

# Building Health Homes for Iowa Medicaid Members

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## Section 2703 of the ACA

- Option to submit State Plan Amendment (SPA) depicting a health home model targeting chronic conditions:
  - Primary Care SPA:
    - Approved June 8, 2012
    - Effective July 1, 2012
  - Specialized Population SPA (kids Mental Health focus):
    - In development
    - TA and CMS consultations Summer 2012
    - Target effective date early 2013
- Draw 90/10 Federal match for 8 Qrts for Health Home Services



## What can be achieved in a health home approach?

### • For Members

- Better coordination and management of their often complicated and complex care.
- Help navigating multiple systems
- More engagement in their own care
- Access to a wider range of services

### • For Providers

- Providers practice more proactive, coordinated care that they want to provide, because of a new reimbursement structure.
- More opportunities to track, coach and engage the patients
- Improved communication and coordination for better patient outcomes
- Improved utilization of health information technology



## What is the benefit to the state?

- Improved health for a segment of Iowa Medicaid population with difficult health challenges
- Savings due to reductions in usage of health care services (expect reduced use of ER increased avoidance of hospital admissions)
- Projected savings between \$7 million and \$15 million in state dollars over three-year period (\$4.9M built into Governor's budget)
- Access to enhanced funding (temporary 90% FMAP) under the Affordable Care Act to implement



## “Primary Care”

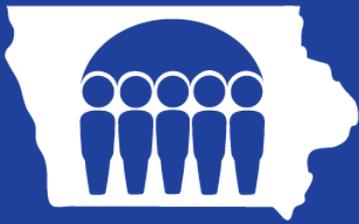
### Early Health Home Statistics for Providers

#### 10 Health Home Entities Enrolled:

- 11 counties
- 40 different clinic locations
- 467 individual practitioners

#### IME Support of new network:

- Two Implementation TA meetings (1:1)
- Collaborative Learning Network (Monthly)



## “Primary Care”

### Early Health Home Statistics for Members

#### August Member Enrollments

- 765 members assigned
  - 48% Tier 1
  - 38% Tier 2
  - 12% Tier 3
  - 2% Tier 4
- Almost half are Duals (Eligible for both Medicare and Medicaid)



## Primary Care HH Payment Methodology

In addition to the standard FFS reimbursement...

### Patient Management Payment :

- Per Member Per Month (PMPM) targeted only for members with chronic disease
- Tiered payments increase (levels 1 to 4) depending on the number of chronic conditions
- Performance payment tied to achievement of quality/performance benchmarks



## Primary Care Payment Rate

Member's Tier	PMPM Rate
Tier 1 (1-3 chronic conditions)	\$12.80
Tier 2 (4-6 chronic conditions)	\$25.60
Tier 3 (7-9 chronic conditions)	\$51.21
Tier 4 (10 or more chronic conditions)	\$76.81

- Practice uses Patient Tier Assessment Tool to identify correct tier
- Health Home submits monthly HCFA claim with diagnosis codes that support the tier
- Payments are verified retrospectively through claims data, using the normal IME verification process.



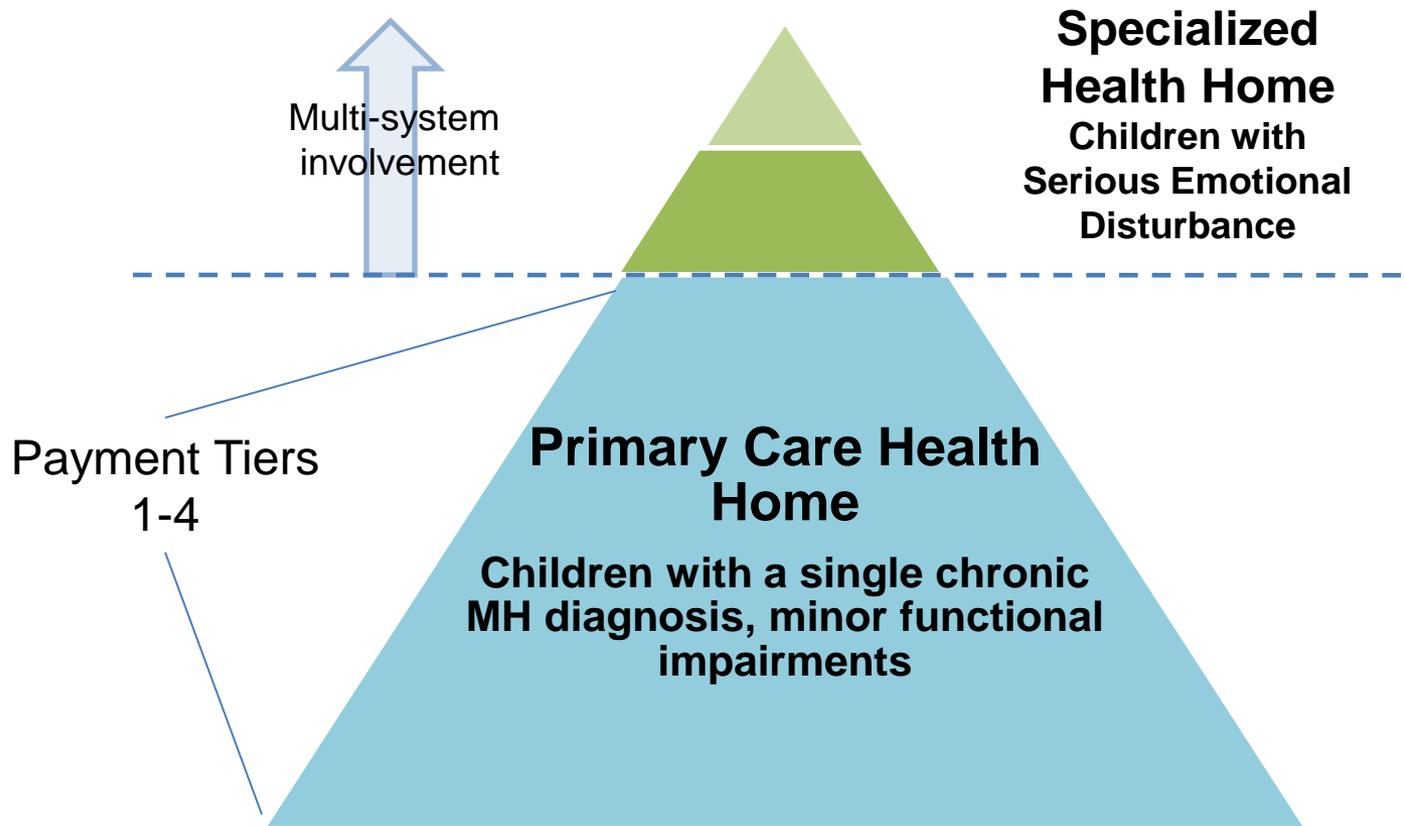
## Ensure desired outcomes are achieved

Payment is directed to only practices that commit to providing:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Support Services



## Primary Care and Specialized Health Home Model – example for children with mental health condition





## “Specialized” Health Home

- Expansion of health home model for adults and children with serious and persistent mental illness
  - Pilots operating for adults
  - Children’s concept developed by Children’s Disability Workgroup to implement “**Systems of Care model**”
  - Many details yet to be determined, but key details very likely to include:
    - Specialized provider requirements due to special population needs
    - Administered through the Iowa Plan
    - Additional payment tiers above the current 4 tiers due to high need of the population
    - Patient/Family Centered, peer support, team approach



## Questions?

### Contact

Medicaid Health Home Program

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