



## **IowaCare Medical Home Model**

### **I. Background**

1. IowaCare is an 1115 demonstration waiver that expanded Medicaid to 200% of the Federal Poverty Level for adults (age 19-64) who do not 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 services statewide.
2. 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 FQHCs 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**

1. 1-2 FQHCs in the State of Iowa
2. Broadlawns Medical Center
3. University of Iowa Hospitals and Clinics

### **III. Goals**

1. Increase IowaCare member satisfaction with health care.
2. Improve statewide access of IowaCare members to quality health care.
3. Reduce duplication of services.
4. Enhance communication among providers, family, and community partners.
5. Improve the quality of health care to IowaCare members through the patient-centered medical home model.
6. Promote and support a plan for meaningful use of health information exchange (HIE) in accordance with the Federal Register requirement.



#### **IV. Iowa Care Medical Home Minimum Standards**

##### **Medical homes in the IowaCare Medical Home Pilot must:**

1. Sign contract or three year commitment in Medical Home Pilot.
2. Comply with NCQA Recognition/Certification Requirements. Practices must demonstrate a patient-centered approach and have implemented processes that, at a minimum, are consistent with must-pass elements outlines in the NCQA PPC-PCMH standards.
  - A. Practices must complete NCQA Level 1 recognition (or the equivalent, as determined by the Department), by the end of the first year (i.e., September 30, 2011, for those beginning October 1, 2010), transitioning to permanent recognition, as determined by the Medical Home Reform Committee.
  - B. Complete Transformed Baseline Assessment or Primary Care Development Corporation Baseline PCMH Self-Assessment to demonstrate practice readiness within the 20-day period prior to member enrollment and provide results to the Department within the same timeframe.
  - C. Submit a quarterly report to the department during the first year of participation in the program outlining progress toward obtaining Level 1 recognition. Those providers who are not able to obtain Level 1 category during the first year will not be allowed to continue in the medical home pilot. (Quarterly report template is located at [http://www.ime.state.ia.us/docs/IowaCare\\_QuarterlyMedicalHomeActivityReport.docx](http://www.ime.state.ia.us/docs/IowaCare_QuarterlyMedicalHomeActivityReport.docx))
3. Provide Provider Directed Care Coordination Services aimed at managing all aspects of a members care, ensuring quality of care and safety.
4. Complete a comprehensive evaluation. Within 120 days of the medical home being notified of newly enrolled members, all newly enrolled members will have a comprehensive evaluation, include a physical examination. Comprehensive evaluations will be provided as indicated thereafter, based on age, gender, and risk factors and following established clinical guidelines. Each evaluation should include a personal treatment plan (PTP). Comprehensive evaluations may occur in conjunction with other services and may or may not be completed all at one time, but should be associated with codes for preventive



medicine, general medical or health examination and/or health supervision.

- A. Definition for newly enrolled members: Newly enrolled members include those members who have enrolled in IowaCare on or after the Medical Home start date found on the signed Agreement for Participation. Newly enrolled members residing in one of the counties covered by a medical home will be assigned to the appropriate medical home. These members will require a comprehensive evaluation to be provided through the medical home within 120 days of enrolling.
5. Develop a Continuity of Care Document (CCD) for each member that details important aspects of member's medical needs. This document will be updated and maintained by the medical home and will be updated regularly as a means of communication between the referring provider and the consulting provider.
6. Submit a CCD and PTP prior to each referral
7. Provide access to care and information;
  - A. Maintain system and written standards/protocols for tracking patient referrals, patient access and patient communication. Develop and maintain a secure connection between the FQHC and the referring center.
  - B. Maintain -24 hours/day accessibility with a health care provider on call
  - C. Provide onsite triage during regular office hours. Same-day services will be provided or arranged, if determined appropriate.
  - D. Complete and submit activity reports, based on member access and specialty referrals, to the Department on a quarterly basis (Add location of approved report template here).
8. Demonstrate the above components in the medical home's administrative policies and procedures. Establish formal care management at the medical home.
  - A. Designate a Dedicated Care Coordinator at each provider site. The dedicated care coordinator will be responsible for the following including, but not limited to:
    - i. Providing care coordination.
    - ii. Acting as a key contact person for each provider site.



- iii. Providing members with community resources, information and support to assist member with adhering to PTP, including, but not limited to:
        - a. Assisting member with medication adherence
        - b. Assisting with appointment and referral scheduling and reminders
        - c. Assisting with member wellness education, health support, and/or lifestyle modification and behavior changes
        - d. Further responsibilities to be determined
9. Establish a disease management program. Each provider site will have at least one formal Diabetes Disease Management Program during the first year. Subsequent disease management programs will be added based on population-specific disease burden, or as directed by the Department. The Disease Management Program goals will be:
  - A. Improve health outcomes using evidence based guidelines and protocols
  - B. Report outcomes on a quarterly basis using evidence-based guidelines. Diabetes clinical outcomes will be measured for timeliness, completion, and results of A1C, LDL, microalbumin, and eye examinations for each member identified with diabetes.
10. Establish a Wellness/Disease Prevention Program with quarterly reporting on quantities and activities. This program will:
  - A. Promote behavior modification aimed at supporting health management (i.e., documented obesity counseling, tobacco cessation)
  - B. Promote health screening based on age, gender, and health risks (i.e, Pap smears, mammograms, colon screening)
  - C. Provide coaching for patient self-management; assisting members to both understand and mitigate identified risks.
11. Implement and/or utilize Health Information Technology (HIT);
  - A. Demonstrate evidence of acquisition, installation and adoption of an electronic health record (EHR) system.
  - B. Establish a plan for meaningful use of health information exchange (HIE) in accordance with the Federal Register requirement.



- C. Report chronic conditions “registry data” once the IME registry guidelines are established. An assumption can be made that the guidelines will adopt the PQRI/Meaningful Use data format.
- 12. Develop or plan to develop a reminder service to inform members of appropriate preventative services. Each Medical Home will report on their process quarterly.
- 13. Develop or plan to develop an effective system of sharing clinical information with UIHC, and an efficient process for referrals to the UIHC for specialty care. Each center is to report on their process quarterly.

**V. Payment System Methodology**

- 1. Performance Reporting and Quality Improvement
  - A. Follow evidence-based medical guidelines.
  - B. Submit quarterly reports to the Department on member outcome and process measures. Quarterly reports are not directly tied to payment. Quarterly reports are only considered if medical home does not pass all components of annual report.
  - C. Submit annual report to the Department on member outcome and process measures.
- 2. Payment
  - A. A care coordination PMPM payment shall be paid the second Monday of the month. The medical home payment shall begin the first day of the month following the member’s assignment to the medical home.
    - i. The Medical Home monthly payment fee may change based on NCQA recognition level at anytime during the SFY, following the initial 12 month period.
  - B. A possible performance-based component PMPM payment shall be paid at end of each state fiscal year based on evidenced based quality measures and member outcomes and available state funding:
    - ii. The State Fiscal Year ends June 30.
    - iii. The Medical Home shall submit their annual performance report by August 1st or the first business day thereafter.

*Level of Recognition/Year	Monthly Care Coordination PMPM	Performance Based Reimbursement	Possible Total Reimbursement PMPM
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Initial 12 Months of operation	\$3.00	\$1.00	\$4.00
Month 13 through the end of the second SFY of participation			
Level 1	\$1.50	\$1.50	\$3.00
Level 2	\$2.50	\$1.50	\$4.00
Level 3	\$3.50	\$1.50	\$5.00

\*Amended annually per NCQA recognition standards. The Department will also analyze data collected and consider trends identified in the program and may adjust payment scales for future years as appropriate.

## VI. Specialty Consultant Reimbursements

Reimbursement will be provided to the specialty consultant for peer-to-peer conferencing (i.e., UIHC will be reimbursed for providing specialty care consultation to an FQHC or Broadlawns). All routine, non-urgent consultations at UIHC will be arranged through the IowaCare Assistance Center (ICAC). Please call (319) 356-1000 during regular business hours. Requests for urgent/emergent consultations and for those outside of normal business hours should be directed to the Integrated Call Center at (800) 322-8442. Routine requests for services/consultations will not be directed through the UIHC Emergency Treatment Center.

1. Peer-to-peer evaluations are defined as communication by a primary care provider to another physician, usually a specialist (the “consultant”), for the purpose of obtaining the consultant’s professional opinion or plan for a specific IowaCare member.
2. Peer-to-peer codes must be billed with the UB modifier.
3. The specialty consultant only can bill for online, telephone, and email conferencing. The primary care provider compensation is a combination of the billable encounter and the monthly PMPM care coordination reimbursement for participating in the Medical Home program.
  - A. Online evaluations include telemedicine or other means of real-time video conference evaluations using the internet or other secure electronic connections. These evaluations require the presence or



- participation of the IowaCare member at one end of the communication. Email correspondence is not considered a billable online evaluation. (99444, fee \$44.37)
- B. Telephone consultation can be conducted by voice connection alone. Presence and/or participation of the IowaCare member may or may not occur.
    - I. 5-10 Minutes of medical discussion (99441, fee \$20.30)
    - II. 11-20 Minutes of medical discussion (99442, fee \$37.21)
    - III. 21-30 Minutes of medical discussion (99443, fee \$55.25)
  - C. Email correspondence containing medical discussions may be billed using code 99499 only (fee, \$20.30). Presence and/or participation of the IowaCare member may or may not occur.
4. In order for the specialty consultant to submit a claim for reimbursement, the evaluation must not originate from a related service or procedure (including the same type or other type of peer-to-peer consultation) in the previous 7 days by the consultant, or the immediate scheduling of a service or procedure by the consultant or consultant's partners, midlevel providers, or trainees. If the consultant's opinion requires that a treatment plan, other than diagnostic testing, be initiated and evaluated by the consulting physician prior to the availability of appointments by the consultant, the peer-to-peer evaluation may be reimbursed according to the standard scale.
  5. Documentation must be generated in the IowaCare member's medical record for all online, telephone, and email encounters by both the primary care provider and the consultant. This documentation may be requested by the Department of Human Services during claim processing.
  6. When immediate consultation is not available or not warranted as determined by the ICAC, it is expected that ICAC will affect triage of the call and the consulting physician or center will be notified within four hours with an approximate timeline for the consultant's availability for peer-to-peer consultation.



## VII. Performance Reporting and Outcome Measurement

All data must be reported through the end of the first state fiscal year of participation, June 30, and submitted to the Department by August 1, or the next business day thereafter ([Add location of approved annual report template here](#)). Data will be reported for any member enrolled and assigned to a Medical Home for 180 days or more in the reporting year (this number would be considered the denominator for reporting purposes). Medical Homes will be expected to meet all criteria (1 –10 listed below) to be awarded the additional PMPM payment. Criteria will be reviewed annually. It is expected that over time, measurement will move from the process to the outcomes of the process and align with national quality reporting standards.

Medical Homes not meeting the full criteria at the end of the first SFY of participation will have the opportunity present information outlining why they still should receive additional payment, with the Department making all final decisions. Full documentation of an earnest attempt to meet the outlined measures must be provided. Considerations will be given to the quarterly data collected about proportions of members assigned to whom services have not been provided. The Department may choose to interview the Medical Home to confirm reported results.

1. As reported by each Medical Home, at least 65 percent of members enrolled in the pilot, over the age of 50, should have their colon cancer screening status reviewed on an annual basis. Colon checks could be performed by any method with appropriate follow up based on US Preventive Services Task Force (USPSTF) guidelines, including:
  - Fecal occult blood test
  - Flexible sigmoidoscopy
  - Double contrast barium enema
  - Colonoscopy
2. As reported by each Medical Home, at least 75 percent of members enrolled in the pilot should have their body mass index (BMI) measured or calculated and recorded in their medical record, and reported to the Department on an annual basis. BMIs should be reported in aggregate to be aware of the status of the population.



3. Educational and informational printed material provided to the enrolled members should be culturally and linguistically appropriate to the medical home patient population. Each medical home is to report a list of available languages for printed material, samples of a patient medication list, two examples of patient home-bound instructions, and two examples of patient reminder notices. Additional information should be provided on the current process in place to improve this form of communication to patients.
4. All members referred to UIHC for secondary and/or tertiary care should be tracked via a referral tracking system (either manually [paper based] or electronically maintained). Each Medical Home is to report on their process for ensuring the referral tracking system and to report any known or suspected failures of tracking.
5. As reported by the Medical Home, an active medication list must be maintained for at least 80% of all members enrolled by having at least one entry (or an indication that the patient is not currently prescribed any medication) recorded.
6. All members enrolled in the Medical Home Pilot are entered into the registry according to their chronic condition(s). Only a Diabetes Registry is required during year one. Each center is to report on their process for ensuring entry into the registry and to report any known or expected failures.
7. As reported by the Medical Home, at least 75 percent of all members enrolled in pilot will have their tobacco use status documented.
8. Each Medical Home is to report the number of members enrolled in the program who have had annual immunizations or there is documentation that immunizations were offered, education provided to member, and member refused.
9. As reported by each Medical Home, at least 70 percent of all eligible women enrolled should have an age appropriate cervical screen or documentation of need for exam.
10. As reported by each Medical Home, at least 80 percent of all enrolled members with a diagnosis of diabetes have had at least one A1C annually.



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

\*\*\*Must Pass Elements



## IX. Definitions of Care:

### 1. Specialty Care –

#### Johns Hopkins Medicine

Definition of Broad Specialty Care: Specialized health care provided by physicians whose training focused primarily in a specific field, such as neurology, cardiology, rheumatology, dermatology, oncology, orthopedics, ophthalmology, and other specialized fields.

Definition of Tertiary Care: Specialized consultative care, usually on referral from primary or secondary medical care personnel, by specialists working in a center that has personnel and facilities for special investigation and treatment. (Secondary medical care is the medical care provided by a physician who acts as a consultant at the request of the primary physician.)

### 2. Primary Care –

#### American Academy of Family Physicians

Primary care is that care provided by providers specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.

Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal provider often collaborating with other health professionals, and utilizing consultation or referral as appropriate.

Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care.



3. Care Coordination –Below are definitions from the Iowa Administrative Code for IowaCare and Iowa Code for Medical Homes.

(92.1) Provider-directed care coordination services means provider-directed services in a clinical setting aimed at managing all aspects of a patient's care to ensure quality of care and safety. All aspects of care are coordinated by the clinical team under the direction of a physician. The team must include a dedicated care coordinator.

[135.158(2)c] Whole Person Orientation. The personal provider is responsible for providing for all of a patient's health care needs or taking responsibility for appropriately arranging health care by other qualified health care professionals. This responsibility includes health care at all stages of life including provision of acute care, chronic care, preventive services, and end-of-life care.

[135.158(2)d] Care is coordinated and integrated across all elements of the complex health care system and the patient's community.