U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

MEDICAID HEALTH HOMES IN IOWA:

REVIEW OF PRE-EXISTING INITIATIVES AND STATE PLAN AMENDMENT FOR THE STATE'S FIRST HEALTH HOMES UNDER SECTION 2703 OF THE AFFORDABLE CARE ACT

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Iowa's Health Home Program at a Glance	
Health Home Eligibility Criteria	2 chronic conditions, 1 chronic condition and at risk of another
Qualifying Conditions	• Mental health condition • Substance use disorder • Asthma • Diabetes • Heart disease • Body mass index (BMI) over 25 • Hypertension • BMI over 85th percentile for pediatrics
Enrollment*	4,396
Designated Providers	Any Medicaid-enrolled provider that meets health home standards
Administrative/ Service Framework	The state offers health home services statewide. Providers include primary care practices, community mental health centers, federally qualified health centers, and rural health centers.
Required Care Team Members	• Designated practitioner • Dedicated care coordinator • Health coach • Clinic support staff
Payment System	Per member per month (PMPM) care management fee, plus lump-sum performance-based incentive
Payment Level	PMPM fee varies by patient acuity tiers: Tier 1--$12.80 Tier 2--$25.60 Tier 3--$51.21 Tier 4--$76.81 Incentive pay based on achievement against 16 measures.
Health Information Technology (HIT) Requirements	Health home providers are required to implement an electronic health record, demonstrate compliance with federal meaningful use requirements, and employ a population management tool. Providers are also encouraged to use technology where possible to enhance patient access and self-management. Additionally, providers are also expected to connect to and participate in the statewide Health Information Network.
* January 2014 data provided to the Centers for Medicare and Medicaid Services' (CMS') Health Home Information Resource Center.	

Introduction

Iowa's Section 2703 Health Home State Plan Amendment (SPA) was approved on June 7, 2012, with an effective date of July 1, 2012. Iowa Medicaid Enterprise (IME), which manages the Medicaid program within the state's Department of Human Services, is responsible for implementation of the state's Medicaid health homes. The state is targeting beneficiaries with two or more chronic conditions, or individuals with one chronic condition and at risk of developing another (see Table 1). Qualifying conditions include mental health conditions and substance abuse disorders, asthma, diabetes, heart disease, high body mass index (BMI), and hypertension. Iowa is using the U.S. Preventive Services Task Force guidelines to inform its definition of "at-risk," which includes genetic predisposition, a diagnosis with established co-morbidities that include one of the qualifying conditions, and environmental exposures known to cause those conditions.

The state offers health home services statewide. As of January 2014, more than 4,300 Medicaid beneficiaries were enrolled in the health home program. Providers include primary care practices, community mental health centers (CMHCs), federally qualified health centers (FQHCs), and rural health centers (RHCs). To be considered a health home, providers must attest to meeting state standards and, in cases where a practice includes multiple sites, share policies, procedures, and electronic systems across locations. The state is also developing a second SPA focusing on adults and children with serious and persistent mental illness.

Implementation Context

Iowa Medicaid includes both a categorically and medically needy program, and covers nearly half a million people, 93,000 of whom are estimated to be health home-eligible.[1] The state operates both fee-for-service and managed care programs. Since 2012, Meridian Health Plan has served as the state's only health maintenance organization, and enrolled approximately 41,000 beneficiaries in 23 counties.[2] Meridian covers only physical health services, as the state carves out behavioral health services. These are managed under a contract with Magellan Health Services.

The state is pursuing a number of simultaneous reforms to its physical, behavioral, and long-term care systems, several of which are relevant to the health home population. Three initiatives in particular have directly informed the development of health homes: the IowaCare Medical Home Project, the Magellan Integrated Health Homes pilot, and the Statewide Mental Health System Redesign.[3]

The IowaCare Medical Home Project began in 2005 under a Section 1115 waiver.[4] The goals of the demonstration are to expand access to health care coverage, improve care quality through the medical home model, and provide financial stability for safety net hospitals with high levels of uncompensated care.[5] IowaCare enrollees are

assigned to a participating medical home, and receive inpatient and outpatient hospital services, physician and nurse practitioner services, some prescription drug and dental services, preventive medical exams, and smoking cessation services.[6]

The demonstration targets two populations:

- Single adults and childless couples between the ages 9-64, who are living at or below 200% of the Federal Poverty Level (FPL) and who are either uninsured or whose insurance does not cover their medical condition.

- Pregnant women with income at or below 300% FPL whose medical expenses--or those of their family--reduce their available income to 200% of the FPL.

The initial phase of the demonstration included two FQHC networks located in Iowa City and Des Moines. By 2010, 39,000 individuals had been enrolled. IME amended its waiver in 2010 to expand IowaCare services into a broader network of FQHCs throughout the state, bringing the total number of participating networks to eight. As of June 2012, IowaCare was providing health care services to over 60,000 Iowans.[7] IME will phase out IowaCare when the Affordable Care Act's Medicaid expansion goes into effect in 2014.

Another building block in the state's health home program was a pilot project run by Magellan Behavioral Care of Iowa, the state's behavioral health managed care provider. As part of its contract with the state, Magellan allocates a portion of its annual capitation payment to fund innovative pilots through its Community Reinvestment Fund.[8,9] From June 2011 through December 2012, Magellan piloted an early form of health homes which targeted individuals with major depression, bipolar disorder, and schizophrenia who were receiving care from one of five participating behavioral health providers. Each of these behavioral health providers partnered with a local FQHC to provide or coordinate primary care services. The care team included a care coordinator, peer support specialist, and a primary care nurse case manager. Nurse case managers were embedded at each site to provide consults to behavioral health staff as well as direct primary care services.

In addition to implementing these two projects, Iowa is in the process of restructuring the funding and management of its mental health and disability services system. The ultimate goals of the system redesign are to expand statewide access to behavioral health services and address the funding imbalances that often underpin access problems. The state legislature passed a bill in 2012 (Senate File 2315) requiring the current county-based system to be reorganized into a regional system by 2014, and created a list of core services to be offered in every region. These core services include treatment, crisis response, community and social support services, and service coordination through case management and health homes. The state also defined baseline requirements related to the administrative, financing, and service structures that each region must establish. The details of these regional structures and processes are still under development, but each region's service management plan

must include provisions to ensure individuals with co-occurring conditions can access the services they need.[10]

The state is aligning this redesign with a federal Balancing Incentive Payment Program (BIPP) demonstration, which targets the long-term services and supports (LTSS) system.[11] This grant provides an increased federal match of 2% for noninstitutional community-based services. The enhanced match will support: (1) the establishment a single-entry point (SEP) system of referral to LTSS; (2) the development of a standardized assessment tool to determine both eligibility for services, as well as individual service needs; and (3) case management services to coordinate community-based services. As part of the mental health system redesign, regional systems will establish agreements with local entities that will act as SEP agencies. In addition to providing information, assessments and referrals, these agencies will also provide follow-up to referred services, including health homes.[11]

Health homes will play a role in Iowa's State Innovations Model Design grant, awarded in February 2013 by the Center for Medicare and Medicaid Innovation (CMMI). The grant provided support for the development of a State Health Care Innovation Plan, which involves developing integrated care delivery models and strategies for payment realignment.[12] Under the current proposal, Iowa will develop a plan to implement an accountable care organization (ACO) structure similar to that developed by Wellmark BlueCross BlueShield of Iowa, and will expand this model to include LTSS and behavioral health services. Eventually, the state plans to serve all Medicaid and Children's Health Insurance Program (CHIP) beneficiaries through these ACO structures. Health homes will be among the various participating providers.[13] The details of how health home payments and quality measures will align with those developed for the new ACO structures are still under discussion.

Implications for the Iowa Section 2703 Medicaid Health Homes Evaluation

Health homes build on the state's prior experience with medical or health home-type initiatives, but are just one component of much broader systems-level changes underway. Fundamental questions to be addressed in the evaluation are the role of the enhanced federal match for health home services, the extent to which the health home demonstration represents a new kind of service rather than an expansion or continuation of existing services, and how health homes are being integrated into broader systemic reforms such as the mental health system redesign and the state innovations grant planning. The integration of health homes with several related initiatives in the broader system reform presents a challenge for isolating health home effects.

Eligible providers range from primary care clinics to RHCs and FQHCs, to CMHCs and may have differing levels of experience with--and infrastructure to support--integrated service delivery and coordination. Providers that participated in the

IowaCare demonstration or the behavioral health pilot may be farther along than other providers enrolling in health homes. It will be important to understand the structures and processes that are in place at baseline and to characterize the changes made as a consequence of becoming health homes. Some of the structures and processes that will underpin health homes, such as a statewide health information network (HIN), are not yet in place, and the state may make adjustments to aspects of the program based on feedback from providers and periodic internal review. It also will be necessary to take into account both the participants' and providers' time in program in assessing implementation progress and outcomes.

Population Criteria and Provider Infrastructure

Iowa offers health home services to categorically and medically needy beneficiaries with either two or more chronic conditions, or one chronic condition and the risk of developing another. Qualifying chronic conditions include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, BMI over 25 (or BMI over 85th percentile for children), and hypertension (see Table 1). The definition of at-risk is based on guidelines from the U.S. Preventive Services Task Force, and includes a diagnosed condition with established chronic co-morbidities, a documented family history of a heritable condition included among the state's qualifying conditions, or environmental exposures known to contribute to those conditions.

Health home practices may include, but are not limited to: primary care practices, CMHCs, FQHCs, and RHCs. Designated practices may have multiple sites, provided that these sites are identified as members of a single organization with shared policies and practices and are supported by a common information technology infrastructure. In the original SPA, the state required that health home-eligible beneficiaries receiving targeted case management (TCM), case management, or community-based waiver services be disenrolled and shifted into a health home practice. However, in July 2013 the state amended the SPA to require that health home providers collaborate at least quarterly with the case managers assigned to their health home patients.

Enrollment

The health home enrollment process is initiated by providers, who are encouraged to identify and enroll eligible beneficiaries from their existing patient panel. The state may also identify beneficiaries from claims and notify a health home of their eligibility, but this is intended only to assist providers in identifying and prioritizing patients for enrollment. The provider is still responsible for assessing and enrolling those patients. The state adopted this enrollment strategy in order to allow providers to implement the health homes program at their own pace, but may pursue an auto-enrollment strategy at a later date.

Service Definitions and Provider Standards

Iowa has laid out seven key provider standards to which Designated Providers must adhere in order to operate as a health home practice. These include:

1. Recognition/certification.
2. Personal provider for each patient.
3. Continuity of care document (CCD).
4. Whole-person orientation.
5. Coordinated and integrated care.
6. Emphasis on quality and safety.
7. Enhanced access.

The state definitions for each of these seven attributes are presented in Table 2. To qualify as a health home, providers must attest to meeting these standards by signing an agreement with the state. Providers must complete and submit the TranferMED Patient-Centered Medical Home (PCMH) self-assessment at the time of their enrollment, and are expected to achieve the National Committee for Quality Assurance (NCQA) recognition (level unspecified), or another national recognition, within the first year of operation as a health home. Exceptions to these requirements are allowed in cases where a provider has submitted an application and the ruling is still pending. However, if a provider has not achieved the required recognition/certification within two years of operation, the state may terminate that health home's status. The health homes agreement also stipulates that the state may revoke health home status for any reason with 30 days' notice.

Health home service definitions are reproduced in Table 3. Primary responsibility for each service is assigned to a particular provider. With the support of a care coordinator and a health coach, the designated practitioner is charged with care management and shares responsibility for health promotion and transitional care needs of health homes beneficiaries. Care coordination and referral to community and social support services are led by the care coordinator, while the health coach is the lead provider for individual and family support services.

Use of Health Information Technology

Health home providers are required to implement an electronic health record (EHR), that includes referral tracking capabilities, and have in place a plan for complying with federal meaningful use requirements. Providers also must employ a population management tool, such as a patient registry, and are encouraged to use email, text messaging, patient web-portals, and other technology where possible to enhance patient access and self-management.

Providers are also expected to connect to and participate in the statewide HIN, which was implemented in 2012. The state is working to make the HIN available to

health home providers as part of a joint effort between the health home team and the state health information technology (HIT) team. The HIT team is responsible for monitoring the rate of adoption and meaningful use of EHRs within the Medicaid program, and for monitoring and reporting on the progress of HIN creation.

Payment Structure

Base Payment

Payment for health homes services is made on a per member per month (PMPM) basis, and is comprised of four tiers, with each tier reflecting increasing levels of patient risk (see Table 4).

The rate is based on estimates of provider time required for care coordination, and on the assumption that this work would be distributed among care team members paid at different rates. The number of patient conditions serves as a proxy for the time required to coordinate patient care, and is expressed in minutes per month in Table 4.

All qualifying beneficiaries are automatically considered to be Tier 1. At the time of their enrollment, the health home uses the state's Patient Tier Assignment Tool to assess each patient's chronic conditions and determine if they qualify for a higher tier. The health home then requests member enrollment through the Iowa Medicaid Portal Access application, after which they may begin submitting monthly claims for Patient Management Payments.

Payment is contingent on several criteria outlined in the SPA. Patients must meet health home eligibility requirements, must have full Medicaid benefits at the time of payment, and must be fully enrolled with the designated provider. The health home must be in good standing with IME and, at a minimum, provide a health home service as defined by the SPA or conduct care management monitoring to identify any treatment gaps that may be addressed through a health home service. The provider also must document these activities in the patient's EHR.

Pay-for-Performance (P4P)

In addition to the above PMPM fee schedule, Iowa has incorporated a P4P component into their health home program. Incentive payments are based on achievement of selected quality and performance benchmarks that health homes will report annually to the state. These 16 measures are separated into five categories: preventive measures, diabetes/asthma measures, hypertension/systemic antimicrobial measures, mental health measures, and total cost of care.

Each category of measure is weighted based on importance and attainability, which is expressed as a percentage of the total incentive payment. Within these categories, the health home must meet the minimum established benchmark for each

measure, otherwise the category is valued at zero (see Table 5). The maximum incentive payment (MIP) that a health home can attain is 20% of the total annual PMPM payments made to that health home. Payment will be distributed on a lump-sum basis within three months of the end of the performance year.

Payments were scheduled to begin in the second year of Iowa's health home program (starting July 2013), but due to ongoing HIT implementation challenges, it is unclear whether the incentive payment program will be operational within the two-year timeframe of the health homes program.

Quality Improvement Goals and Measures

Iowa has identified two key goals for the health homes program:

1. Change patient behavior to increase the use of preventative services, and increase awareness of appropriate chronic condition management.

2. Transform provider practices by the adoption of the PCMH model to improve the population health of members.

The selected quality measures are listed in Table 6. They are based on both National Quality Forum (NQF) and Children's Health Insurance Plan Reauthorization Act (CHIPRA) measures, although the exact specification for some these measures are not detailed in the SPA. Some measures overlap with those selected for quality incentive payment benchmarks, and as with the P4P program, all measures will be generated from claims data collected through the state health information exchange.

Evaluation Measures and Methods

The evaluation measures and methodology described in the SPA are reproduced in Table 7, with the exception of avoidable hospital readmission and cost savings, which are discussed in greater detail below. Most of the data collected for evaluation purposes will come from Medicaid claims. As part of the assessment, the state will also solicit provider and patient input on implementation, quality improvement, clinical outcomes, and lessons learned. Clinical data will also be collected as part of the state's evaluation of chronic disease management and care coordination efforts. The SPA does not specify how this clinical data will be collected.

Iowa tracks avoidable hospital readmissions through a system that records events rather than individual beneficiaries; after the first admission, readmission events are calculated for periods of seven, 14, and 30 days afterward.

The University of Iowa Public Policy Center will determine overall cost savings through two analyses. One analysis will compare the PMPM costs for health home

enrollees in the year prior to their enrollment in the program to those for the first six, 12, and 18 months after joining. Costs will be tracked and compared every six months. Researchers also plan to match each enrollee who has been in the health home for one year with one who has been enrolled in Medicaid, but not a health home. They will control for age, gender, and condition in the match, and adjust the regression using propensity scoring to reduce bias.

The state will also compare hospital admissions and emergency department visits for these two groups, using Healthcare Effectiveness Data and Information Set (HEDIS) specifications. Skilled nursing facility admissions will be assessed individually to determine the reason for admission and the associated costs.

TABLE 1. Target Population and Designated Providers--Iowa	
SPA Approval (Effective Date)	June 7, 2012 (July 1, 2012)
Designated Provider(s)	Medicaid-enrolled practices adhering to the Health Home Provider Standards including, but not limited to: • Physician clinic • CMHCs • FQHCs • RHCs
Health Home Team Composition	Required: • Designated practitioner • Dedicated care coordinator • Health coach • Clinic support staff
Target Population	Beneficiaries must have 2 chronic conditions or 1 chronic condition with the risk of developing another
Qualifying Chronic Conditions	• Mental health condition • Substance use disorder • Asthma • Diabetes • Heart disease • BMI over 25 • Hypertension • BMI over 85th percentile for pediatric population

TABLE 2. Health Home Provider Standards--Iowa	
Recognition/ Certification	• Comply with all federal and state laws in regard to recognition and certification. • Comply with the standards laid out by the Iowa Department of Public Health, when they are finalized (these will likely include NCQA recognition or another national accreditation). • In the interim, providers must: - Complete the TransforMED self-assessment and submit this to the state at the time of program enrollment. - Achieve NCQA or other national accreditation within the first year of operation.
Personal Provider for Each Patient	Ensure that every patient has an ongoing relationship with a personal provider, physician, nurse practitioner, or physician assistant who serves as the first point of contact and provides continuous, comprehensive care.
Continuity of Care Document (CCD)	The provider will keep an updated CCD for all eligible patients, detailing important aspects medical needs, treatment plan, and medication list.
Whole Person Orientation	Provide or arrange for care through other qualified professionals for acute care, chronic care, preventive services, long-term care, and end-of-life care.
Coordinated and Integrated Care	• Assign a care coordinator to each patient to assist with medication adherence, appointments, referral scheduling and follow-ups, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. • Communicate with patients and families/caregivers about care decisions in a culturally appropriate manner. • Arrange, track, and evaluate evidence-based preventive services. • Either directly provide or coordinate mental/behavioral health, oral health, long-term care, chronic disease management, recovery services and social health services, patient self-management support, transitional care. • Assess the social, education, housing, transportation, and vocational needs that may inhibit patient self-management. • Maintain systems and protocols for tracking referrals.
Emphasis on Quality and Safety	• Demonstrate use of clinical decision support within the practice workflow. • Demonstrate use of a patient registry, as well as the ability to evaluate results, implement interventions, and improve outcomes. • Implement an EHR and establish a plan to comply with federal meaningful use requirements. • Participate in the statewide HIN. • Implement or support an evidence-based diabetes disease management program that includes diabetes clinical outcomes. • Implement subsequent disease management programs required by the state following the first year of enrollment. • Implement a formal screening tool to assess mental health, substance abuse and physical health care needs. • Report annually on outcomes and process measures.
Enhanced Access	• Provide for 24/7 access to the care team that includes, but is not limited to, a phone triage system with appropriate scheduling during and after regular business hours. • Monitor access outcomes such as the average third next available appointment and same-day scheduling availability. • Use of email, text messaging, patient web-portals and other technology as available to the practice to communicate with patients.

TABLE 3. Health Home Service Definitions--Iowa	
Care Coordination	Assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. Coordinate, direct, and ensure results are communicated back to the health home.
Comprehensive Care Management	• The responsibility of the Designated Practitioner role within the health home and must include at a minimum: • Providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. • Developing and maintaining a CCD for all patients. • Implementing a formal screening tool to assess behavioral health treatment needs along with physical health care needs.
Health Promotion	• Coordinating or providing behavior modification interventions aimed at supporting health management, improving disease outcomes, disease prevention, safety and an overall healthy lifestyle. • Use of Clinical Decision Support within the practice workflow. • Implementation of a formal Diabetes Disease Management Program. • Health Promotion services are the responsibility of the Health Coach and Designated Practitioner.
Comprehensive Transitional Care	• Includes the services required for ongoing care coordination. For all patient transitions, a health home shall ensure the following: • Receipt of updated information through a CCD. • Receipt of information needed to update the patients care plan that includes short-term transitional care coordination needs and long-term care coordination needs resulting from the transition. • The Designated Provider shall establish personal contact with the patient regarding all needed follow-up after the transition. • Comprehensive transitional care services are the responsibility of the Dedicated Care Coordinator and designated practitioner.
Individual and Family Support Services	Communication with patient, family, and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives. This is the responsibility of the Health Coach.
Referral to Community and Social Supports	Includes coordinating or providing recovery services and social health services available in the community, such as understanding eligibility for various health care programs, disability benefits, and identifying housing programs. This is the responsibility of the Dedicated Care Coordinator.

TABLE 4. Health Home Payment Tiers--Iowa			
Tier	**Minutes Per Month**	**Patient Acuity**	**Rate**
1	15	1-3 chronic conditions	$12.80
2	30	4-6 chronic conditions	$25.60
3	60	7-9 chronic conditions	$51.21
4	90	10+ chronic conditions	$76.81

TABLE 5. Health Home Quality Incentive Payment Formula--Iowa		
Category	**Measures (reported to the state HIN)**	**Percent of the MIP**
1. **Preventive** (best 2 out of 3 measures are counted)	• Immunization screening for children by age 2 • Influenza vaccination, ages 6 months+ • Documentation of BMI and appropriate follow-up when needed	35%
2. **Disease Option 1** (health home picks most applicable condition for their population)	Diabetes management: • Annual dilated eye exam • Annual microalbumin • Annual foot exam • HbA1c levels <8 • LDL levels <100 Asthma management: • Asthma-related emergency department visits • Use of appropriate medications for people with asthma • Percentage of asthma patients age 5-40 who have been seen	30%
3. **Disease option 2** (health home picks most applicable measure for their population)	• Hypertension: Proportion of patients with blood pressure <140/90 • Antibiotic use: *Otitis Media*--Avoidance of inappropriate use of systemic antimicrobials	20%
4. Mental Health (health home picks most applicable measure for their population)	• Percentage of patients age 6+ hospitalized for a mental health condition who had an outpatient visit, intensive outpatient encounter, or partial hospitalization with mental health practitioner within 7 days of discharge • Clinical depression screening	15%
5. Total Cost of Care (reporting only)	• Total cost of care per member per year	0%

TABLE 6. Goal-Based Quality Measures--Iowa	
Change Patient Behavior to Increase the Use of Preventative Services, and Increase Awareness of Appropriate Chronic Condition Management	Increase use of preventive services: • NQF #38: Childhood immunization status Comprehensive diabetes care: • NQF #55: Annual dilated eye exam • NQF #62: Annual micro albumin • NQF #56: Annual foot exam • NQF #575: Proportion with HbA1c <8.0 • NQF #64: Proportion with LDL <100
Transform Provider Practices by the Adoption of the PCMH Model to Improve the Population Health of Members	• CHIPRA #10: Well-child visits in the first 15 months of life • CHIPRA #21: Follow-up care for children prescribed ADD medication • CHIPRA #13: Annual dental visit • NQF #31: Breast cancer screening • NQF #32: Cervical cancer screening • NQF #41: Percent of patients aged 6 months and older who received an influenza immunization

TABLE 7. Evaluation Methodology--Iowa	
Hospital Admission Rates	Medicaid claims data will be assimilated to determine hospital admission rates in categories established through NCQA HEDIS specifications. Rates and costs will be compared for the pre/post-program period for enrollees in a health home and those who are not enrolled.
Chronic Disease Management	Clinical data received from providers on health home enrollees.
Coordination of Care for Individuals with Chronic Conditions	Clinical data received from providers on health home enrollees.
Assessment of Program Implementation	This will consist of a review of program administrative costs, reported patient outcomes, and overall program cost savings and patient surveys. A formative evaluation that details the process of implementation and the challenges experienced and adaptations that were made will be undertaken.
Processes and Lessons Learned	An evaluation that includes provider and patient input on the health home program will inform the state on ways to improve the process. As more successful health homes are identified via clinical data and claims data, implementation guidelines and suggestions will be documented and trained to further promote success statewide.
Assessment of Quality Improvements and Clinical Outcomes	An evaluation that includes provider and patient input on the program. An evaluation of the clinical data shared by providers will allow the state to adjust the clinical outcome measures to ensure the optimal results and continued improvement.
Estimates of Cost Savings	Population: • There are two populations of interest--those who enter Medicaid and the health home at the same time and those who have been in Medicaid for a period of time and then enter the health home. Cost savings will be estimated for both groups. Methodology: • Regression analyses will be utilized to determine the expected PMPM for enrollees in the health home assuming the health home were not in place. Limitations: • There may be a propensity for enrollees who have the most to gain from the health home to enroll earlier than those with less to gain. Additionally, dual eligibles may be difficult to include.

APPENDIX: Pre-Existing Initiatives in Iowa					
	IowaCare[3]	**Magellan Behavioral Health Homes**[8]	**Statewide Mental Health System Redesign**[10]	**BIPP**[11]	**State Innovations Model Design**[13,14]
Timeline	Launched in 2005; expected to be eliminated December 31, 2013 in transition to Health Care Exchanges	Pilot began July 1, 2011; funded through December 2012	Began July 1, 2012; full regional implementation effective December 31, 2013	Projected to run from 2012 through 2016	March 2013-September 2013
Geographic Area	Phase one: 2 FQHC networks in Iowa City and Des Moines; later expanded to broader network throughout state	Statewide	Statewide	Statewide	Statewide
Sponsors	CMS, Iowa Department of Health Services (DHS)	IME, Magellan Behavioral Care of Iowa	DHS	IME; Mental Health and Disability Services Division of DHS	CMMI
Scope	• 60,000+ patients • 8 participating FQHC networks	• 740 enrolled adults • 4 behavioral health providers partnering with FQHCs and 1 hospital	All Iowans receiving state behavioral health services	All Iowans receiving state LTSS	• Medicare, Medicaid, CHIP beneficiaries • Wellmark BlueCross BlueShield (Iowa's largest commercial payer)
Goals	• Expand access to health care coverage • Improve care quality • Provide financial stability for safety net hospitals	Coordinate primary care services for individuals with depression, bipolar disorder, and schizophrenia	• Reorganize the county-based system into a regional system by 2014 • Expand statewide access to behavioral health services • Address statewide variation in funding for behavioral health services	• Shift LTSS for the disabled towards community-based care • Establish a SEP system of referral • Develop a standardized assessment tool to determine service eligibility and needs • Provide case management for community-based services	• Develop integrated care delivery models and strategies for payment realignment • Develop an ACO implementation plan • Ensure all Medicaid and CHIP beneficiaries can receive care through ACOs

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	IowaCare[3]	**Magellan Behavioral Health Homes[8]**	**Statewide Mental Health System Redesign[10]**	**BIPP[11]**	**State Innovations Model Design[13,14]**
Payment Approach	• PMPM payment between $2 and $5 for services rendered consistent with U.S. Office of Management and Budget circular A-87 • Program receives federal matching funds at Medicaid program rate	No information found	No information found	No information found	• ACOs may elect to share 50%, 60%, or 70% of savings or losses relative to a set PMPM cost savings target • ACO may earn additional shared savings payment if their actual PMPM approaches the Consumer Price Index target
Technical Assistance (TA)	No information found	No information found	No information found	CMS has contracted with Acumen, LLC and the Mission Analytics Group to provide technical assistance to participating states[14]	• State will work with technical assistance offered by CMS • Wellmark BlueCross BlueShield of Iowa will also provide technical assistance • State will also seek an additional technical assistance vendor
HIT Use	• Providers must have an EHR or have a plan for adopting 1 within the extension period • Medical homes must have a disease registry in operation that it uses to manage at least 1 chronic disease	No information found	State is requiring that qualified TCM providers use electronic systems of record keeping	• State is developing a SEP website under the BIPP • State also plans to implement electronic collection of functional assessment data • State has implemented electronic case management files for LTSS recipients	State plans to support data-sharing and analysis by ACOs through the Iowa HIN
Evaluation Methods	State must conduct annual performance review on selected evaluation measures	No information found	Annual report required from each region	No information found	No information found

Endnotes

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This paper is an attachment to the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) report "***Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report - Year Two***". The full report is available at: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm.

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Files Available for This Report

Full Report (including state appendices)
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