
Petra Lamfers
Mary Larew
Teresa Nece
Patty Quinlisk
Peter Reiter
Kim Stewart
Bill Stumpf
John Swegle
Debra Waldron (Sonali Patel)
Kurt Wood (John Stites)

Members Absent
Kevin de Regnier
Steve Flood
Ro Foege
Michelle Greiner
Jeffery Hoffmann
Don Klitgaard
Linda Meyers
Tom Newton

Others Present
Angie Doyle Scar
Abby McGill
Karith Remmen
Lindsey Drew
Leah McWilliams
Mikki Stier
Pete Damiano
Sarah Dixon Gale
Dan Garrett
Janelle Nielson
Noreen O'Shea
Kathy Kunath
Jay Iverson
Jackie Stoben
Vincent Mandracchia
Marni Bussell
Judith Collins

Meeting Materials

- Agenda
- Commonwealth Fund Project- Safety Net in Iowa Post Health Care Reform
- Consumer Operated and Oriented Plans
- Health Home Provider Standards
- Health Homes for Medicaid Enrollees with Chronic Conditions PPT
- Iowa eHealth
- IowaCare Medical Home First Year
- MH-PCCM Advisory Council Vision

Topic	Discussion
Welcome	Council members and others present introduced themselves.
Council mission, name, and draft workgroups *Tom Evans* *Council Discussion* **Handout:** MH-PCCM Advisory	• Discussion took place about the MH-PCCM Advisory Council Vision and workgroups. In 2008 when these Councils were established, the main goal was to bring a variety of key stakeholders to the table to have discussions about spreading medial home across Iowa and equipping them to do so. Today, the focus is shifting in many ways to care coordination and bringing all of medicine together, while figuring out how to do more with less and looking at the bigger picture. The vision is patient-centered transformation of the health care system and coming together and figure out how to promote community care coordination and advancement the patient-centered medial home (PCMH). Creating respect and synergy with the partners at the table is vital to success. • A comment was made that we should not lose sight of the PCMH being a main focus

Council Vision	because PCMH, Health Homes, and Accountable Care Organizations (ACO) are happening and things are moving in that direction. A number of national studies are being released proving the savings and benefits of the PCMH. The PCMH is the mechanism used to operationalization our vision. Bill Stumpf commented that when talking to the community about the PCMH, many have no idea what that means and education and outreach should be a focus. • The Federal Government has developed a National Strategy for Quality Improvement in Health Care which describes that we not only need to focus on the process of the health care system, but to focus on sustainability and changing communities. The National Quality Strategy will pursue three broad aims. These aims will be used to guide and assess local, State, and national efforts to improve the quality of health care. They are: 1. Better Care: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe. 2. Healthy People/Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care. 3. Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government. • To advance these three aims, the National Quality Strategy focuses initially on six priorities: 1. Making care safer by reducing harm 2. Ensuring that each person and family are engaged in their care 3. Effective communication and coordination 4. Effective prevention and treatment for leading causes of mortality, beginning with cardiovascular disease 5. Promote the wide use of best practices 6. Making quality care more affordable by developing and spreading new health care delivery models • A set of ten basic principles were articulated, which will govern how health care services should be provided and how institutions and health professionals should conduct their activities. **1. Person-centeredness and family engagement** **2. Specific health considerations** **3. Eliminating disparities in care** **4. Aligning the efforts of public and private sectors** **5. Quality improvement** **6. Consistent national standards** **7. Primary care will become a bigger focus** **8. Coordination will be enhanced** **9. Integration of care delivery** **10. Providing clear information** • Tom Evans summarized that the lawmakers and the general public are becoming more aware that the national debt is largely caused by health care costs and the health care system and this has become a national priority. Additionally, the baby boomers are coming to age and we will have the largest demographic that will become Medicare eligible. Community engagement will be a key piece of the strategy and national priories will need to shift from providing more health care to focusing on delivering high quality health care.
Council Legislative Update	A brief update was given that the MH/PCCM Advisory Council is included in the Governor and Senate budget, but is eliminated from the House budget. The legislative session is expected to go beyond the scheduled finish date.
Commonwealth Fund Project-Health Care Safety	• Implementation of the Patient Protection and Affordable Care Act (ACA) has the potential to significantly alter the health care delivery system in the United States. It is unknown how these changes will impact the health care safety net that delivers care to vulnerable citizens. This study, done through the University of Iowa Public Policy Center, is one of four projects

Net in Iowa- Post Health Care Reform *Pete Damiano* **PowerPoint:** Commonwealth Fund Project- Safety Net in Iowa Post Health Care Reform	funded by The Commonwealth Fund to assess the impact of the ACA on the safety net. The other three projects—at Harvard, Rand and the National Academy for State Health Policy (NASHP)—investigate federal-level impacts. • This project uses Iowa as a laboratory to evaluate the potential impacts of the ACA on states and identify opportunities for integration and coordination in the health care delivery system. The Wellmark Foundation has also contributed support for this project. **The primary objectives of this study are to:** 1. Determine the current funding, expenditures, and infrastructure of the health care safety net at the state level, using Iowa as an example. 2. Evaluate the potential implications of the ACA on funding, expenditures and infrastructure of safety net-related activities at the state level. 3. Develop strategies for improving integration and coordination of safety net providers and organizations within the health care delivery system. • The project will emphasize the impact of the ACA on primary care providers (Federally Qualified Health Centers (FQHCs)/Community Health Centers (CHCs), local Public Health Departments that provide primary care, Family Planning Clinics, Rural Health Clinics, Free Clinics, Home health/Visiting Nurse Association (VNA), community mental health and substance abuse) and on programs that fund the primary care safety net (Medicaid, Children's Health Insurance Program (CHIP), Medicare, Title V, Title X). • Primary care services are defined as medical, preventive, dental, mental health, substance abuse and pharmacy, as well as community utility or wrap-around services (e.g., transportation, translation, care coordination of health care services, and case management of non-health care services). • The project will be guided by experts in the field including: ○ Steering Committee ○ State Leadership Group ○ State Advisory Group ○ National Advisory Committee • Key project activities include: ○ Holding weekly steering committee meetings ○ Hold quarterly State Leadership Group calls ○ Hold quarterly State Advisory Group meetings ○ Researching/writing inventory reports of safety net providers/payers ○ Conducting legal analysis of ACA as it relates to safety nets ○ Developing subcommittees to delve deeper into questions for a safety net provider, payer and service area • This is a 18-month project is divided into seven phases that incorporate background research, analysis of the ACA law and associated implementation, analysis of the gaps in knowledge, an assessment of the impact of the law on the safety net funding and delivery of services, and identification of opportunities for integration and coordination with the private sector. • This project will go through September/October 2012 and the final report will be due out this Fall. The Supreme Court ruling will make a huge impact on the Safety Net and the decision should be made late June 2012. • It is also important to note that under the ACA is a Medicaid expansion, and therefore the IowaCare program will end right when Medicaid expands. Using the IowaCare data will be of great value to other states and it makes Iowa unique because no other state has this type of data. • More information about the project can be found at the following website: http://ppc.uiowa.edu/pages.php?id=263.
Iowa Collaborative Safety Net	• The National Academy for State Health Policy (NASHP) has selected Iowa as one of seven states chosen competitively to participate in an initiative that seeks advance partnerships to improve access to care for vulnerable populations. The University of Iowa Public Policy

Provider Network • **NASHP Technical Assistance** *Sarah Dixon Gale*	Center joins the Iowa Primary Care Association and the Iowa Medicaid Enterprise (IME) in the Medicaid-Safety Net Learning Collaborative. This is part of NASHP's ongoing work to provide information and technical assistance to states to help them improve their Medicaid programs. • This project seeks to: ○ Develop a plan to maximize participation among eligible safety net providers and patients in IME's 2703 Health Home Program with the goal of recruiting at least 25,000 Medicaid members to participate in the first year of the program and at least 50,000 in the second year. ○ Expand integrated health home services available to members with behavioral health needs by closely exploring the lessons learned from several pilot projects working to integrate primary care and behavioral health services. ○ Gather information to understand how safety net providers can meaningfully participate in value-based purchasing agreements such as Accountable Care Organizations.
Iowa e-Health *Karith Remmen* **PowerPoint:** Iowa eHealth	• Iowa e-Health has recently reached a significant milestone. After passing both the House and the Senate, Governor Branstad signed SF 2318 into law on Thursday April 12th. • Karith updated the council on the Iowa Health Information Network (IHIN)System Development, Provider Adoption, Communication & Outreach, and Evaluation & Reporting. • The IHIN is the electronic movement of health-related information among organizations according to nationally recognized standards. Communication and Outreach will be a key focus for 2013. • Attendee registration for the 2012 Iowa eHealth Summit opens on May 2. The Summit is being held on Wednesday, August 8 and Thursday, August 9. Visit www.telligenhitrec.org for more information, including registration details. • Visit **www.IowaeHealth.org** to gain more information about the Iowa e-Health Workgroups, the Iowa e-Health Executive Committee/Advisory Council Meetings, and to subscribe to the *e-Health Connection* monthly newsletter.
Health Benefit Exchange *Angie Doyle Scar*	• In September 2010, IDPH was awarded a one-year grant to plan for the Health Benefits Exchange (HBE) for $1 M. A no-cost-extension is in place to allow us to continue the efforts from the planning grant and continue drawing down the funds. An Interagency Workgroup has been formed with IDPH, Iowa Department of Human Services (DHS) and the Iowa Insurance Division (IID). • A major part of the planning grant was a series of regional meetings and focus groups across Iowa to ensure considerable stakeholder involvement throughout the planning of the HBE. The information gathered from the meetings was compiled into a Final HBE Regional Meeting and Focus Group Summary. • Iowa has recently been awarded almost $8 million to continue the planning process through Level 1 of the Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges. The grant narrative can be found here: Iowa HBE Level 1 Narrative. The purpose of this Level 1 grant application is to continue the planning process for a HBE in Iowa. IDPH is the lead applicant for this grant and is collaborating closely with IID and DHS as part of the Interagency Planning Workgroup. The last page of the January-February 2012 edition of the Check Up describes the activities that each agency will be completing during the Level 1 project period. • The Level 1 Grant money is going to DHS to do background research and begin the plan to update their IT system for eligibility and to IID to do insurance market analysis and financial assessments. • IDPH's main role is to develop a plan for a comprehensive public education and outreach campaign to educate Iowans on the HBE. IDPH is partnering with the Safety Net Network to develop a toolkit and hold regional meetings targeted at safety net providers and patients to educate participants on the implementation process and how to make use of the HBE once it is live. IDPH will also conduct a consumer and business research survey to allow Iowa to predict the feasibility of the HBE and will help design and structure the education and

	outreach programs. • Navigators will play a major role in helping consumers learn about and choose health coverage. States running HBEs are required to establish navigator programs. Navigators will be required to: 1. Conduct public education activities 2. Raise awareness of the availability of qualified health plans 3. Distribute fair and impartial information concerning enrollment in qualified health plans 4. Distribute fair and impartial information on the availability of premium tax credits and cost-sharing reductions 5. Facilitate enrollment in qualified health plans 6. Provide referrals to any applicable office of health insurance consumer assistance or any other appropriate State agencies 7. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the HBE. • The ACA requires states to have an exchange certified or conditionally certified on January 1, 2013, or the federal government will operate an exchange for the state. States will need to prepare for Federal or state-based exchange either way. Even if the Federal government were to operate the exchange, Iowa would still need to update IT eligibility system for Medicaid. • The State Partnership Model is also another option for states to consider. The Partnership model describes Exchanges where both HHS and a state work together to operate different functions of the Exchange. The goal of the Partnership is to take advantage of the state's expertise and knowledge of their insurance markets to support a seamless consumer experience. States may use Exchange grant funding to support the functions they choose to operate under the Partnership that are related to establishing the Exchange. These options reflect the comments that we have heard from states and stakeholders to date, and we look forward to more comments on these Exchange Partnership opportunities.
PCMH Certification CO-OP *David Carlyle* **PowerPoint:** Consumer Operated and Oriented Plans	• Section 1322 of the ACA calls for the establishment of the Consumer Operated and Oriented Plan (CO-OP) Program, which will foster the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets. The federal government is offering loans to non-profit organizations to help establish CO-OPs. • CO-OP loans support the creation of new innovative health insurers, which will promote competition and increase choice in the insurance market. As consumer-directed organizations, CO-OPs are designed to be accountable to members and responsive to the specific health care needs of plan members by using profits to lower premiums, improve quality, and expand benefits or enrollment. • A proposal from Midwest Members Health, seeking to offer CO-OP coverage in Iowa and Nebraska, was awarded a loan of $112,612,100 to support its operations. This money cannot be used for marketing and it does not pay federal corporate income taxes. All activity must be in the individual market or the small group market. • The CO-OP will support Integrated Care (including the PCMH and ACO) which is ""approach to care. . .includes a payment process that incentivizes a system of care coordination to provide safe and clinically based quality health care in the most efficient and evidence-based manner" • David also informed the Council that McFarland Clinic in Ames has recently become Level 3 NCQA Certified.
IowaCare- Year One Data *Jason Kessler* **PowerPoint:**	**IowaCare Expansion** • Collaboration continues with Medicaid in the development the IowaCare Medical Home Model , established in SF 2356. The expansion is phasing in FQHCs to provide primary health care services to the IowaCare population and to comply with certification requirements of a Medical Home. Initially, the FQHC's will be required to meet a set of

IowaCare Medical Home First Year	medical home minimum standards.
	• IowaCare members have a high incidence of unmanaged chronic disease
	  ○ 23% have never had health insurance; 59% have not had insurance for more than 2 years
	  ○ 42% of patients have one or more chronic conditions (diabetes, chest pain, coronary artery disease, cancer, high blood pressure, pain)
	  ○ IowaCare patients self report poorer health status than the general Medicaid population
	  ○ 36% of IowaCare patients self report depression
	• The goals of the IowaCare expansion include:
	  ○ Increase IowaCare member satisfaction
	  ○ Improve statewide access of IowaCare members to quality health care
	  ○ Reduce duplication of services
	  ○ Enhance communication among providers, family, and community partners
	  ○ Improve the quality of healthcare through the patient-centered medical home model
	• A few caveats of the measures are that there is no baseline data (this data has never been collected before). Also, IME did not publish measures specifications resulting in the possibility of variability in reporting and calculation methods.
	• Data from the first year and a number of success stories/testimonies were presented to the Council and can be located in the PowerPoint.
	• Data from the first year of the expansion shows that IowaCare members are receiving significantly more preventative and coordinated care for individuals with key chronic diseases compared to the Medicaid population.
	• The expansion has had its challenges and successes. The Medical Home does improve care, but a limited benefit program is a difficult testing ground. Lessons learned will be applied to future Medical Home projects such as the Health Home for Medicaid Enrollees with Chronic Conditions.

Medicaid Health Care Reform Implementation
• **ACA's Health Homes for Enrollees with Chronic Conditions**
• **Discussion about duel eligibility**
Marni Bussell
 	
PowerPoint:
Health Homes for Medicaid Enrollees with Chronic Conditions PPT
 	
Handouts:
Health Home Provider Standards
	• Section 2703 of the ACA gives states the option to submit a State Plan Amendment (SPA) depicting a health home model of care. There is a drawdown of funding a 90/10 Federal match rate for eight quarters for specific health home services. States are required to consult with SAMSHA to ensure integration of mental and behavioral health services. The project
	• A health home offers Whole Person, Patient Centered, Coordinated Care for all stages of life and transitions of care. It following the 7 Joint Principles of the Patient Centered Medical Home (PCMH) with added flexibility around the location which care coordination is provided. The value added for comprehensive care coordination expects initial increases in office visits, and prescription drugs utilizations, as well as savings in ER, inpatient and avoidable hospital admissions.
	• What does a health home/medical 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.
	• Individuals eligible for the program include those diagnosed with at least one serious and persistent mental health condition, 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 for adults or 85th percentile for children)
- Hypertension

• Note that dual eligible's for Medicaid and Medicare are eligible to participate.
• Medicaid anticipates beginning enrolling providers starting mid 2012.

Qualifications to become a health home include:

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
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

***Input needed- "Dual Eligibles" Proposal**- DHS is currently seeking approval from CMS to move forward with implementation of a comprehensive approach aimed at integrating care and improving patient health for dually-eligible Medicaid and Medicare members. The proposal focuses on care coordination, the reduction of avoidable hospital readmissions and transitions from an inpatient stay to other settings. Medicaid will use previously unavailable data to unlock details which will let us target interventions where needed. The whole person, care coordination envisioned in the proposal has the potential to improve care for nearly 66,000 disabled and elderly, vulnerable Iowans while realizing savings in the system. The proposal utilizes current systems and builds upon current assets and delivery systems to create this new opportunity.

Click here to review the proposal & share your comments to mbussel@dhs.state.ia.us by May 16th.

The next meeting of the Medical Home/Prevention and Chronic Care Management Advisory Council will be held **Wednesday, July 25th, 9:30 – 3:00 at the YMCA Healthy Living Center.**

2012 Meeting Schedule

- **Wednesday, July 25, 2012- YMCA Healthy Living Center, Rooms 1 and 2**
- **Friday, September 21, 2012- YMCA Healthy Living Center, Rooms 1 and 2**
- **Wednesday, December 5, 2012- YMCA Healthy Living Center, Rooms 4 and 5**