Iowa Medicaid Enterprise Health Home Program

Iowa Medicaid Enterprise (IME) presents a Health Home model to providers that care for Medicaid members. A health home is whole-person, patient-centered, coordinated care for all stages of life and transitions of care. IME expects comprehensive care coordination will both improve health outcomes for members and reduce avoidable expenses in ER, Inpatient and hospital readmissions.

Program and enrollment details can be found at: http://www.ime.state.ia.us/Providers/healthhome.html

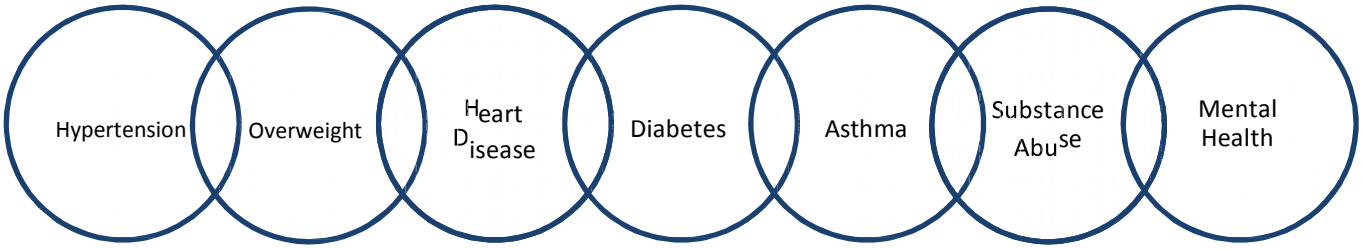
ProviderQualifications:

1. Medicaid enrolled practices including, but are not limited to: • Physician Clinic • Community Mental Health Centers, • Federally Qualified Health Centers • Rural Health Clinics	2. Fulfill, at a minimum, the following roles: • Designated Practitioner • Dedicated Care Coordinator • Health Coach • Clinic support staff
3. Adhere to the Health Home Provider Standards	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
7. Connect to Iowa's Health Information Network (IHIN), when available	

The Provider Standards document contains a complete list of provider expectations, all of which support the concepts of a patient-centered medical home model and can be found at: http://www.ime.state.ia.us/Providers/healthhome.html .

MemberQualifications:

- Includes members enrolled in full Medicaid benefits, Medicaid-Medicare members (Duals), adults, and children
- Excludes IowaCare members
- Member must have at least two chronic conditions from below list, or
- One chronic condition and at-risk of a second condition from the list:



- Providers enroll members in the health home through an online process using Iowa Medicaid Portal Access (IMPA)
- How will you identify your Medicaid population that qualifies?
- A member must opt-in to the program, through the engagement of the providers
- How will you talk to your patients about the health home program?

Iowa Department of Human Services

HealthHomeServices

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

PaymentMethodology:

In addition to the standard FFS reimbursement (or encounter based for FQHC/RHC):

1. 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
    - Providers submit monthly PMPM claim / retrospectively verified through claims data

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

2. Performance payment tied to achievement of quality/performance benchmarks:
    - Using the State HIN 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

A Patient Tier tool contains details on how to tier a member and how to submit a PMPM claim.

ProposedHHQualityMeasures:

Starting in year two (2), a provider can earn a bonus payment for reaching quality benchmarks. The bonus amount is no more than twenty (20) percent of the total PMPM payments made to the health home during the reporting year. The measures are arranged into four (4) categories. Each category is weighted; if a provider reaches the benchmark in all four categories they would earn 100% of the total bonus payment available to them.

Measures	Assigned Value	Source
Category: Preventive Measures, (best two out of three measures count)		
Pneumococcal vaccines Flu shots BMI and appropriate follow-up planning when needed.	35%	EHR/IHIN
Category: Disease Options 1, (Health Home picks the measure that most aligns with the practice population)		
Diabetes: Dilated Eye Exam Microalbumim (annual) Foot Exam (annual) Proportion with HgA1c less than 8 Proportion with LDL less than 100	30%	EHR/IHIN
Asthma Asthma Patients with Asthma-		

related Emergency Room Visit		
Category: Disease Option 2, (Health Home picks the measure that most aligns with the practice population)		
Hypertension:	20%	EHR/IHIN
Systemic Antimicrobials:		
Category: Mental Health, (Health Home picks the measure that most aligns with the practice population)		
MH Discharge follow-up	15%	EHR/IHIN
Clinical depression screening		
Category : Cost		
Total Cost of Care	Reporting Only	

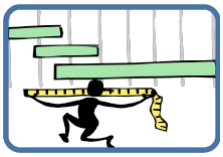
Measure Specifications will soon be available from the IME.

NextStepsforinterestedPractices:

- Contact Pamela Lester plester@dhs.state.ia.us
- Visit the website: http://www.ime.state.ia.us/Providers/healthhome.html
- Evaluate your practice/organization:

Identify if your Practice is ready to enroll

- Review HH Provider Standards and Qualifications
- Assess volume of Medicaid patients



Start PCMH Recognition Process

- Review NCQA, Joint Commission requirements
- Identify gaps, create action plans to be recognized in 12 months.

Identify Qualifying Members to enroll

- Outreach to qualifying members
- Perform Tier Assessments
- Explain HH to members/Opt-in