



Health Home Program
(Section 2703)
Iowa Medicaid Enterprise

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Two Health Home Programs: Same Triple Aim Goals

- **Chronic Condition Health Home:**
 - Primary Care Focus
 - **Effective July 1, 2012 Statewide**
 - Enrollment Approach: Members Opt-in at Provider's office
- **Integrated Health Home:(Members w/SPMI)**
 - Behavioral Health Focus
 - **Effective July 1, 2013** (in 5 counties, *expand statewide in 2014*)
 - *Enrollment Approach: Members Opt-out from notification letters*



Challenges of 2703 Federal Regulations

- Lack of enhanced funding for provider supports
 - Positive outcomes require provider transformation
 - Provider transformation requires provider supports
- Developing one program that works for Adults and Kids



Iowa Department of Human Services

Chronic Condition Health Home



Chronic Condition Health Home Member Qualifications

Hyper-
tension

Over-
weight

Heart
Disease

Diabetes

Asthma

Substance
Abuse

Mental
Health

Adults and Children with
at least two chronic conditions, or
one chronic condition and at-risk of a second condition
from the above list.



Chronic Condition Health Home Provider Qualifications

1. Designated Provider must be Medicaid enrolled and at a minimum fulfill the following roles:

- Designated Practitioner
- Dedicated Care Coordinator
- Health Coach
- Clinic support staff

2. Seek Medical Home recognition or equivalent within 12 months

3. Effectively utilizes population management tools to improve patient outcomes

4. Use an EHR, registry tools, and connect to Iowa HIE (IHIN) to report quality data



Chronic Condition Health Home Payment Methodology

In addition to the standard FFS reimbursement...

Patient Management Payment :

- Per Member Per Month (PMPM) targeted only for members with chronic disease
- Performance payment tied to achievement of quality/performance benchmarks



Chronic Condition Health Home 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 tool to identify correct tier
- Practice submits claim with diagnosis codes that support the tier
- Payments verified retrospectively through claims data

Challenge – Technical and resource hurdles for clinic to develop process to submit PMPM claims

Adjustment - Switching to a capitated payment in early 2014



Chronic Condition Health Home Quality Measures

- ✓ Preventive (pneumococcal vaccines, flu shots and BMI)
 - ✓ Diabetes or Asthma
 - ✓ Hypertension or Systemic Antimicrobials
 - ✓ Mental Health (discharge follow-up or depression screening)
 - ✓ Total Cost of Care Measure –
(*Not realized until SIM is implemented, likely 2016*)
- Providers must submit CCDs through the IHIN Direct Messaging to qualify for an Incentive
 - **Challenge:** Technical delays with EHR vendor to submit CCDs



Iowa Department of Human Services

Integrated Health Home



Integrated Health Home for individuals with SPMI

A **team of professionals** working together to provide whole-person, patient-centered, coordinated care for all situations in life and transitions of care to **adults with SMI** and **children with SED**.



IHH Member Qualifications

SMI

- Psychotic Disorders,
- Schizophrenia,
- Schizoaffective disorder,
- Major Depression,
- Bipolar Disorder,
- Delusional Disorder,
- Obsessive-Compulsive Disorder

Consideration also given for members with a Global Assessment Functioning (GAF) score of 50 or less

SED

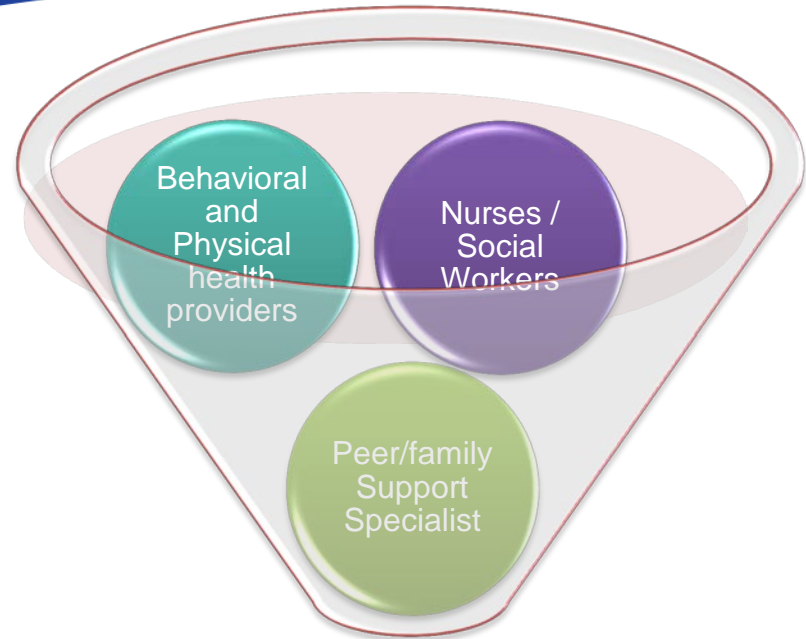
- A diagnosable mental, behavioral or emotional disorder of sufficient duration to meet DSM diagnostic criteria
- Results in functional impairment



Team Approach

The Integrated Health Home (IHH) is not a place.

- The IHH is a service delivery model designed to utilize a team
- They have a set of unique skills based on their experiences and education
- All work together for the member
- Works with primary and specialty care



Care Coordination
Health and Wellness Education
Resource Direction
Family Support Services
Transitional Care Support



IHH Team Roles & Responsibilities

Lead Entity (Magellan)

- Selects IHH community providers
- Provides care management support through
 - ✓ Claims-based reporting to identify gaps in care
 - ✓ Risk analysis
 - ✓ Development of online toolsto support daily service delivery and population management needs and provider transformation

Community IHH Provider

- Develops care teams to work with members
- Uses data and technology to oversee and intervene in the total care of the member
- Works with community services and supports to address member/family needs
- Develops whole-health approaches for care



Specialized Attention

Strengths:

- Trained in managing SED/SMI population
 - Follow a System of Care approach for children
- Participate in practice transformation classes held by the lead entity
- Provide trained peer/family support specialist
- Coordinate all community and social needs



Integrated Health Home Payment Rate

Member's Tier	PMPM Rate
Adult or Child	\$128.00
Adult or Child with Intensive Care Management	\$348.00

- Lead entity is paid monthly by Medicaid
- Community IHHs under contract with lead entity
- Monthly withhold paid out quarterly to IHHs that the comply with quality reporting requirements and practice transformation efforts



Adults with SMI Pilot Outcomes

- June 2011 – July 2013
- Limited in size (750 members)
- Five participating sites in phase one counties
- Opt-in approach

- ✓ ER visits for MH reasons decreased 26%
- ✓ Members using ER decreased by 16%
- ✓ Psychiatric admissions decreased by 36%
- ✓ Members admitted for psychiatric reasons decreased by 40%
- ✓ 94.8% overall satisfaction by members in pilot at least 3 months (43.3% response rate)



Estimated Eligibility/Enrollment for both programs

- Roughly **600,000** Iowa Medicaid members (SFY2013)
 - **100,000+** members estimated eligible for health home services
 - Between **23,000 and 30,000** members projected for year one enrollment
 - Actual current enrollment is **19,000**



Chronic Condition Health Home

Current Provider Enrollment

30 Health Homes
27 of 99 Counties
20 Health Homes actively enrolling
14 Achieved NCQA PCMH

Challenges

Provider Transformation –practices struggle with attrition/turnover, and resources to implement process improvements

Current Member Enrollment

4,000 members
40% are dual eligibles
500 are under age 19

Challenges

Low enrollment – need to boost provider supports, but state resources are limited

A program for both Adults & Kids –
Need to modify to include more Children with Special HealthCare Needs



Chronic Condition Health Home **Strengths**

- Primary Care Community responds to approach
 - A few PCMH hold backs, but most accept this as the future of primary care
 - Early (baseline) data confirms we are reaching the chronically ill, high ER utilizers



IHH

Current Provider Enrollment

One Lead Entity
12 Community IHHs in 5 counties

Challenges

Rural Areas- Developing rural IHHs to serve SMI/SED populations-

Strengths

Lead Entity approach allows us to support a group of community providers that are far behind primary care in EHR adoption, PCMH adoption and integration.

Current Member Enrollment

15,000 members attributed to an IHH
45% engaged in Health Home Services

Challenges

Member Outreach Efforts- under estimated Time and resources needed to engage members
Adjustment in payment to reflect outreach prior to engagement in 2014



Questions?

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<http://www.ime.state.ia.us/Providers/healthhome.html>

<http://www.magellanofiowa.com/for-providers-ia/integrated-health-home.aspx>