***Financial Models to Support State Efforts to Coordinate Care for Medicare-Medicaid Enrollees***

***Demonstration Proposal***

***Iowa***

**Summary:** In July 2011, CMS released a State Medicaid Directors' letter regarding two new models CMS will test for States to better align the financing of the Medicare and Medicaid programs, and integrate primary, acute, behavioral health and long term supports and services for Medicare-Medicaid enrollees. These two models include:

- Capitated Model: A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.
- Managed Fee-for-Service Model: A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

To participate, States must demonstrate their ability to meet or exceed certain CMS established standards and conditions in either/both of these models. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for the selected financial model(s). The Iowa Department of Human Services has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time, interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

**Invitation for public comment:** We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m. EDT, June 29, 2012. You may submit comments on this proposal to IA-MedicareMedicaidCoordination@cms.hhs.gov.

Iowa Department of Human Services

Iowa Medicaid Enterprise

# Financial Alignment Demonstration Proposal for Medicare-Medicaid Members

May 29, 2012

Iowa Department of Human Services

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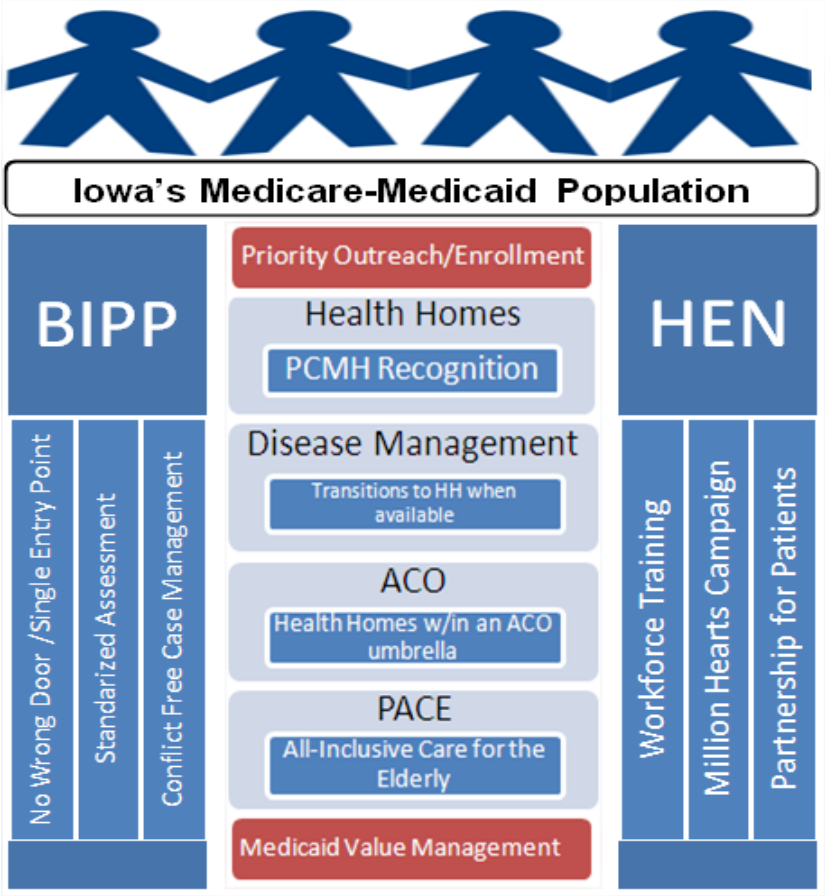
Iowa Department of Human Services

## A. Executive Summary

The Iowa Medicaid Enterprise (IME) is administered by the Iowa Department of Human Services. It is a combination of state staff and vendors, all proven leaders in their areas of expertise. The creation of the IME stems from the idea that there must be a collaborative spirit shared among program members, providers, and the state. To ensure effective collaboration among program stakeholders, the IME is designed as a unique infrastructure that encompasses the varied elements of Medicaid. Staff work together to eliminate redundancies, share information, and reach the common goal of improving health care across the state.

The IME is in the process of implementing a comprehensive care management approach for our Medicare-Medicaid members with the goal of integrating care and improving health outcomes. A summary of each component of this multifaceted approach within our Managed Fee-For-Service (FFS) model is described below. The HEN project listed below features an initiative driven by the Iowa Healthcare Collaborative, an organization independent of IME, but they share IME's vision.



- Beginning July 1, 2012, the IME will implement **Health Homes** under the guidance of a State Plan Amendment per Section 2703 of the Patient Protection and Affordable Care Act (PPACA). The program will enhance care coordination to Medicare-Medicaid members, focus on reducing avoidable hospital readmissions, and better coordinate transitions from inpatient stays to other settings. Both short and long-term strategies will be applied to maximize benefits to Medicare-Medicaid members, and lower expenditures to both (Medicare and Medicaid) programs.

- **Disease Management** (DM) programs focus on enhanced care coordination to assist in the prevention of Ambulatory Care Sensitive (ACS) hospitalizations, decrease non-emergent Emergency Room (ER) use, and decrease hospital readmissions through the use of telephonic health coaches. Current DM programs within the IME and Magellan Behavioral Health Services are expanding to include Medicare-Medicaid members not in a Health Home. As Health Home services expand statewide, a DM health coach works to transition care plans and care history to the new Health Home care coordinators. This component of the managed FFS model drills in on the challenges unique to Medicare-Medicaid members and provides extra care that positively impacts the member's health and expenditures.

- TriHealth, Inc., a Northwest Central Iowa Medicaid provider is participating in the Pioneer **Accountable Care Organization** (ACO) program with the Centers for Medicare and Medicaid Services (CMS). In support of this alliance, Iowa is developing an ACO program for TriHealth and other systems that may develop the capacity to operate as an ACO, which focuses on care coordination and improved outcomes for Medicare-Medicaid members. The ACO model supports the Health Home concept and allows multispecialty practices to share risks and potential savings without jeopardizing health outcomes of members.

- **The Program of All Inclusive Care for the Elderly (PACE)** is a medical home and managed care program that provides all preventive, primary care, social services, acute and long-term services to Medicare, Medicaid and dual Medicare-Medicaid members aged 55 and older. A PACE member must be living in their in the community, and not in a LTC facility at the time of enrollment. The PACE interdisciplinary team (IDT) is diverse, consisting of at least 11 disciplines. As the member's support needs may change the IDT coordinates and insures quality of care in whatever acute, long term care or end of life environment is required. Iowa requests that CMS consider the expansion of the PACE program in Iowa as a viable strategy to integrate and improve the care of the Medicare-Medicaid members through the Managed FFS model. Through the three year demonstration period, Iowa projects the PACE service area will expand to cover 11 counties in central Iowa.

- **Infrastructure Supports**: Iowa is committed to implementing a Balancing Incentives Payment Program (BIPP) to improve care and rebalance Long Term Supports and Services (LTSS) received in a home and community based setting (HCBS). Iowa is developing a No Wrong Door/Single Entry Point (NWD/SEP) system that establishes needed infrastructure to identify members in need and train local Health Home providers. As part of the BIPP requirements, Iowa will train the workforce on community long-term care options.

- Transitioning case management to Health Home providers supports the BIPP requirement of **conflict-free case management**. By implementing the appropriate tools and infrastructure, Health Homes can provide continuity in case management during transitions for LTSS that are currently lacking. This continuum of care both decreases potentially avoidable admissions and is more likely to provide the correct level of care for members in a managed FFS model.

- **Data Analysis:** Medicaid Value Management (MVM), an existing IME program, analyzes data to better understand the quality of services provided to Medicaid members. Recent access to Medicare data (Parts A, B and D) will provide valuable missing information about Medicare-Medicaid members. This information will be used to identify points in care delivery that will be targeted to improve health outcomes and reduce care deficiencies which put members at risk for short and long-term complications. Analyzing current data and reviewing historical trends, the MVM focus is aimed at improving health outcomes for members. Leveraging access to the Medicare data, the IME will use predictive modeling software to identify and prioritize member outreach efforts to connect them to Health Homes, Disease Management and ACO's available in their communities.

## B. Background

The strategies discussed above impact our target population as follows:

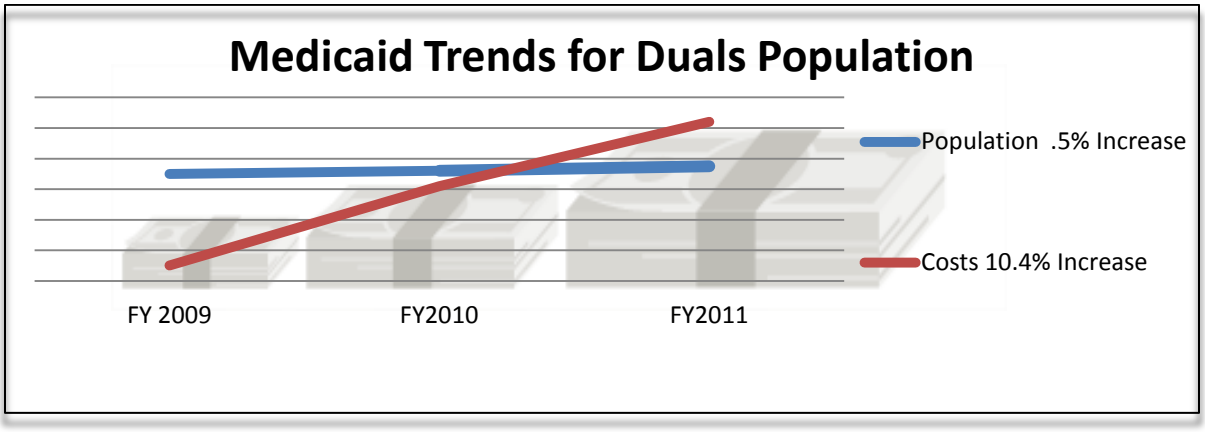
| Medicare-Medicaid Population – Projected Impacts | |
|---|---|
| Target Population | All full benefit Medicare-Medicaid enrollees |
| Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide (April 2012) | 62,714 |
| Total Number of Beneficiaries Eligible for Demonstration | 62,714 |
| **Health Home Projections:** | |
| Year 1 | 2,000 |
| Year 2 | 6,000 |
| Year 3 | 18,000 |
| **Disease Management Projections:** | |
| Year 1 | 2,000 |

| | |
|---|---|
| Year 2 | 2,500 |
| Year 3 | 2,000 |
| **ACO Projections:** | |
| Year 1 | 0 |
| Year 2 | 250 |
| Year 3 | 5,000 |
| **PACE Projections:** | |
| Year 1 | 500 |
| Year 2 | 750 |
| Year 3 | 1200 |
| **Infrastructure Support projects (BIPP/HEN):** | |
| Year 1 | 62,714 |
| Year 2 | 62,714 |
| Year 3 | 62,714 |
| **Data Analysis (MVM/Predictive Modeling Enrollment Activity):** | |
| Year 1 | 62,714 |
| Year 2 | 62,714 |
| Year 3 | 62,714 |
| Geographic Service Area | Statewide |
| **Summary of Covered Benefits** | Full Medicaid Benefits<br>Full Medicare Benefits<br>HH Services<br>NWD/SEP<br>Waiver Services |
| **Financing Model** | Health Home in a FFS environment |
| **Summary of Stakeholder Engagement/Input** | Leadership Advisory Group meeting 9/20/11<br>MAAC 11/16/11<br>MH-PCCM Advisory Council12/1/11<br>Leadership Advisory Group meeting 3/8/12<br>FQHC/RHC Safety Net Provider Subcommittee 3/8/12<br>MH-PCCM Advisory Council 4/12/12<br>MH-PCCM Advisory Council 5/25/12<br>MH-PCCM Advisory Council 7/25/12 |
| **Proposed Implementation Date** | January 1, 2013 |

The IME's shared vision with CMS to integrate care for Medicare-Medicaid members is to provide access to comprehensive coordinated care through a Health Home model that considers the whole person and emphasizes home and community based care when appropriate. This shared vision eliminates redundancies and removes barriers that Medicare-Medicaid members face within the system and proposes payment reform models consistent with CMS programs.

In the current delivery system, care for Medicare-Medicaid members is divided and paid between Medicare and Medicaid, with each program covering different parts of a member's care. Information on member care (service utilization) and provider payments (expenditures) for this population do not reside within a single payer entity, making it difficult to accurately identify costs and needs of this population. Iowa's recent efforts to collect Medicare Part A, B and D data permits MVM studies to more easily identify care gaps and focus interventions that have positive impacts.

Reported in a recent MVM study [1] of Iowa Medicare-Medicaid members, looking only at Medicaid claims data from 2009 to 2011 establish the population to have increased by only 0.5 percent, while members with at least one paid claim decreased by 5.0 percent, and costs in the same time period increased 10.4 percent.




Medicaid agencies have very little influence over hospital actions when developing programs for Medicare-Medicaid members, since Medicare not Medicaid, is the primary payer of hospital services. Hospital admissions and ER visits are considered a major revenue source for hospitals. The expected payer savings in these areas is a concern for hospitals[1]. The development of hospital based ACO's provides an avenue for hospitals to share risks and savings and allows more incentives to participate in Medicaid administered programs that focus on the Medicare-Medicaid population.

Until the development of the Financial Alignment Demonstration Proposal, it was difficult for Medicaid agencies to cost-justify the inclusion of Medicare-Medicaid members in intervention strategies like Health Homes, ACOs, or Disease Management. Recent focus on this population reveals that both the Medicare and Medicaid programs will benefit from a Managed FFS model in Iowa. With the chance to share savings with Medicare, doors for Medicare-Medicaid members are opening with greater opportunities to integrate the care delivery system for this population.

[1] Cited in part from ICRC Technical Assistance Brief, February 2012: Integrating Care for Medicare-Medicaid Enrollees Using a Managed Fee-for-Service Model

Iowa Department of Human Services

The table below identifies the number of individuals receiving long term care services in both institutional and HCBS settings as well as those with a diagnosis of serious mental illness. The LTSS and SMI population represent a key group that needs improved care coordination and an integration of delivery systems. Of the Medicare-Medicaid members receiving LTSS, seventy percent (70%) are under the age of 65.

| **Iowa LTSS Statistics** | | | |
|---|---|---|---|
| | Overall | Individuals receiving LTSS** in institutional settings | Individuals receiving LTSS** in HCBS settings |
| **Total receiving LTSS** | 27,866 | (21%) 13,010 | (24%) 14,846 |
| **Individuals age 65+ receiving LTSS** | 8,300 | 2,432 | 5,868 |
| **Individuals under age 65 receiving LTSS** | 19,566 | 10,578 | 8,988 |
| **Individuals with serious mental illness** | 15,404 | | |
| **Overall Total* Medicare-Medicaid Population evaluated as of April 2012 = 62,714**<br>***Overall total: Excludes QMB/SLMB.***<br>****LTSS = Long Term Supports and Services*** | | | |

| **Iowa Medicare-Medicaid Members – Receiving Mental Health Services in CY 2011** | |
|---|---|
| **Under Age 65** | **7,020** |
| **Top diagnoses include** | • Schizophrenia,<br>• Bi-polar disorder,<br>• Major depression<br>• Adjustment disorder<br>• Substance use disorders |
| **Service Utilizations** | |
| **Type of Service** | % of Duals that used the service type |
| **Outpatient Mental Health** | 55 |
| **Community Support Services** | 30 |
| **Targeted Case Management** | 21 |
| **Outpatient Substance use disorder** | 12 |
| **Home Psych Nursing** | 8 |
| **Intensive Psychiatric Rehabilitation** | 4 |
| **Assertive community treatment** | 3 |
| **Intensive Outpatient program** | 3 |
| **Substance use disorder** | 3 |
| **Mobile Crisis** | 2 |
| **Inpatient Mental health** | 2 |

| Service Utilizations | |
|---|---|
| **Mental health - skill training** | 1 |
| **Residential substance use disorder** | 1 |

| **Age 65 and Over** | **363** |
|---|---|
| **Top diagnoses include** | • Schizophrenia,<br>• Bi-polar disorder,<br>• Major depression<br>• Adjustment disorder<br>• **Dementia**<br>• Substance use disorders |
| **Service Utilizations** | |
| **Type of Service** | % of Duals that used the service type |
| **Outpatient Mental Health** | 53 |
| **Community Support Services** | 25 |
| **Home Psych Nursing** | 13 |
| **Targeted Case Management** | 11 |
| **Outpatient Substance Use Disorder** | 4 |
| **Inpatient Mental health** | 2 |
| **Mobile Crisis** | 2 |
| **Assertive Community Treatment** | 2 |
| **Intensive Psychiatric Rehabilitation** | 1 |

## C. Care Model Overview

Iowa operates primarily in a Fee-For-Service (FFS) environment with a Mental/Behavioral Health Managed Care carve-out operated by Magellan Health Services of Iowa and one PACE provider as a State Plan home and community/long term care option added in March of 2008.. The IME is administered by the Iowa Department of Human Services; it is a combination of state staff and vendors, all proven leaders in their areas of expertise. The IME vendors and partners, like Magellan Health Services, work in concert under the direction and supervision of the state. The Care Model overview described below is coordinated and overseen by the IME who is the Accountable Entity for this proposal.

### Delivery System: Health Home for Members with Chronic Conditions

A Health Home model of care for members with chronic conditions will begin in Iowa on July 1, 2012. This statewide program hinges on practices ready and willing to participate. Practices that meet Health Home criteria will enroll qualifying members they serve. It is estimated that 93,000 Iowa Medicaid members will qualify in 2012. From that list, almost 24,000 are Medicare-Medicaid enrollees, 25% of the total Health Home qualifying member population.

The state will identify Medicare-Medicaid members who are at greatest risk by using a predictive modeling tool currently used within the Disease Management program. Members living in an area served by a Health Home will be encouraged to connect to local Health Home providers. Providers enroll members in the Health Home after discussing program benefits with the member. Providers share what type of additional services the member should expect (e.g., care coordination, health coaching, medication adherence, medication reconciliation, expanded access to care, etc…). Providers will then complete member health assessments to assist in developing comprehensive care plans and then enroll members who agree to participate by accessing an online provider portal administered by the State. The state is committed to help providers reach out to identify high risk Medicare-Medicaid members in their community.

Health Home providers must meet standards outlined by the state. Those standards include enhanced access that features a phone triage system with appropriate scheduling during and after regular business hours. They must monitor access outcomes such as the average 3rd next available appointment and same day scheduling. Health Homes are encouraged to use email, text messaging, patient portals and other technology as available to the practice to communicate with patients and ensure access to quality care. Iowa's State Plan Amendment, attached to this proposal describes in detail the standards providers must follow to participate as a Health Home provider.

The care team staff must consider both physical and mental/behavior health needs of the member when developing a comprehensive care plan. The standards ensure coordinated care during transitions from inpatient stays, often critical for the reduction of avoidable readmissions. The standards also ensure members are receiving health education, medication adherence assistance, nutritional counseling, and social supports when needed.

Medicare-Medicaid members connected to a Health Home can expect enhanced services designated as Health Home services including:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care/including appropriate follow-up, from inpatient to other settings
- Individual and Family Support Services (including authorized representatives)
- Referral to Community and Social Support Services

Health Home providers are expected to embed evidence-based guidelines into their practice workflow, ensuring consistent quality care across the practice/clinic while delivering the above mentioned services. Medicare-Medicaid members can expect

services that will better assist them in managing their chronic conditions; more effectively help them navigate the health care delivery system, have improved access to needed services and ultimately better health outcomes.

The IME is building off an Integrated Health Home (IHH) pilot project operating in Iowa since July of 2011. With the direct assistance of Magellan Health Services, five IHHs are serving adults with Serious and Persistent Mental Illness (SPMI), including Medicare-Medicaid members. An IHH is a Community Mental Health Center (CMHC) that has a partnership with a local Federally Qualified Health Center (FQHC). A care coordinator from the CMHC works with the member to ensure both physical and mental health/substance abuse needs are addressed. A nurse dedicated to the IHH assures medical needs are being met and coordinated. And, a peer support specialist is part of the team connecting with members in the community and modeling recovery and whole health.

In the IHH pilot, routine medical and preventative services are available at the CMHC site to provide greater access to physical health care services to members with a SPMI. Care coordinators and peer support specialists link with the members with SPMI on health goals, accessing care and assuring a whole person plan that is coordinated. The pilot program also includes three provider sites of an Assertive Community Treatment (ACT) Team working to provide whole person care to members at a critical and unstable point in their lives.

The IME is using lessons learned from the IHH pilot during the development of the statewide Health Home program and expects IHH providers to lead the way in establishing Health Homes for members with SMI under the IME Health Home for Members with Chronic Conditions program.

Health Home providers assume additional responsibility to provide or coordinate the full array of services that members need. That increased responsibility is reimbursed to Health Homes by two methods. The first is a Patient Management Payment, ranging from $12 to $76 per-member per-month (PMPM) and the second is an annual quality bonus starting in 2013, for those Health Homes that succeed in quality patient outcomes. Providers are expected to report quality measures via a direct messaging connection within the Iowa Health Information Network (IHIN). To track progress, providers will have access to real-time data for Health Home performance measures.

In addition to real-time data reports on quality measures, the IME is establishing a method to share data quarterly with Health Homes on patient utilization patterns and total cost of care information. IME is also developing a method to share daily reports of ER or inpatient admissions with Health Homes based on a process established with the Disease Management program. A secure file transfer process (SFTP) has been designed and daily inpatient census reports are received at the IME from hospitals serving Medicaid members. Early identification and real time data allows the DM

program (and soon the Health Home program) the opportunity to outreach to members prior to discharge to focus on issues like medication adherence, appointment scheduling, transportation needs, and any other coordination needed for the transition. This effort will prevent Ambulatory Care Sensitive (ACS) hospitalizations (hospitalizations that are preventable through better primary care), reduces non-emergent ER use, and reduces the chance of member readmissions within 30 days of discharge and have a positive impact on the Medicare and the Medicaid programs for this population.

The Iowa Health Home model effective date is July 1, 2012, pending an approved State Plan Amendment from CMS.

### Delivery System: Disease Management

Disease Management in Iowa can be identified by four separate programs; all with telephonic health coaches in direct contact with members. With access to the Medicare Part A, B and D data at our fingertips, and the opportunity within this demonstration proposal, these programs are able to expand services to Medicare-Medicaid members not being cared for by a Health Home provider.

Magellan Health Services is working in several states, implementing programs that address the specific integration needs of members with mental health and substance abuse needs. In Iowa, Magellan manages the Iowa Plan as IME's Mental Health Managed Care Organization (MCO). The Iowa Plan currently serves Medicare-Medicaid members in need of mental health and substance abuse services, including members under the age of 65, a population with a high prevalence of mental health conditions.

The Iowa Plan also began managing the mental health and substance abuse needs of those Medicare-Medicaid members aged 65 and over in 2010. Magellan initiated a *SeniorConnect* program with clinicians dedicated to increasing the access of these services for this population. A dedicated phone line was initiated for providers, members, family members and other stakeholders to provide referrals and ongoing disease management activities. *SeniorConnect* staff work closely with providers and other key stakeholders to enhance service options for the Medicare-Medicaid members who are 65 and over. Access to Medicare Part A, B and D data will increase the effectiveness of the *SeniorConnect* program.

Magellan has an Intensive Care Management (ICM) program that serves its high need members. This program is intended for members who exhibit continued symptoms and poor functioning in the community due to a mental health and/or substance abuse diagnosis. Target populations include:

- Frequent use of the emergency room or psychiatric hospital
- Co-occurring conditions (mental health and substance abuse/intellectual disabilities/medical)

- Children being served in multiple systems with a need for coordination.

Within ICM, Magellan uses Joint Treatment Planning to achieve a coordinated and consensus-based treatment plan. Magellan involves the client or parent/guardian for a child in the process and invites treatment team members to join in person or on the phone. Magellan leads the Joint Treatment Planning to obtain all input with the member and family in charge of decision-making for services and supports for a treatment plan.

As part of the Intensive Care Management, Magellan partners with IME to assure that members in disease management through IME have an opportunity to access needed mental health or substance abuse services when indicated through a clinical screening process. IME connects directly with Magellan staff to connect the member to services and to perform crisis counseling in severe situations. Again, access to the Medicare Part A, B and D data will increase the ability to identify and include Medicare-Medicaid members in the ICM program.

The partnership established between IME and Magellan is only strengthened in this shared vision of improving the care of this population.

All members enrolled in Medicaid's Iowa Plan are eligible for Disease Management services. As an expansion effort, Magellan plans to use Medicaid Part D data for Iowa Plan Medicare-Medicaid members to identify gaps in prescription refills. Two key activities include reconciling medications and supporting adherence, both have shown to be effective in improving outcomes and decreasing hospital readmissions. In addition to the more common tools to identify drug-drug interactions, Magellan has built guidelines to identify drug-disease interactions and concerns that are specific to the Serious Mental Illness (SMI) Medicare-Medicaid members and their therapies. The new access to Medicaid Part D data allows Magellan to more effectively manage Medicare-Medicaid members.

The IME manages an in-house disease management program that focuses on the high risk population. Medicaid members engage with health coaches that encourage better adherence to evidence-based practices, help to coordinate needed services, and employ methods for members to have successful provider visits. Health coaches monitor prescription adherence and establish relationships with members to ensure better health outcomes. Predictive modeling tools allow IME to identify members most in need. The members most in need (highest health risks) that do not reside in a Health Home service area are encouraged to participate in IME's disease management program. Those in a Health Home service area are encouraged to connect to a Health Home. As the Health Home network of providers grows, members in disease management will be transitioned to a Health Home in their community.

Building on the existing Disease Management program, the IME has established protocols with several hospitals across Iowa to provide daily censes files of Medicaid

members that have presented at an emergency room or been admitted to the hospital. As the Disease Management program grows to include Medicare-Medicaid members, and Health Homes are established across Iowa, as mentioned earlier in this proposal, sharing this data with Health Home care coordinators will enhance coordination, improve transitions in care settings, and reduce avoidable hospitalizations

The IME also manages a lock-in program that identifies members that are abusing medical services, most commonly, dangerous, addictive prescription medications. These members often move from provider to provider to hide this behavior and take advantage of the open access FFS environment in Iowa. The IME lock-in program identifies members abusing prescription drugs and locks them into four specific providers for which they can receive care. In an effort to better manage Medicare-Medicaid members that qualify for lock-in, the state requests a partnership with CMS to better manage this population. Using the Medicare Part A, B and D data and an existing algorithm, the IME can identify Medicare-Medicaid members that qualify for the Medicaid lock-in program and share that information with CMS. CMS could move these members into a Part C plan or work with the IME in establishing a lock-in program similar to what IME has in place for Medicaid members.

### Delivery System: ACO Model

Although early in the stage of development, the IME is committed to work with systems willing to operate as an ACO and flexible in payment reform concepts. Using the TriHealth Pioneer ACO relationship with CMS, the IME is working to identify a method in which we can share savings for the Medicaid population in the same market as the Medicare Pioneer ACO. The TriHealth group is also engaged with IME in the Health Home program and determining how to best fit Health Home requirements into practice workflow.

### Infrastructure Support System: BIPP and the NWD/SEP for Home and Community Based Services

Iowa is committed to improving care and rebalancing Long Term Supports and Services (LTSS). In a system with the BIPP principles in place (conflict free case management, efficient enrollment processes, standardized assessments, etc.), a Health Home has the needed infrastructure and tools to coordinate care for members transitioning to LTSS in both a Home and Community Bases Setting (HCBS) or an institutional setting.

Analysis of Iowa's Medicare-Medicaid population includes the following:

- 24% have a serious and persistent mental illness (SPMI)
- 19% are in an institution
- 27% are currently receiving waiver services
- 54% are disabled, (SSI)
- 73% of Medicaid's expenditures for this population is for LTSS

It is likely that all Medicare-Medicaid members across Iowa will benefit from a No Wrong Door and Single Entry Point (NWD/SEP) system that focuses on the development of an infrastructure that supports both workforce training and helping members make the right decisions for needed care.

One of the infrastructure developments supported by the BIPP is known as Iowa's Information and Referral Network (I&R network). The I&R network ensures LTSS information is consistent and that access is streamlined for all Iowan's in need. The IME is partnering with the Department of Human Services – Mental Health and Disability Services Division, and the Iowa Department of Aging to establish the I&R Network. The I&R Network provides a resource for Health Home providers (or any provider) to connect Medicare-Medicaid members to the right services when needed. In addition, the state is developing a single entry point (SEP) website that will house a state-wide assessment and application for DHS services, including Medicaid eligibility, food assistance and waiver services. The new SEP system will provide an immediate response to members indicating they will receive by email or telephone within two working days, the name of a SEP coordinator who is assigned to their application.

The No Wrong Door (NWD) awareness and education campaign is targeted to members, family members, and providers to use this simple, streamlined approach to access information, referrals, and services so members in need can access the care that is available to them. Workforce training that focuses on Options Counseling and action plans developed from the MDS Section Q are components that need consideration when coordinating care for Medicare-Medicaid members and will be part of the workforce training for the BIPP.

Workforce training that has a direct impact in reducing avoidable hospitalizations and Institutional LTSS should occur within the state from multiple locations. The BIPP Initiative and the Health Home program are just two programs directly managed by the IME designed at integrating and managing these transitions in care settings. However, healthcare organizations across the state are engaged in innovative programs like Partnership for Patients and the Million Hearts campaign. The workforce training in those initiatives that impact Medicare-Medicaid members are described in Section J "*Interaction with Other HHS/CMS Initiatives"* of this document.

Part of the BIPP strategy is entwined in a current state-wide effort to redesign the mental health delivery system. Wrought with inconsistency of available services, and numerous barriers to access care, the 2011 Iowa Legislature mandated the elimination of the current county-funded system beginning in July 2013. Iowa is implementing a system comprised of standardized assessments, uniform access to core services, and conflict free case management. The development of regional-based entities instead of county-based entities is one of the proposed design elements of the new system.
A well know challenge in implementing the requirements of BIPP in Iowa is the lack of community capacity. The Olmstead Plan cites such wide-ranging issues as provider

staff training to address the needs of individuals with challenging behaviors, under developed supportive employment services, and lack of accessible housing and transportation. Much of the state is rural and factors such as the acute shortage of mental health professionals can severely limit supports and services. Redesign legislation as well as other on-going initiatives, like the Health Home program are intended to address many of these issues.

Coordinating with partnering agencies and utilizing the resources of the IME, the BIPP project is on target for implementation in 2013. This effort will be closely controlled within the IME to ensure the correct policies and procedures are in place to meet the vision of better integrated care for all members, including Medicare-Medicaid members both in and out of Health Home service areas.

Iowa Department of Human Services

## Member Profiles for Managed FSS Environment:

James is a 67 year old Medicare-Medicaid member with a history of osteoarthritis, degenerative disc disease and has had two back surgeries. He has limited range of motion in his extremities, daily pain, and requires the help of another person to bathe safely and to dress each day. He is not able to cook nutritious meals for himself or manage his medications safely. He has been depressed since his last back surgery, after which he had to be placed in a nursing home for recovery.

| **Health Home** | **BIPP** | **No Managed FFS** |
|---|---|---|
| *If James was connected to a health home prior to his back surgery, the hospital discharge planner (trained through HEN outreach) would have contacted his Health Home Care Coordinator to establish a discharge plan that works for James. They would have placed him in a nursing home close to family supports and began to update his care plan to address changes to his mobility, medication management and goals to return home.* | *With a successful awareness campaign and implementation of strong information & referral network, James is likely to access the Elderly Waiver program. The care team could order a standardized assessment that would indicate that James is a candidate for Home and Community Based Care, allowing him to live at home while a team of professionals provide needed care like transportation assistance, meal delivery and personal care.* | *Without the Health Home assisting the discharge planner, James would likely be placed in a nursing home outside of his community. Without family support, awareness of waiver programs, or the standardized assessment, James' recovery in a nursing facility could turn into a long-term stay, increasing his depression and adding barriers that potentially prevent his return home.* |

Annie is 47 years old and is disabled due to Multiple Sclerosis (MS). Because of her inability to walk on her own, she is unable to exercise and what was once an overweight condition has become a morbid obese condition. She was very scared when she needed to be hospitalized for pneumonia over the winter. She had been hearing stories from other MS patient on her online patient support group of long illnesses, incomplete recoveries and even deaths after what should have been minor illnesses.

| **Disease Management** | **HEN** | **No Managed FFS** |
|---|---|---|
| *Annie recently began talking to a Health Coach at the IME. Daily Census files from the hospital alerted the IME to Annie's hospitalization. Her coach was able to talk to Annie prior to discharge and encouraged her to follow up with her primary care office, per the hospital recommendations. She also walked Annie through her new medication list and helped her establish an action plan for recovery.* | *Annie's hospital recently worked with an Improvement Advisory supplied from the Iowa Hospital Engagement Network. During that session, they implemented new protocols to prevent hospital-acquired infections and standardized evidence-based protocols. Their commitment to the Partnership for Patients Initiative was evident by the professional and caring service they gave Annie. Annie left the hospital confident with her recovery.* | *Annie's apprehension of the hospital could have been inflated by a care team not prepared to deal MS /obesity in addition to the pneumonia. Worst case scenario may have acquired a staph infection that extended her stay and threatened Annie's life. Without the contact with her health coach and lack of trust in the hospital staff, Annie is likely to not follow the discharge plan, miss use her medications, and her conditions will continue to worsen.* |

Bertie is sick. She is 55 years old and a morbidly obese diabetic. She has chronic obstructive pulmonary disease (COPD), rheumatoid arthritis, and is nearly blind. She has been hospitalized 10 times in the past year and is a regular at the local emergency department, where she has been nicknamed "Back-Again Bertie" by staff. She has no regular doctor, but claims she receives all the primary care she needs from the ER. The ER has referred her to several internists, but she never keeps the appointments. She has never been adequately diagnosed, but it is believed she has bipolar disorder. Her purse is filled with prescription bottles of meds all written by different providers. She takes whichever she feels she needs at the moment.

| **Disease Management** | **Health Home** | **No Managed FFS** |
|---|---|---|
| *Using predictive modeling, the IME identified Bertie as a candidate for coordination. There is not a current HH in her community so an IME Nurse Care Coordinator reaches out to Bertie. Together they develop a care plan and she begins to educate Bertie on the need for a PCP instead of the ER. The nurse helps Bertie with transpiration services, once she discovers the ER is on the bus route but the primary care office is not. She has finally regulated her COPD and has a complete list of medications in her purse.* | *After 1 year of disease management, the IME identifies a health home provider for Bertie. Her PCP just signed up to be a health home. The IME nurse calls the HH care coordinator to provide her care plan and needed information about transportation services and Bertie's desire to stay at home. The Health Home recently added a depression screening to their workflow and from the results, has arranged an appt at the local CMHC for Bertie.* | *Without Managed FFS opportunities' Bertie is likely to continue to use the ER, and never gain control of her chronic conditions. Hospital discharge planning w/o a designated care coordinator becomes increasingly difficult. With each hospitalization the likelihood of Bertie returning home decreases, and eventually Bertie will end up in a LTC facility, and may never get the mental health services she needs.* |

## D. Stakeholder Engagement and Beneficiary Protections

### Description of Stakeholder Engagement:

The state is engaged with several groups of stakeholders comprised of providers, member advocacy groups, policy makers, group associations, and State agencies while developing our Health Home State Plan Amendment. The tables on the following pages describe stakeholder involvement.

Iowa Collaborative Safety Net Provider Network Leadership and Advisory Group Meeting

**Members include representation from: FQHC Consumer Representatives, Iowa Department of Public Health, Local Public Health Departments, Safety Net Providers, Behavior Health Associations, Pharmacy Associations, and Medical Associations**

| Date of Meeting | Relevant Agenda Item | Summary of Outcome |
|---|---|---|
| **9/20/11** | Status of 2703 Amendment<br><br>and<br><br>Update on Magellan Integration Projects | **Obstacle identified:** CMHCs have a technology barrier, as being excluded from EHR Incentive programs**.**<br>**Action identified:** IME is working closely with Magellan (MCO) to identify and overcome barriers for CMHCs to participate as a Health Home provider.<br><br>One example is Joint Commission Standards specific to mental health be utilized for PCMH recognition.<br><br>A LL from the integrated HH pilot is that SMI adults are seeking medical care from sources outside of the FQHC partner.<br><br>Working to develop this integrated pilot in a rural setting. |
| **3/8/12** | IME's Health Home Update | **Obstacle identified:** Some practices ability to hire care coordinators and health coaches to support Health Home activities. |
| **3/8/12** | Breakout Subcommittee of Leadership: Discussion of ACA impacts to Safety Net Providers | **Action identified:** A Core group formed to work with NASHP on a Technical Assistance Grant that assists states in developing work plans to increase the effectiveness of Safety Net providers delivering Health Home services to members, including Medicaid-Medicare members. |

Medical Assistance Advisory Council (MAAC)

This meeting is open to the public and is held in a location that allows individuals with disabilities to access in person or through a teleconference. The agenda and minutes of this meeting is publicly available.

**Members include representation from: various associations, various State Departments and agencies, University of Iowa College of Medicine, Coalition of Family and Children's Services in Iowa, Members of the General Assembly from the House and Senate. A complete list of members can be found at: http://www.ime.state.ia.us/MAAC/#search='MAAC'**

| Date of Meeting | Relevant Agenda Item | Summary of Outcome |
|---|---|---|
| **11/16/11** | Medical Home Update | Reviewed the HH SPA submission and intent to implement in mid-2012. |
| **3/21/12** | Health Home | Discussed the progress of Section 2703 and the states intent to develop a "Duals Proposal" and the five proposed strategies. |
| **5/16/12** | Duals Proposal | Described the Managed FFS model and the focus on Medicare-Medicaid members. Walked through details of each component and urged comments and written responses to DHS. |

Medical Home System Advisory Council/Prevention and Chronic Care Management Advisory Council **– Combined in January 2012 to MH/PCCM Advisory Council**

**Members: The Advisory Councils includes representation from health care, state agencies, academia and consumers. A complete list of members can be found at: http://www.idph.state.ia.us/MedicalHome/ or http://www.idph.state.ia.us/ChronicCare/**

| Date of Meeting | Relevant Agenda Item | Summary of Discussion |
|---|---|---|
| **12/1/10** | IowaCare Expansion, Medicaid Health Care Reform Implementation | Reviewed Several PPACA opportunities for Medicaid to implement. |
| **5/24/11** | IowaCare Medical Homes and ACA Health Homes<br><br>and | A discussion around who is best to coordinate the care for a member with SPMI. Is this at the primary care setting or the community mental health center?<br><br>Concern that the integrated pilot is underestimating the medical needs of these patients. |

| | | |
|---|---|---|
| | Integrating Health Homes and Mental Illness | The pilot is an attempt to merge the care, build relationships between primary and mental health providers and give the patient a true Health Home. |
| **6/16/11** | Medicaid Health Care Reform Implementation – ACA Health Homes for Enrollees with Chronic Conditions | Received additional conditions to consider for HH services: Traumatic brain injury, cancer, premature birth, and neurological conditions.<br><br>IME is considering additional SPAs that focus on specialized populations. |
| **12/1/11** | Medicaid PPT – Iowa Section 2703 Health Home Development | Discussed the inclusion of Medicare-Medicaid populations in the Health Home program.<br><br>Discussed how IME can provide technical assistance to providers to identify members.<br><br>Council reviewed the Member Agreement forms – (No feedback was received to the IME).<br><br>Question received on how to incentivize the member to participate. Iowa applied for the Section 4108 grant to give incentives to members, but was not awarded. |
| **4/12/12** | Medicaid Health Care Reform Implementation | Discussed Section 2703.<br>• Comments were received on the complexity of the peds population and the need to address this is future iterations.<br>• Discussed excitement on this movement moving forward in Iowa<br>Discussed Duals Population. The IME requested feedback on Posted draft to integrate care for Duals. |
| **5/25/12**<br>**7/25/12** | Future | Future |
| 2012 Health Care Reform and Community Resources Summit<br>A FREE education event hosted by the Iowa Insurance Division Consumer Assistance Program http://insuranceca.iowa.gov/outreach_events/summitflyer.pdf | | |
| **5/3/12** | Iowa Medicaid Enterprise | Walked attendees through the Duals proposal. Received questions about how this will eliminate barriers for Duals and if one benefit of a health home will be improve access. |

### Description of Member Protections:

Medicare-Medicaid members are not required to participate in the Health Home, PACE, or any Disease Management program. Once enrolled, the member may elect to opt-out of these programs at any time. Regardless of the participation of the member in one of these programs, or decision not to participate, the member retains the inherent rights under the Medicaid program. These include, among others, the right to select a provider, the right to review medical records, the right to a second opinion and the right to a state fair hearing when the member is aggrieved. Medicare-Medicaid members follow the same grievance process, established for all Medicaid members and is outlined in "Your Guide to Medicaid" found at http://www.ime.state.ia.us/docs/Comm20.pdf. The grievance process is also available to members calling the Member Services center. An IME member service representative assists members in knowing their rights and how to request an appeal of decision.

The member's decision to participate or to not participate in a health home or Disease Management program does not remove or modify any other provision of the Medicaid program to which the member is entitled.

The IME operates a secure system of claims data and follows guidelines to ensure privacy of member health records. All members, including Medicare-Medicaid members have access to view their own Medicaid claim history. The IME Member Services Center assists members with this request process.

### Description of Continuation Efforts:

The State plans to continue engaging the above identified stakeholders and advisory groups through the implementation and operational phases of the project. The advisory and consumer groups identified are active and engaged, and continue to receive project updates and provide comments that shape this project as it moves forward.

The State is in the midst of redesigning the Department of Human Services (DHS) website and once completed, intends to post 508 compliant Health Home information specific to Medicaid providers and members for universal access.

Although the initial member engagement in a Health Home comes from the Health Home provider, members receive confirmation of their Health Home enrollment by an informational letter sent through the US Postal Service from the IME. The IME is developing methods to identify Medicare-Medicaid enrollees with the highest risk and qualify for Health Home services using predictive modeling tools and then send correspondence that refers them to local Health Home providers.

All DHS correspondence is available in English and Spanish and translation services for most languages are available through the Member Services call center language line (M-F 8am – 5pm). Members have access to the Member Services call center (via

telephone, email or mail) during operation hours to discuss or ask questions about the Health Home and any correspondence they have received. Members are referred to their Health Home when appropriate to seek quality medical care.

## E. Financing and Payment

### Description of Payment Reform:

The IME infuses dollars into the primary care setting to focus resources on comprehensive patient care with an emphasis on care coordination. The Health Home State Plan Amendment authorizes the State to pay Health Home providers for Health Home services; Since Iowa is primarily a FFS state, this proposal uses the Managed FFS financial alignment model to engage in a shared savings opportunity with CMS.

### Description of Health Home Payment Methodology:

In addition to the standard FFS payments to providers, the IME pays designated Health Home providers a Patient Management PMPM payment for each qualifying Medicaid member, including Medicare-Medicaid members. At the time of enrollment, the provider conducts a health assessment to tier the patient into one of four levels that indicates the level of risk and acuity of the member's chronic conditions.

| **Patient Management Payment** | |
|---|---|
| **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** |

Health Home providers submit an electronic claim each month for Health Home services. The minimum service meriting a Patient Management PMPM payment is that the person has received care management monitoring for treatment gaps defined as Health Home services in the State Plan, or any covered service defined in the State Plan was provided and has been documented in the member's electronic health record (EHR).

Health Home providers are further incentivized by an annual lump sum performance payment, starting in year two, that could equal as much as twenty percent of the sum PMPM payments received by the Health Home during the reporting year. To qualify for the performance payment, Health Home providers must reach quality thresholds in categories covering a range of prevention, disease management, and mental health integration measures.

## F. Expected Outcomes

The IME agrees to share data with CMS to inform program management, rate development and evaluation of this proposal. To the extent possible, the state will work

to collect additional data needed to support program management, rate development and evaluation of this proposal to share with CMS.

### Description of High Quality Care Evaluation:

The IME is working with the University of Iowa Public Policy Center (PPC) to conduct yearly evaluations of the overall Health Home program by developing a compare study of a control and non-control group. The PPC currently has access to Medicaid claims data and will soon have access to Medicare A, B and D data. A component of the evaluation focuses on Medicare-Medicaid members; however the CMS resources to support these efforts is a great aid, as neither the IME nor the PPC have experience in analyzing Medicare data.

The evaluation includes the member's access to care, utilization of services, and overall cost savings. Additionally, the PPC conducts a PCMH CAHP patient survey to assess the member's experience. The program evaluation compares quality of care using HEDIS measures, NQF endorsed measures, CHIPRA measures and the Core Health Home measures required by CMS. Public Policy Center posts all evaluation reports on their website for public access.

The IME is also conducting a quality-based Performance Payment that requires Health Home providers to connect to the IHIN and report quality outcome measures directly from the patient's Electronic Health Record (EHR) data. The Performance Payment is measured within the IHIN's quality portal through a direct messaging system that passes Continuity of Care Document (CCD) information for Heath Home members to the IME. Providers have real-time access to quality reports as they track their progress throughout the measurement year. These reports combine all Health Home members for the Health Home provider. The state does not have the ability to separate measure data for the annual quality bonus measures to distinguish Medicare-Medicaid members from Medicaid only members.

### Description of Improvement Targets/Measures:

1. Core Health Home measures:
    - Adult BMI Assessment
    - Ambulatory Care-Sensitive Condition Admission
    - Care Transition – Transition Record Transmitted to Health Care Professional
    - Follow-up after Hospitalization for Mental Illness
    - Plan – All Cause Readmission
    - Screening for Clinical Depression and Follow-up Plan
    - Initiation and Engagement of Alcohol and Other Drug Dependency Treatment
2. Program Monitoring and Evaluation
    - Avoidable Hospital Readmissions
    - Cost Savings from Improved Chronic Care Coordination and Management
    - Hospital admissions (HEDIS specs, compare control and non-control)

- Emergency room visits (HEDIS specs, compare control and non-control)
- SNF Admissions (monitoring through claims data and manual review of reason for admission)
- Estimate of Cost Savings (NOTE: This is from Medicaid's perspective, the State needs CMS's assistance in determining Medicare's cost savings for Medicare-Medicaid members in a Health Home.)

3. Program Quality Measures
   - Increase use of Preventive Services (NQF038)
   - Improved Diabetes management
     - Dilated eye exam (NQF055)
     - Microalbumin (annual) (NQF062)
     - Foot exam (NQF056)
     - Proportion with HgA1c less than (NQF0064)
     - Proportion with LDL less than 100 (NQF013)
   - Follow-up care for children prescribed ADD medication (CHIPRA21)
   - Child Visit in the first 15 months of life (CHIPRA10)
   - Annual Dental Visit (CHIPRA 3)
   - Breast cancer screening (NQF031)
   - Women who received one or more Pap tests to screen for cervical cancer (NQF032)
   - Patients aged 6 months and older who received influenza immunization (NQF041)
4. Provider Quality Measures for Performance Payment
   - Increase use of Preventive Services (NQF038)
   - Flu Shots for Adults (NQF041)
   - BMI documented with appropriate follow-up (NQF421 and 0024)
   - Diabetes Management (NQF055, NQF062,NFQ056, NQF0064, NQF013)
   - Asthma Management(CHIPRA20)
   - Hypertension Management (NQF013)
   - Systemic Antimicrobials (CHIPR16, PQRI93)
   - Mental Health discharges w/ outpatient encounter within 7 days (CHIPR23, NQF576)
   - Clinical Depression Screening (NQF0418, PQRI134)
   - Total Cost of Care

### Description of Expected Impact:

Iowa has not yet received Medicare Part A, B or D data, and therefore analysis of effects of cost-shifting between the two programs from the above described approach for this population has not been modeled. Iowa has spent time with our actuary analyzing the specific fiscal impacts to Medicare and Medicaid in implementing a Health Home model in Iowa.

- Medicare-Medicaid members represent 25% of the eligible Health Home members in Iowa; however this population more highly represents the less healthy of the eligible Health Home members.
- For the Medicare-Medicaid members, the savings expected for Medicare are proportional to the savings expected for Medicaid. However, the overall Medicare percentage of savings is higher because the payments made to Health Home providers come directly from the Medicaid program.
- An actuarial analysis[2] of the Health Home model comparing low and moderate scenarios projects:
    - $7 to $15 million in savings to the Iowa Medicaid program over a three year period.
    - $17 to $25 million in savings to the Medicare program over a three year period.

## G. Infrastructure and Implementation

### Description of Staffing/Resources:

The concept of IME bringing together a consortium of state staff and vendors is further strengthened by cohesive supervision, the co-location of all staff into a single building, and providing a direct connection to the DHS State network for every staff member. The staff works collaboratively to eliminate redundancies, share information, and reach the common goal of improving health across the state. The Department of Human Services facilitates this type of collaboration by operating in an oversight capacity for the entire program, upholding IME core values and ensuring a unified approach.

Within any organization there can be challenges to integrate projects beyond the normal work boundaries of a department or unit. The IME combats those natural tendencies by establishing regular meetings with department unit leads to discuss project work and bring full awareness to all initiatives within the IME. The IME also provides a weekly email communication, titled “Finger on the “Pulse” at Iowa Medicaid”. “The Pulse” shares a summary of important activity, the achievement of milestones, legislative news, and issues the Medicaid Director is addressing that week. A quarterly IME newsletter also highlights new initiatives, operational program work, and brings cohesion to staff within the IME.

The below list of resources highlights staff within the IME that are responsible for the Managed FFS model described within this proposal.

[2] Milliman Inc., December 7, 2011 - Iowa Chronic Condition Health Home Program Care Coordination Rating Tiers and Financial Impact Analysis.

| Resource Team | Title/Role | Percent Available | Source |
|---|---|---|---|
| Sara Schneider | Policy Specialist – ACA | 15% | IME State Employee |
| Unknown | Policy Specialist – ACA | 25% | IME State Employee |
| Marni Bussell | Project Manager | 40% | Current IME Contractor/ Telligen |
| Jason Kessler, MD | Medical Director | 15% | Current IME Contractor/ Telligen |
| IME Core | Data Technical Support | 10% | Current IME Contractor/ Noridian |
| Randy Clemenson | Data Warehouse Analyst | 10% | IME State Employee |
| Randy Clemenson/ IME Core | Application Development Staff | 10% | IME State Employee and Noridian |
| Magellan Behavioral Care of Iowa | Disease Management | 20% | Current IME Contractor/ Magellan Behavioral Care of Iowa |
| University of Iowa Public Policy Center | Evaluator | As needed | Business Associate of IME |
| Member Services Unit / APS | Disease Management | As needed | Business Associate of IME |
| MVM | Data Analysts | As needed | Current IME Contractor/OptumInsight |
| Provider Services Unit | Provider Support Services | As needed | Current IME Contractor/ |
| Other IME Units | Other IME Units | As needed | Current IME Contractors |

The ***Policy Specialist*** from IME provides valuable insight and direction for current Medicaid programs, Iowa Administrative Code, and Iowa Code to assist in developing an approach that aligns with Iowa rules. The Policy Specialist is a key resource in executing outreach initiatives. Policy staff will also administer access to the Medicare Part A, B and D data for only those initiatives outlined in the State's Data Use Agreement (DUA) for the purpose of integrating care for dual-eligible members.

A ***Project Manager*** for IME provides the team a proven system to deliver a quality product within the timeframe and budget constraints established. With an emphasis on planning, a project management methodology will produce the necessary details to deliver an integrated solution that translates into a smooth implementation plan.

A ***Medical Director*** for IME provides the team the necessary clinical expertise and guidance to design a solution that is practical, innovative and patient-centered.

The ***Data Warehouse*** staff from IME supports the storage and querying of the Medicaid member, provider and claims data, based on the direction of the policy staff. The task of acquiring and linking the Medicare data with the Medicaid data will fall into the realm of the Data Warehouse team.

The **Application Development** staff from IME provides the technical expertise to design and code an Information Technology (IT) solution that supports the deployment of the Health Home model. The IME is currently developing system changes to the Iowa Medicaid Provider Access system (IMPA), the Medicaid Management Information System (MMIS), and the Title XIX systems.

The **Magellan** team provides the necessary expertise in designing and implementing an integrated solution to the duals with a primary diagnosis of a serious mental illness. They are key partners with the IME in the planning and implementation of Health Homes and the analysis of the dual population data and performing disease management services to members that are not part of a Health Home.

The **APS** team provides necessary expertise in identifying Medicare-Medicaid members in the highest risk groups. They assist in connecting those members to a Health Home and if those services are not available to them, will engage those members in disease management services.

The **Evaluator** provides necessary expertise to analyze results of the Health Home program and to see if interventions aimed at improving the care of members (both Medicaid and Medicare-Medicaid) has succeeded.

The **MVM** staff provides necessary expertise to analyze data and draw conclusions on areas of need and where an intervention may have the maximum impact.

The **Provider Services** unit provides support to Medicaid providers enrolling with the IME, provides claims technical assistance, and conducts outreach and engagement efforts under the supervision of the IME.

Other **IME Units** will be utilized, as needed to support the implementation of this proposal. As the Accountable Entity, the IME will utilize all assets to assist in achieving a successful program.

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## H. Feasibility and Sustainability

### Description of Barriers/Challenges for Implementation:

The pace at which Iowa providers sign up and adopt Health Home Provider Standards depends on the maturity of Iowa practices in the area of Health Information Technology (HIT) and Patient Centered Medical Home (PCMH). A qualified Medicare-Medicaid member may have to wait until a practice in their community is able to provide Health Home services. This affects the volume of Medicare-Medicaid members impacted during the demonstration period. The state will consider a Health Home practice facilitation model that accelerates the maturity of Iowa practices in the area of HIT and PCMH.

The effectiveness of the State at connecting qualifying Medicare-Medicaid members to a specific Managed FSS program may be challenging. For members that consider urgent care or emergency departments as their primary access to care should be connected to Disease Management, Health Home, ACO or a PACE program. The state is working on predictive modeling software as a means to identify and connect higher risk members to these programs as quickly as possible.

The state may find challenges in analyzing Medicare Part A, B and D data. The receipt of this data is new to Iowa and although there is infrastructure to receive, protect and report on the data, the technical assistance provided by CMS during this demonstration period is advantageous to ensure successful interventions for Medicare-Medicaid members.

### Description of Statutory/Regulatory Changes needed for Implementation:

**Lock-In Program –** The IME does not require state statutory or regulatory changes for the existing IME Lock-in program, however depending on the means of partnership with CMS, federal level system and regulatory changes may be required.
**Health Homes –** A State Plan Amendment with a July 1, 2012 effective date is currently being reviewed by CMS. The IME is in the process of establishing regulatory rules to effectuate Health Home providers in Iowa.
**BIPP –** The IME is developing and amending regulatory rules for Long Term Care that supports community and institutional care, the expectation of Targeted Case Management, streamlined enrollments and standardized assessments in Iowa.
**ACO –** The IME plans to engage with CMS to establish an 1115 Waiver to establish a Medicaid ACO program with qualified systems in Iowa. In addition to the 115 Waiver, the state anticipates to develop regulatory rules that support the ACO program in Iowa.
**PACE –** The IME requests that CMS consider the expansion of the PACE program a component of the Managed FFS model for this population.

### Description of Funding/Contracting Commitments for Implementation:

The IME has engaged all partners and vendors in the development and implementation of the Health Home program and anticipates entering into a new contract with our

independent evaluator (PPC). Additional contract modifications are not needed to implement the Health Home program however; the IME may establish new contracts or contract modifications to further refine the operation of the Health Home program.

The IME is early into the development of the BIPP and the detailed work plan has not been established. It is likely that the detailed work plan will outline new contracts or contract modifications to carry out the requirements.

### Description of Scalability and Replicability:

The Health Home concept developed by Iowa is adoptable and scaleable for a state working in a fee-for-service environement. The opportunity of Section 2703 of the Patient Centered Affordable Care Act allows any state the option to implement this model of care. To realize the State and Federal vision of integrated care within our health care system, infrustructure and workforce development speak to the degree and ability to which others can replicate change.

The Health Home model will grow in Iowa as the HIT/PCMH maturity increases in Iowa. The efforts to grow HIT, through the EHR Medicare and Medicaid Incentive programs and activity of the State's HIT Regional Extension Center is building the needed infrustructure. The PCMH movement in Iowa is strong and backed by legislatively mandated advisory councils and active provider organizations committed to PCMH. The State's vision to create the IHIN bridges the IT gap in providing appropriate, secure data sharing efforts among Iowa providers to increase coordination and effeciency of the Iowa health care system.

Workforce development also plays a critial role in the scalability and replicability of improved care coordination for all patients, including the Medicare-Medicaid members. The IME is keenly aware of the need to prepare all providers, administrators, and hospital systems to change workflows, increase capacity and reduce waste in our system. The work described in Section J below of Iowa's HEN contractor, along with the eduction campaign of the BIPP initiative, and IME's efforts to spread PCMH to providers is eviendce that Iowa is committed to the innovation needed to achieve success.

## I. Additional Documentation (as applicable)

Documents provided with this proposal include:

- Milliman Report with financial modeling of the Health Home program
- MVM Report on Duals using Medicaid data
- Iowa's HH State Plan Amendment

Iowa Department of Human Services

## J. Other HHS/CMS Initiatives

### IHC's Infrastructure Support System - HEN:

The Iowa Healthcare Collaborative has been awarded the single Iowa-based contract to serve Iowa hospitals as the Hospital Engagement Network (HEN). The HEN was craeted to identify and create innovative solutions designed to reduce patient harm and improve care coordination. CMS awarded 26 organizations a two-year contract to help identify the key improvements and spread initiatives across their defined population. IHC will work with the Iowa Hospital Association (IHA) and Telligen to implement the program. The Partnership for Patients, the HHS Action Plan to Reduce Racial and Ethnic Health Disparties and the Million Hearts Campaign are all initiatives being addresed by this collaborative effort.

Through the HEN collaborative model, IHC will create an interactive group of hospitals and health systems that will take part in education, analysis, information and data exchanges. The collaborative develops a model to track hospitals' process and outcomes data and measure their performance on improvement goals

IHC's vision is to create an Iowa healthcare culture of continuous improvement in quality, safety, and value that provides the most effective and efficient care in the nation.

### Workforce Training:

Over the next two years, the HEN will focus on 10 key areas that will seek to improve hospital performance on the following quality markers: adverse drug events, catheter-associated urinary tract infections, central line-associated blood stream infections, injuries from falls, adverse obstetrical events, pressure ulcers, surgical site infections, ventilator-associated pneumonia, venous thromboembolism, and preventable hospital readmissions.

The HEN will include 116 of Iowa's community hospitals, as well as five hospitals accross state lines affiliated with Alegent Health System. Each hospital leader will designate contacts to lead hospital-based improvements and serve as the point contact with IHC. Hospitals can expect to receive increased access and participation in quality improvement processes that will influence the future of healthcare. Some of the opportunities include:

- Participation in face-to-face Learning Communities throughout the year to share and spread best practices in the applicable areas
- Topically-focused webinars from content experts
- A web-based metric reporting and tracking database, developed by IHA, will provide real-time information to lead process improvement interventions
- An Improvement Advisor will be assigned to each hospital to serve and assist with the work currently being done at the hospital

- Leadership resources to help improve the culture of safety
- Learning networks that will allow hospitals to share success stories and struggles in an effort to raise the standard of healthcare
- Access to a Lean Process Improvement expert through educational opportunities and on-site coaching
- Technical assistance, through Telligen, for hospitals that would like to have content improvement experts work with hospital staff
- Resources to assist hospitals in physician engagement strategies

The HEN will provide a voice for those best practices and successful interventions already deployed by hospitals. IHC hopes to serve as a resource for hospitals to spread these interventions and provide evidence-based best practices to facilitate the improvement process. The HEN will possess a unique advantage with the ability and willingness of Iowa hospitals to collaborate and engage in a statewide effort to provide the most effective and efficient healthcare in the nation. This will impact the health of all patients, regardless of payor status.

## K. Work plan/Timeline:

| Timeframe | Key Activities/Milestones | Responsible Parties |
|---|---|---|
| Jan – May 2012 | Approve State Plan Amendment for Health Homes Section 2703 | State /CMS |
| Jan – May 2012 | IHC's – Phase 1 HEN: Charter, Work Plan and Measurement | IHC |
| March 2012 – Ongoing | Perform outreach and technical support for Health Home Providers | State |
| April 13, 2012 | Milestone – Post Financial Alignment Demonstration Model for 30 day State Comment Period | State |
| April 30, 2012 | Milestone – Apply to CMS for BIPP | |
| May 25, 2012 | Milestone – Post Financial Alignment Demonstration Model for 30 day Federal Comment Period | State |
| June 2012 – Ongoing | Enroll qualified members with Approved Health Home Providers | HH Providers |
| June 2012 – May 2013 | IHC's – Phase 2 HEN: Improvement Work & Monthly Reporting Improvement Work | IHC |
| June 30, 2012 | Milestone – CMS approves Iowa' BIPP application | |
| July 1, 2012 | Milestone - HH State Plan Amendment Effective | |

| Timeframe | Key Activities/Milestones | Responsible Parties |
|---|---|---|
| July 1, 2012 | Milestone – Iowa starts to receive 2% increase in FMAP funding for BIPP | |
| July 2012 – Ongoing | Connect HH Providers to IHIN | State |
| September 1, 2012 | Milestone – Establish ACO model (payment, measures, attribution | State |
| September 1, 2012 | Use predictive modeling to identify Medicare-Medicaid members for HH and Disease Management Services | State |
| September 1, 2012 | Milestone - Signed MOU and Contract | State/CMS |
| September 1, 2012 | Develop a NWD/SEP system work<br>Define Conflict Free case management for BIPP<br>Develop uniform assessment tools | State |
| January 1, 2013 | Milestone- Medicare-Medicaid start receiving Disease Management Services | |
| January 1, 2013 | Milestone – HH Quality/Outcome Reporting for Providers through the IHIN begins | State |
| January 1, 2013 | Milestone – Shared Saving contract for Medicare-Medicaid members begins | State/CMS |
| January 1, 2013 | Submit final work plan to CMS outlining how Iowa will satisfy BIPP requirements (must be 6 months from date that CMS approves BIPP application). | State |
| February 1, 2013 | Milestone – Submit ACO waiver to CMS for Approval | State |
| July 2013 – December 2013 | IHC's – Phase 3 HEN: Improvement work and Monthly Reporting Work | IHC |
| July 1, 2013 | Milestone - One year of Health Home - Evaluation Report work starts | State/PPC |
| July 1, 2013 | Milestone – Have at least one ACO MOU signed with a health system. | State |
| January 2014 | Milestone – At least 15,000 Medicaid members attributed to an ACO in Iowa | |