

IowaCare Medical Home Model

I. Background

- a. IowaCare is an 1115 demonstration waiver that expanded Medicaid to 200% of the Federal Poverty Level for adults (age 19-64) who don't otherwise qualify for Medicaid. The coverage includes single adults and childless couples. The IowaCare program has a limited benefit package (inpatient/outpatient hospital, physician, limited dental and transportation), and a limited provider network. The provider network has been limited to two providers – Broadlawns Medical Center in Polk County and the University of Iowa Hospitals and Clinics in Iowa City, which provides service statewide.
- b. SF2356 as amended and passed by the Senate, expands the provider network under the current IowaCare program to include a regional primary care provider network, beginning with a phased in approach of Federally Qualified Health Centers (FQHC). The bill mandates the FQHC's selected by the Department of Human Services to provide primary health care services to the IowaCare population and to comply with certification requirements of a Medical Home.

II. Establishment of 3-4 Medical home sites beginning with phased in approach;

- a. 1-2 FQHC's on western side of state
- b. Broadlawns Medical Center
- c. University of Iowa Hospitals and Clinics

III. Medical Home Certification

- a. Establish Interim minimum standards for IowaCare Medical Home, transitioning to permanent certification process (if there is not an Iowa certification process we are looking at NCQA).
- b. Medical Home minimum standards;
 1. Access to care and information;
 - Accessibility-24 hours/day, physician on call
 2. Care Management
 - Comprehensive physical exam, and Personal Treatment Plan on annual basis
 - Disease Management Program
 - Wellness/Disease Prevention Program
 3. Health Information Technology (HIT);
 - 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

IV. Payment System Methodology

- a. A monthly care coordination payment PMPM up front at time of member enrollment in Medical Home. Then a possible performance-based component PMPM at end of each year based on evidenced based quality measures and member outcomes

Level of Certification/Year	Monthly Care Coordination PMPM	Performance Based Reimbursement	Potential total Reimbursement PMPM
Year 1	\$3.00	\$1.00	\$4.00
Year 2 -Level 1	\$1.50	\$1.50	\$3.00
Level 2	\$2.50	\$1.50	\$4.00
Level 3	\$3.50	\$1.50	\$5.00

- b. Peer to peer conferencing reimbursement (UIHC reimbursement for providing specialty care consultation to FQHC's).
 - Reimbursement based on telephone evaluation and management (E/M)codes
- c. Possible Federal and State assistance for HIE development, registry expansion, and meaningful use of HIT

V. Performance Reporting and Outcome Measurement

- a. At least 75% of the members enrolled in the Medical Home Pilot entered into the registry according to their chronic condition
- b. At least 75% of all members enrolled in pilot have had their smoking status documented

- c. At least 75% of all members enrolled in the pilot have annual immunizations or there is documentation that immunizations were offered, education provided to member, and member refused
- d. At least 75% of all eligible women enrolled have their annual cervical screen
- e. At least 75% of all enrolled members with a diagnosis of Diabetes have had at least one HgbA1C annually
- f. Each network provider in the pilot has or is in the process of developing a reminder service to inform members of appropriate preventative services
- g. Each network provider in the pilot has developed an effective system of sharing clinical information with the UIHC, and will develop an efficient process for referrals to the UIHC for specialty care
- h. Documentation of referrals

VI. Provider integration/system of care approach

- a. Concentration of care in Medical Home – avoidance of need for specialty visits/hospital care.
- b. Development of referral protocols between providers and UIHC
- c. Peer to peer consultation between medical home and UIHC specialty providers to avoid need for traveling to UIHC and higher level of care
- d. Exploration of telemedicine for specialty care at Medical Home site.
Options- G0406-G0408 Telehealth

PPC-PCMH Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 - 100	10 of 10
Level 2	50 - 74	10 of 10
Level 1	25 - 49	5 of 10
Not Recognized	0 - 24	< 5

Levels: If there is a difference in Level achieved between the number of points and “Must Pass”, the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 “Must Pass” Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 “Must Pass” Elements are not Recognized.

PPC-PCMH Content and Scoring

Standard 1: Access and Communication A. Has written standards for patient access and patient communication** B. Uses data to show it meets its standards for patient access and communication**	Pts 4 5 9	Standard 5: Electronic Prescribing A. Uses electronic system to write prescriptions B. Has electronic prescription writer with safety checks C. Has electronic prescription writer with cost checks	Pts 3 3 2 8
Standard 2: Patient Tracking and Registry Functions A. Uses data system for basic patient information (mostly non-clinical data) B. Has clinical data system with clinical data in searchable data fields C. Uses the clinical data system D. Uses paper or electronic-based charting tools to organize clinical information** E. Uses data to identify important diagnoses and conditions in practice** F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	Pts 2 3 3 6 4 3 21	Standard 6: Test Tracking A. Tracks tests and identifies abnormal results systematically** B. Uses electronic systems to order and retrieve tests and flag duplicate tests	Pts 7 6 13
Standard 3: Care Management A. Adopts and implements evidence-based guidelines for three conditions ** B. Generates reminders about preventive services for clinicians C. Uses non-physician staff to manage patient care D. Conducts care management, including care plans, assessing progress, addressing barriers E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	Pts 3 4 3 5 5 20	Standard 7: Referral Tracking A. Tracks referrals using paper-based or electronic system**	PT 4 4
Standard 4: Patient Self-Management Support A. Assesses language preference and other communication barriers B. Actively supports patient self-management**	Pts 2 4 6	Standard 8: Performance Reporting and Improvement A. Measures clinical and/or service performance by physician or across the practice** B. Survey of patients' care experience C. Reports performance across the practice or by physician ** D. Sets goals and takes action to improve performance E. Produces reports using standardized measures F. Transmits reports with standardized measures electronically to external entities	Pts 3 3 3 3 2 1 15
		Standard 9: Advanced Electronic Communications A. Availability of Interactive Website B. Electronic Patient Identification C. Electronic Care Management Support	Pts 1 2 1 4
		**Must Pass Elements	

