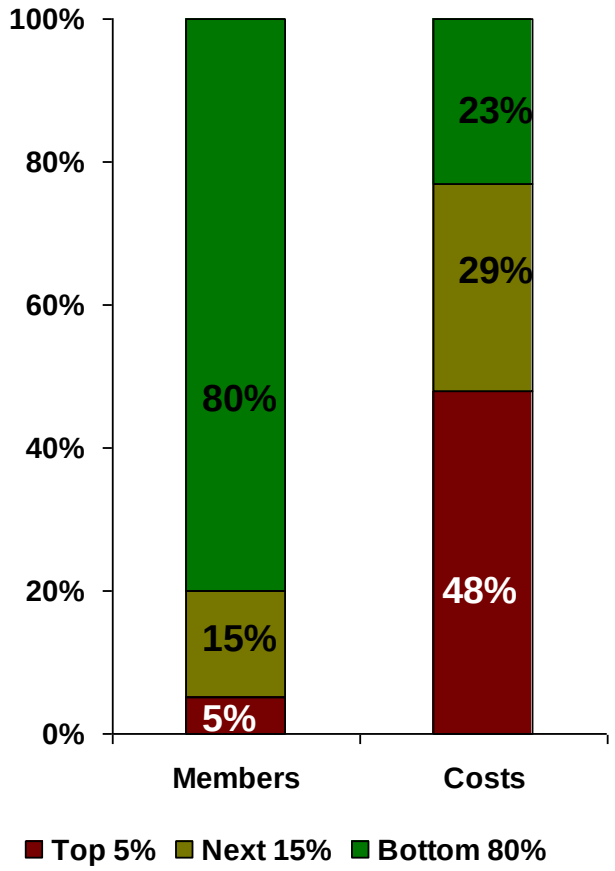
Iowa Department of Human Services

Building a Health Home for Iowa Medicaid Members

Jennifer Vermeer
Iowa Medicaid Director
January 25, 2011



- Individuals with chronic disease drive a significant share of cost in the Medicaid Program
- 5% of members account for 48% of acute care costs*

*Excludes Long Term Care, IowaCare, Dual Eligibles, and maternity

Top 5% High Cost/High Risk Members* Accounted for:

- 90% of hospital readmissions within 30 days
- 75% of total inpatient cost
- Have an average of 4.2 conditions, 5 physicians, and 5.6 prescribers
- 50% of prescription drug cost
- 42% of the members in the top 5% in 2010, were also in the top 5% in 2009

*Excludes Long Term Care, IowaCare, Dual Eligibles, and maternity

What is a health home?

- Patient-centered, whole person coordinated care for all stages of life and transitions of care.
- A model of care where Medicaid members with multiple or chronic conditions can receive help that integrates all their needs into a single plan of care.
- A model of care with flexibility around the location where the care coordination if provided.

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 can practice more proactive, coordinated care that they want to provide, because of a new reimbursement structure.
- More opportunities to track, coach and engage the patient's.
- 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

Is there an opportunity for better delivery of care?

" The Health Home model is an opportunity for Iowa Medicaid to transform the delivery of care to vulnerable individuals with very challenging health issues from a fragmented system to an integrated, person-centered system that can better address their health, social and environmental needs in one coordinated delivery of care."

How is care coordinated?

Medication adherence, appointments, referral scheduling, understanding insurance, wellness education, health support, lifestyle modifications and behavior changes.

Communication with patient and authorized family and caregivers in a culturally-appropriate manner.

Preventive Services

Coordinate or provide mental and behavioral health, oral health, long term care, chronic disease management, recovery services, transitional care.

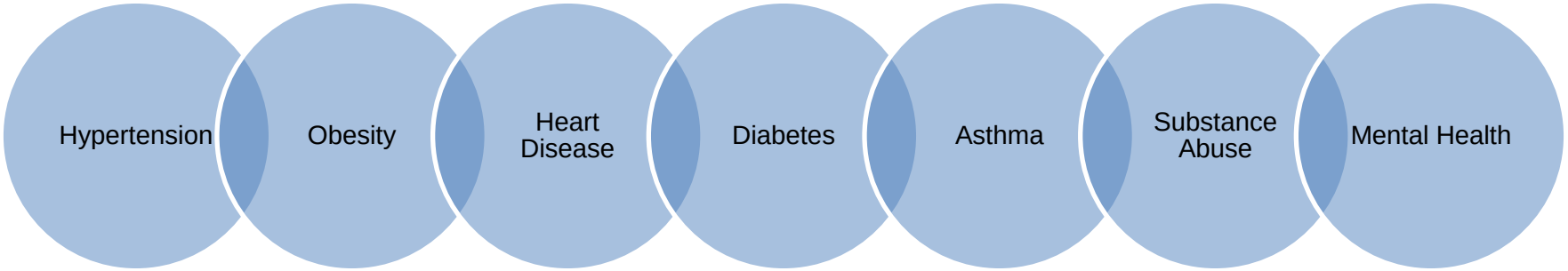
Assess social, educational, housing, transportation and vocational needs that contribute to the disease or present barriers.

Maintain systems for tracking patient referrals.

Health Home Tool kit

- Health Homes need:
  - Patient Registry function in an Electronic Health Record (EHR) to track the population they serve, track clinical data and utilization, to reach out when needed and support care coordination functions
  - Sharing of electronic information so that care providers know what is going on and can coordinate their treatment
  - Dedicated care coordinators
  - Expanded hours for access
  - Alternative means to communicate with patients and get them engaged, such as email, personal health records, reminders, etc.

Who will be served in the initial phases?
Adults or children
with at least two
“Qualifying Chronic Conditions”



**Or one chronic condition and at risk for another

Potential Impact

Estimated Health Home Practices		Estimated Lives Impacted	
• Year 1	20-50	• Year 1	27,000
• Year 1	50-100	• Year 2	50,000
• Year 3	100-300	• Year 3	78,000

How do we proceed?
The Iowa Medicaid Strategy

- Submit a State Plan Amendment
- Draw down the 90/10 federal match for eight quarters
- Ensure integration of mental and behavioral health systems
- Target members with chronic conditions
- Construct a new payment methodology for providers
- Develop quality measures & performance benchmarks

Payment Methodology

In addition to the standard FFS reimbursement…

1. Per-member-per-month Patient Management payment:
   - PMPM targeted only for members with chronic disease
   - Tiered payments increase (levels 1 to 4) depending on the number of chronic conditions
   - Providers submit monthly PMPM claim / retrospectively verified through claims data

Payment Methodology

2. Performance payment for quality

- Using the Iowa Health Information Network to collect measure data
- Annually, starting in year 2 correlating with state fiscal year
- Payment tied to achievement of quality/outcome measures for the health home
- Measures align with meaningful use, national quality programs and other payer initiatives

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

Are there opportunities for providers to help shape this new program?

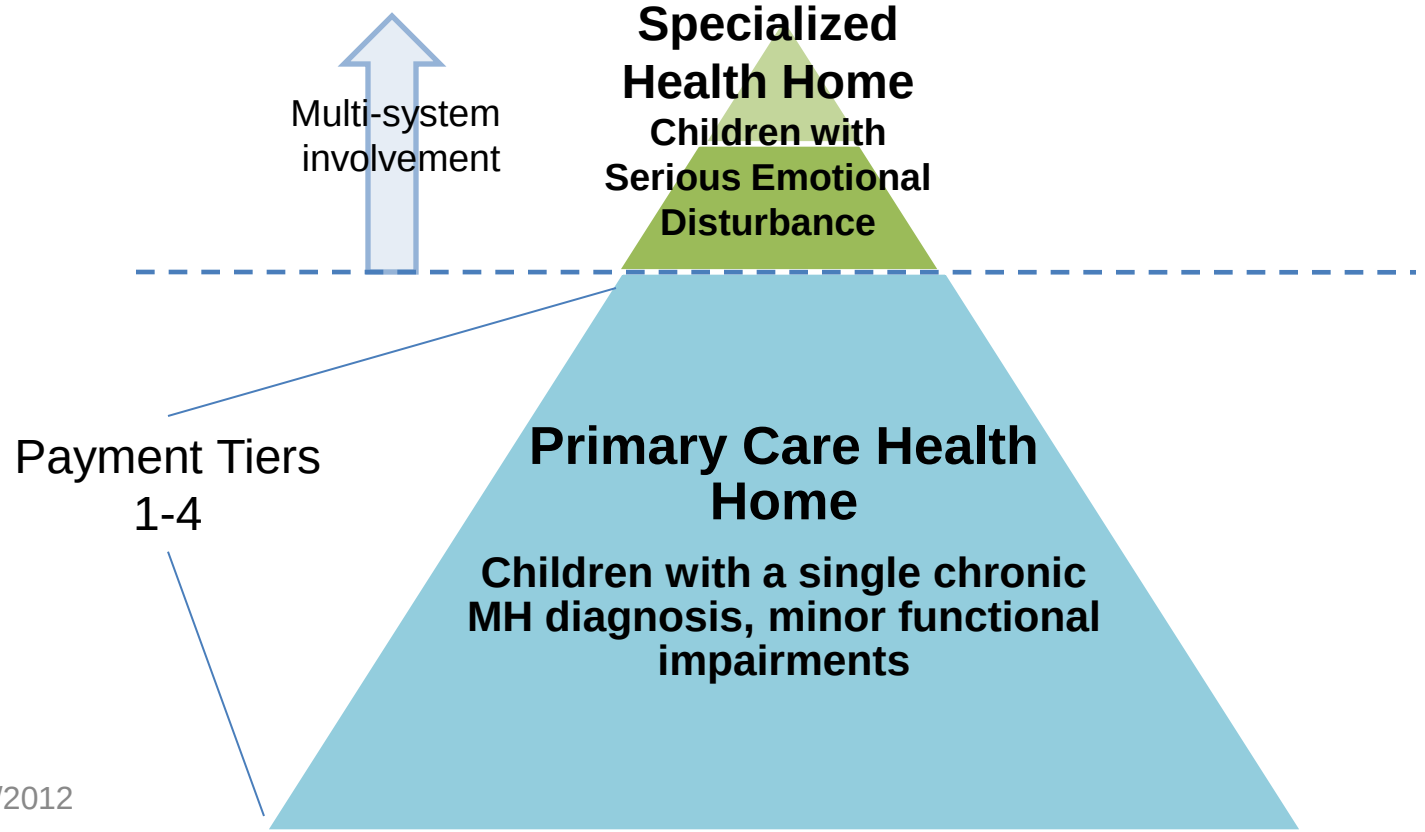
"*There are opportunities for health care providers to help us to shape this program by early participation in the program. We invite providers to work together with Iowa Medicaid early in this process to shape the health home program so that it works well for everyone involved*

Health Home Roll out

The First Two Phases:

1. Primary Care Health Home – July 1, 2012
   - Will be able to meet the needs of the majority of Medicaid members with chronic disease
2. Specialized Health Home – in 2012
   - Will be designed to serve small ,specialized populations who have especially complex needs
   - Different provider qualifications will be required
   - Concept developed as part of the MHDS Redesign Children's workgroup recommendations: Systems of Care model
   - First population will be adults and children with serious and persistent mental illness / Children with Seriously Emotional Disturbance

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



Questions?

Contact

Medicaid Health Home Program

Marni Bussell, Project Manager

mbussel@dhs.state.ia.us

515-256-4659