Program Overview

In 2012, Iowa launched a statewide chronic condition health home program to serve adult and child Medicaid beneficiaries with qualifying chronic conditions, including asthma. Operating under the authority of a State Plan Amendment (SPA), the health home program strives to improve the overall health of its members by providing coordinated, patient-centered care in a primary care setting. To participate in this health home, Medicaid beneficiaries must have at least two qualifying chronic conditions or one condition and risk for a second.

Iowa’s health home program provides a statewide framework but allows participating providers the flexibility to tailor their services to improve health outcomes for patients with qualifying conditions, such as asthma. (See the “Spotlight” on Covenant Clinic-Pediatrics on page 91.) Participating providers use the following clinic-based interventions:

- care coordination
- care management with a focus on self-care support
- referrals to community and social support services

All participating health home providers in Iowa must meet key specified criteria outlined in the SPA. First, providers must attain patient-centered medical home (PCMH) recognition within 12 months of becoming a health home and employ the necessary staff to perform specific health home functions. Health homes must include a designated practitioner, designated care coordinator, health coach, and clinic support staff. In addition, providers are required to use enhanced health information technology, including an electronic health record (EHR) system to support care coordination activities (for example, maintaining a comprehensive medication list and disseminating wellness education), link to evidence-based practices, track referrals, and implement population management strategies (for example, registries). Health home practices are also required to meet other standards, such as providing coordinated and integrated care that is culturally appropriate and family centered.
Financing and Measurement

Participating providers receive a tiered per-member per-month (PMPM) payment to support health home services, in addition to standard fee-for-service reimbursement. The PMPM payment amount is based on a member’s disease burden and is highest for members with the greatest number of chronic conditions. In addition to PMPM payments, the state is developing a second payment component that will allow providers to receive additional incentive-based payments. Providers will have the option to participate in this program, and payments will be based on their performance on a set of quality metrics that cover preventive care, chronic disease, and mental health. Practices will have the option to specifically report on two asthma measures: use of appropriate asthma medication and assessment of asthma severity. Iowa originally intended for providers to report quality measures to the state through the Iowa Health Information Network (IHIN) but is exploring other reporting methods due to system compatibility issues.

Lessons Learned and Next Steps

While numerous states are implementing the health home option to serve Medicaid patients with chronic conditions, not all states have leveraged the model as Iowa has done to specifically serve children with asthma. This is in part because not all states have selected asthma as a qualifying condition. Furthermore, though children are technically eligible to participate in all health home programs, many states report that the vast majority of patients enrolled in the program are adults. Educating practices that they can enroll pediatric patients in the health home has been a key factor to Iowa’s success. Additionally, the state has encouraged practices to create a best practice evidence-based guideline process for caring for their asthma population.
Covenant Clinic-Pediatrics, located in urban Waterloo, has leveraged Iowa’s health home option to improve care for pediatric asthma patients. The practice first chose to focus on asthma after it completed the PCMH accreditation process, which required the identification of a group of children for care improvement efforts. The clinic identified a large gap in care for asthma patients and adapted components of the health home to serve this group. Approximately 1,000 children currently participate in its health home for qualifying conditions, including asthma, obesity, and exposure to secondhand smoke; approximately 300 of those children have an asthma diagnosis.

Each of the required health home staff members plays a defined role in delivering care to children with asthma. The health coach is responsible for reviewing patients’ charts before visits to develop an asthma action plan that assists the family in managing the disease. The health coordinator develops the disease registry to identify patients with asthma and track their wellness exams and doctor visits. The health coach and health coordinator also handle referrals to community and social support services such as First 5, an organization that supports healthy mental development in the first five years of a child’s life, and smoking cessation programs for parents. The clinic leverages other health home requirements, such as providing culturally appropriate care to its patients, by having on-site Bosnian and Spanish interpreters and by connecting with an interpretation organization that offers 180 languages.

One of the critical success factors for the clinic’s ability to function as a health home has been implementing its EHR system, an important health home requirement. The new system allows providers to accurately identify children with multiple chronic conditions and facilitates care coordination. Providers in Covenant Clinic are now able to track referrals to outside services, regardless of whether or not they use the same EHR system, and they are able to see when a visit has been completed. The system also allows providers to see if there is a plan in place to manage a child’s asthma and to track hospitalizations in local hospitals.

Looking forward, the clinic would like to continue to improve its EHR system to be able to track hospitalizations in additional hospitals and to more easily identify vulnerable populations. The clinic would also like to build its capacity to report quality measures to the IHIN in order to participate in Iowa’s health home incentive payment program.

Author’s note: This case study is an excerpt from The Effectiveness of Interventions to Address Childhood Asthma, published in August 2016. The information in this case study reflects data verified as of July 2015.

1All health home references in this case study refer to Iowa’s chronic condition health home. Iowa also has an integrated health home for adults with a serious mental illness and children with a serious emotional disturbance.

2Medicaid health homes are an option under Section 2703 of the Affordable Care Act. States implementing health homes receive an enhanced 90-10 federal-state match for the first eight consecutive quarters of providing health home services and then the state’s regular match resumes. All health home programs must be approved by the Centers for Medicare & Medicaid Services by submitting a State Plan Amendment (SPA). State plans are agreements between states and the federal government that detail how states administer their Medicaid and CHIP programs. State plan changes must be approved through a SPA.

3In addition to asthma, other qualifying conditions include hypertension, being overweight, heart disease, diabetes, substance abuse, and mental health conditions.

4The PCMH is a primary care model for delivering team-based and coordinated care. PCMH providers typically receive enhanced payments for high-quality care (Agency for Healthcare Research and Quality. n.d. “Defining the PCMH.” Online document. Website: www.pcmh.ahrq.gov/page/defining-pcmh.)

5While provider practices are required to have an EHR system in place before they can enroll as a health home, they may receive technical assistance from the Telligen Health Information Technology Regional Extension Center.

