IowaCare: Examining the implementation of the IowaCare program in Federally Qualified Health Centers

Prepared for the Iowa Department of Public Health by:

Natoshia M. Askelson, MPH, Ph.D
University of Iowa
Public Policy Center and Department of Community and Behavioral Health

Elizabeth H. Golembiewski, MPH
University of Iowa
Public Policy Center and Department of Community and Behavioral Health

Mesay A. Tegene, MS
University of Iowa
Public Policy Center and Department of Sociology

Ann M. DePriest, MPH
University of Iowa
Public Policy Center and Department of Community and Behavioral Health

Hannah M. Shultz
University of Iowa
Public Policy Center
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Executive summary

IowaCare, a 1115 Demonstration Waiver, rolled out in mid-year 2005 providing healthcare coverage for adults 19-65 years of age at 200% Federal Poverty Level (FPL) or below who did not otherwise qualify for Medicaid. IowaCare served 144,000 Iowans over the course of its eight-year run ending on December 31, 2013.

The IowaCare provider network initially consisted of two major medical centers in Polk and Johnson Counties, respectively, later expanding to incorporate six Federally Qualified Health Centers (FQHCs) across the state. Participating FQHCs were required to meet minimum certification standards to qualify as a patient-centered medical home (PCMH).

The present study sought to qualitatively investigate changes related to access, quality, improved health status and prevention efforts from the perspective of the FQHCs as a result of involvement in the IowaCare program, and how this experience prepared clinics for future changes in health care and health insurance. In-depth telephone interviews (n=13) were conducted with administrators to elicit perceptions of the IowaCare program and its impact on the patient population along with clinic capacity and structure.

The general assessment of the IowaCare program by the FQHCs was mixed. Respondents cited challenges like the overwhelming number of enrollees in the program, the medical complexity and severity of these patients, gaps in service coverage, and issues with care coordination between clinics and hospital partners. Important successes—including enhanced clinic capacity and patient gratitude—were also noted. Most respondents agreed that while IowaCare was flawed, it nevertheless had provided a much-needed resource for low-income Iowans who had been without sufficient healthcare for a long time.

Most respondents gave anecdotal indications that IowaCare had improved health outcomes among its enrollees, particularly with regard to common primary care issues like diabetes management and cancer screenings. However, gaps in service coverage by the IowaCare program—namely transportation, prescription medications, and certain diagnostic services—along with issues related to coordination of care were cited as significant challenges to patient care and organizational function. Many challenges related to IowaCare participation were cited as learning opportunities that better prepared clinics to face the implementation of the Affordable Care Act in Iowa.

Introduction

Background on IowaCare

The IowaCare program began on July 1, 2005 as a 1115 Demonstration Waiver, providing healthcare coverage for adults 19-65 years of age at 200% Federal Poverty Level (FPL) or below who did not otherwise qualify for Medicaid.1 IowaCare was administered by the Iowa Medicaid

Enterprise (IME), a division of the Iowa Department of Human Services, and featured a limited benefits package that included: inpatient and outpatient hospital visits, physician office visits, and limited dental coverage. The IowaCare 1115 Demonstration Waiver expired on December 31, 2013. Over the eight years of its implementation from 2005 to 2013, the IowaCare program served 144,000 Iowans who would not otherwise have been eligible for state-sponsored health insurance coverage.\(^2\)

Initially, IowaCare service coverage for enrollees was limited to two providers in the state: Broadlawns Medical Center in Des Moines and the University of Iowa Hospitals and Clinics in Iowa City. To accommodate growing enrollment in IowaCare, the Iowa State Senate approved provisions in 2010 expanding the program’s provider network beyond the two hospitals and establishing existing Federally Qualified Health Centers (FQHCs) as regional points of care within the IowaCare primary care provider network. Participating FQHCs, as selected by the Iowa Department of Human Services, were mandated to provide covered services to IowaCare members and adhere to patient-centered medical home certification requirements.

In order for an FQHC to obtain status as a medical home, compliance with Level 1 Recognition criteria of the National Committee for Quality Assurance (NCQA) Recognition and Certification Requirements was necessary. Clinics were required to demonstrate a patient-centered approach implementing processes consistent, at minimum, with certain “must-pass” elements outlined by the NCQA to achieve Level 1 Recognition. Examples of the elements included are: 1) implementing evidence-based guidelines for at least three different chronic or clinically important health conditions, 2) whole-patient orientation, 3) systematic tracking of tests, diagnostics orders, and referrals, and 4) care that is coordinated and integrated.\(^3\)

Once designated a patient-centered medical home, each of the six participating FQHCs were assigned IowaCare enrollees based on their county of residence. As a medical home, these clinics were responsible for all primary care services of their assigned members; specialty and hospital services were obtained at the two participating hospitals through a referral process originating with providers and staff at the medical homes. The overarching goal of the medical home model is to provide patients with enhanced access to care that is preventive and coordinated in order to improve health outcomes at a reduced cost to patients and the system.

The IowaCare program was responsible for covering inpatient and outpatient hospital services, primary care clinic visits, limited dental services, and annual physicals. Participating FQHC primary care providers often provided additional services to IowaCare patients using internal funding and resources. In general, IowaCare providers covered generic prescription medications, some durable medical


equipment, and certain laboratory and diagnostic imaging services.\textsuperscript{4} The IowaCare program established three funding pools intended to offset the cost to clinics for providing services related to lab and radiology, care coordination following an inpatient hospital stay, and emergency department admissions.\textsuperscript{4}

**Purpose**

The purpose of the present study was to qualitatively investigate changes related to access, quality, health status, and prevention efforts from the perspective of administrators resulting from involvement in the IowaCare program. The study also explored ways in which experience in the IowaCare provider network prepared clinics for future changes in health care and health insurance moving forward, especially with regard to ongoing implementation of the Affordable Care Act. The protocol was also designed to elicit views on practice-level changes that may have occurred as a result of participation in the IowaCare program and how this experience has prepared clinics to face the challenges of a changing health care system. More generally, the interview protocol was oriented to evaluate challenges faced by administrators and clinics in serving IowaCare enrollees and implementing the components of a medical home. Finally, respondents were asked about points of success related to understanding the program, communication with program administration, administrative logistics, and payment/financial issues.

The main research questions were:

- What were the general experiences (including challenges and successes) of clinics related to participation in the IowaCare provider network?
- How was communication between clinic staff and Iowa Medicaid Enterprise/the IowaCare program characterized?
- How was care coordination between clinics and the participating medical centers characterized?
- Have there been changes in health outcomes of IowaCare enrollees as a result of participation in the program?
- How did clinics handle any gaps in coverage as a result of services needed or sought by patients that were not covered by the IowaCare program?
- What impact has IowaCare participation had on present or future clinic capacity to address any changes in patient population that may result from ongoing implementation of the Affordable Care Act?

**Methods**

In-depth, telephone interviews were conducted with administrative representatives from six Federally Qualified Health Centers (FQHCs) involved in the IowaCare program.

Administrative staff were contacted via email and telephone to schedule the telephone interviews. Interviews were conducted in December 2013 during the final month of the IowaCare program. Interviews were conducted with FQHC CEOs, medical directors and IowaCare care coordinators. Five CEOs, two medical directors, five IowaCare care coordinators, and one billing manager were interviewed.

The interview protocol asked open-ended questions to elicit the largest breadth of responses. The interview guide can be found on page 39 (Appendix A).

The telephone interviews were digitally recorded and transcribed. The codebook was determined in advance of coding. The codes were developed based on the original purpose of the interviews. The transcripts were coded by a team of four coders. Intercoder reliability was established through the coding of one transcript by all coders. The coded transcripts were compared and the codebook was further revised. The coders were retrained, coded another transcript for comparison, and reached sufficient intercoder reliability.

**Results**

A total of 13 interviews were conducted; however, one interview had two respondents participating from the same clinic.

The following section presents the main themes uncovered by the interviews organized under five overarching categories: 1) general impact of the IowaCare program, 2) characteristics of and interactions with the IowaCare program and hospital partners, 3) financial and payment issues, 4) issues and improvements related to patient care, and 5) discussion of steps moving forward, including speculation on the impact of ACA implementation in Iowa and continuing gaps in patient healthcare services in this population.

**I. General impact of program**

**Overall assessment**

The general assessment that respondents gave about the IowaCare program was one of contradictions. One respondent summarized her thoughts:

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<th>Federally Qualified Health Centers (FQHCs) in Iowa</th>
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<tr>
<td><strong>Name</strong></td>
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<tr>
<td>Primary Health Care, Inc.</td>
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<td>Siouxland Community Health Center</td>
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<td>Peoples Community Health Clinic, Inc.</td>
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<td>Crescent Community Health Center</td>
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<td>All Care Health Center Community Health Centers, Inc.</td>
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“think the legislature as the overall concept was presented to them really had high hopes...I would say it was but in the details and the complexity of this whole thing, that’s where the program fell through.

While the respondents could clearly outline the limitations of the program, they believed that the program provided much needed care to people who would not have received any care if IowaCare had not existed. As one respondent stated:

...granted you know nothing’s perfect, no program’s ever perfect, it is always requiring adjustments throughout and you find that as you’re doing it. But you know it was a good program for the people that needed it, you know it wasn’t able to provide everything but at, at least they were able to receive some services and some medical care which some states don’t even, you know, have-- so you know...all of the patients were pretty lucky to be able to utilize this program and hopefully it just gets better you know as, as everything changes and, and moves forward.

The experiences of one respondent represented the general consensus of the clinics’ initial involvement with the IowaCare program:

...We were excited for the concept of it to reach out to patients who had not gotten health care before due to restrictions on, y- you know, not having insurance...or access… I’m gonna say we geared up as we thought possible, you know we got a dedicated phone line, the phone, you know, calls came to me; we thought we had it covered. The first couple days, I bet we had probably five hundred calls. Yeah, it was so overwhelming that I, I (laughs) I thought we would never, never get through our list. It probably took us three and a half, four months to get through our list of patients because the calls just kept coming in, coming in. We discovered, so, and then we had to do a prioritization as far as … the acuity of the patients because we had so many new patients that, I mean, it, it was overwhelming our schedules, everything, it was, oh my gosh (laughs). As you can tell, it was a big nightmare...and then the first patients that we started seeing were, you know, a young patient who was a diabetic who was losing his toes. You know, just the severity of, of their chronic diseases was overwhelming. Um, I honestly can’t remember...amount of cancer patients, you know, the amount of diagnoses of cancer. I mean it was just, I would say the first year of it was so overwhelming just on how many patients it touched.

Respondents believed that the program was designed to fill a gap, and that program staff did their best to make IowaCare beneficial for recipients within the constraints of the program. Many respondents also stated that the clinics, the providers and the staff learned a great deal from the entire process of serving IowaCare patients. One respondent called it a “real educational experience.”

There was, however, a feeling that the clinics, hospitals and the IowaCare program staff were not always working towards the same goal, as suggested by this respondent:

I think… the way the program was set up from the beginning, it was just
right for (inaudible) relationships between the primary care sites and the
two hospitals. There was no vested interest, collective vested interest,
you know, in trying to make it work for the patient. Um... you know we
weren’t all in it together, there was no shared, you know, shared benefit
or, or shared loss ...in the way the program was set up. You know, it was,
you know every person for themselves in terms of the providers that were
involved.

Benefits to clinics

Participating in IowaCare did provide the clinics with some unique
learning experiences and, in some cases, access to a new patient
population. Providing referrals and locating supplies and services in the
community that were not covered by IowaCare resulted in many of the
clinics learning more about the services and partners available in their
community. Some clinics also reported that through developing these
relationships with other providers in the community, it raised the clinic
profile in the community and resulted in more people knowing about
the services they provide. One respondent said, “...we have a huge referral
system, which I think we’re, we’re going to do awesome with that.”

For some clinics, IowaCare enrollees might have been seen at the clinic
before it was part of the IowaCare system. These clinics saw some
financial benefit because they were now being paid for services they had
been providing previously to these un- or under-insured patients for little
or no cost. According to one respondent:

...from a financial standpoint, it was a great impact to us, because
once again we shift those patients from uninsured, and now they were
paying patients on our schedule, so it was surely an enhancement to us
financially once we were taking care of those patients.

Most of the clinics reported that working with the IowaCare population
gave them a better understanding of patients with complex medical
histories and issues. Some clinics administrators mentioned how these
complex patients nudged the clinics further along in the transition to the
medical home model. As one responded stated:

... this is a group of patients who really hadn’t accessed care, so I think,
you know, understanding that complexity, we were into the patient
centered medical home, you know, prior to the IowaCare piece, but that
really helped to continue to move us along that direction, so, you know,
really looking at, you know, how to be a patient centered medical home
and working in that arena, I think it really helped us to continue to
move, move along in that way, and, you know it gave us a few additional
resources to be able to try to manage the population better so I think it
was, I think it was a good, you know, it, in, in some respects it was, it was
a good practice for hopefully what will happen in the future and we were
able to work through, or at least understand some of the, the challenges
that we will be facing.

Organizational changes to clinics

All of the respondents reported that the clinics had to make changes in
order to meet the new demands of the IowaCare program and patients.
Clinics were pushed to adopt more characteristics of medical home, such as developing and refining existing referral systems. One respondent provided an example of how the referral process at his clinic had been improved as a result of participation in IowaCare:

> We’ve got a couple of DME suppliers that you know are really good to us and, you know, not only with our IowaCare patients but with our uninsured patients as well, on getting a, you know, the services that, that we needed or, we have a great relationship with our public health department and they do do home health and they have some grant money that they’ve gotten for, you know if, if I need up to go in and maybe do a home visit for somebody or, uh, you know maybe they needed home health for uh, a few days, you know, they’ve got that grant funding to where they can, you know, go do those services for our patient and it’s at, you know, doesn’t cost the patient anything.

Most of the clinics found they needed to hire additional staff as a consequence of taking on an influx of IowaCare patients. Some practices developed special services like a Coumadin clinic, or explored ways to provide more services in-house, such as imaging, mental health and oral health. One respondent detailed how the clinic had met the challenge of a larger patient population by hiring and utilizing additional staff:

> …we have several providers that are targeted just for IowaCare’s patients, so we can get them in in a more timely fashion instead of, you know, setting up a new patient appointment and it taking anywhere from six to ten weeks for them to get in. We’ve designated providers for that to give them more access here.

In order to meet certification standards as a medical home, many clinics had to hire care coordinators, as illustrated by the following respondent quote:

> … our care coordinator coming to us with a social work background, and really just took the ground uh, went forward running with, when the program was introduced. And we brought her on as a result of that, we hired uh through some supplemental grant funding an assistant care coordinator which we were able to uh, to stay after those funds went away. I can see us needing additional persons in that area, but I think we have uh a good infrastructure uh for the referral process uh but once again um having a, a greater demand with those patients now uh being able to service them, I think we were handling about three hundred referrals monthly.

Another change to clinic structure reported by many respondents was related to quality improvement and better health outcomes for patients:

> I gotta know who’s out there in my patient panel that needs their A1C under or their blood pressure better controlled. But I gotta figure out a way to do that, I mean, one way is when they come in to see me, but in other ways, to be proactive and say, hey look, you know, we’ve got X number of patients with A1C’s that are, you know, pick a number over ten....we need to get them in, and, you know and, and try to improve their scores.
Clinics also reported that changes had to be made to accommodate the complexity of these newly insured patients, including the hiring of additional support staff:

I think it’s also required us to get much more sophisticated in how we provide services to patients in group settings. Using non-position personnel, managers, health educators, health coaches, all of, all of that kind of thing in trying to get people to improve, or ha- give them the resources they need to improve their health.

**Challenges to clinic**

The demands of serving a medically needy population that had limited or no access to healthcare in the past, along with the constraints and requirements of the IowaCare program, created significant challenges to clinics.

One of the initial burdens was the overwhelming influx of IowaCare enrollees into these clinics when they first joined the program. One clinic administrator detailed how the clinic had estimated the arrival of 600 IowaCare recipients, but instead had received 3 times that number of new patients enrolled in IowaCare:

> The first couple days I bet we had probably five hundred calls. Yeah, it was so overwhelming that I, I (laughs) I thought we would never, never get through our list. It probably took us three and a half, four months to get through our list of patients because the calls just kept coming in, coming in.’

Another respondent reported similarly:

> The number of those …that would come in that hadn’t gotten care and I, I know right at the very beginning we were extremely overwhelmed, I was so overwhelmed I thought ‘this is it, I, I’ve gotta get out of this because I can’t do it,’ it was just, it w- it was so much for a system and our system definitely was not set up for the number of assignees that we were assigned to, we, we definitely weren’t ready for that.

For one clinic:

> the only downfall was we did lose quite a few established patients just because initially, um, the amount of IowaCare patients that were getting in was so large that we didn’t, you know, have spots that were no longer open, for our established patients to get in as soon as they wanted to.

In addition to the larger volume of patients, it was also not always clear which IowaCare enrollees were assigned to which clinic. Sometimes the lists clinics had did not agree with the lists maintained by the Iowa Medicaid Enterprise. As one respondent noted:

> that attribution thing is just a big, a huge challenge...and then, you know, and then that ties right into reporting because it’s hard to report, or, you know, make positive changes in the, the patient panel that you’re working with, if you have trouble figuring out who your patient panel is.

The complex patients required additional time and resources for which
the clinics were not necessarily prepared or equipped:

…at least when we first started seeing some of these patients, our providers were just I, I guess ‘frustrated,’ maybe is the word, because there were so many things that this patient needed to have taken care of and, and frankly they were all at the top of the priority list and so...how do you-- how you address one issue and yet still have the through put of being able to see 10, 20 whatever 25 patients a day when the demands of that 1 or 2.

These complex patient cases also required services and supplies that the clinics did not readily have access to; as stated by one respondent, “alright we, we are a, like a primary clinic setting so we did not have a lot of, like IV meds um, durable me- you know, medical equipment, um you know hospi- things like that.”

Another challenge mentioned by respondents was working with the hospital partners:

In the beginning the UI was very helpful at helping us set up things when the money was there but of course, you know money starts running out everywhere...and then you know when, you know it was no longer they could do mammograms, they could no longer do X-rays, you know things like that, then it got pretty... hard to get our patients...what was requested. And you know, and with labs not being paid for you know it’s, in order to help a diabetic, in order to help, you know, high cholesterol, you’ve got to have lab tests...to go along with it, so it was, I mean it, it nearly, nearly broke our clinic…

Respondents also talked about the financial burden of seeing patients with complex medical problems who only had access to a partial insurance plan like IowaCare. One respondent summed the situation up by stating, “…it was painful, it was somewhat painful financially, it was somewhat painful in terms of, you know, trying to work out all these arrangements, but we did it because we thought it was the best thing to do for the patient.”

II. Characteristics of and interactions with the IowaCare program

Frustration at the system

Frustration with the healthcare system was manifest in feelings of dissatisfaction expressed during the interviews. This dissatisfaction came from all levels - including the patients, providers, and clinics and was frequently related to practices or circumstances of participation in the program, such as when patients needed services the clinic could not provide. Because of the overwhelming demand and the constraints of the IowaCare program, many respondents expressed such frustration:

…it was frustrating for both patients and primary care providers alike when they needed services that we don’t provide and… and… you had to depend on the two hospitals to provide the services. And then there was a constant argument...they turned it, they turned the principle of medical
Another significant source of frustration expressed by many clinic administrators was related to tension resulting from uncovered medical services or supplies and the issue of who was responsible for paying those bills. According to one respondent, “...it was just an argument over who was gonna pay for the uncovered service, what are they pay, you should pay because you’re the medical home and we said no, no, no, (laugh) so that, that was very frustrating as well.”

Some clinics also reported frustration in trying to explain IowaCare coverage to patients. Patients often did not understand what services were covered and who was responsible for covering services.

All of the clinic staff interviewed expressed frustration with the constant changing of IowaCare rules, policies and procedures. Shifting coverage of labs and radiology services were two examples of these types of changes. As one respondent explained:

…Many of the health centers don’t provide in house radiology or, in house labs, we contract with other people to do it... so we, we actually had a pool that other providers that the folks we contracted with could bill that pool so that our patients could get access to, locally, to lab and ra- you know, diagnostic services, lab and radiology. Well that pool ran out very early on, and, for whatever reason, they couldn’t appropriate money to that pool so we had to come up with a, or, IME came up with this other very complicated way of allowing patients to access those resources locally, but basically it meant that the health center had to bill for the services that we didn’t provide, um, and then IME would pay us through a negotiated, renegotiated fee for service rate which still wasn’t our cost rate but was higher than the original fee for service rate we were paid. And then we would have to pay the provider, and that was, I mean we had no option because without, w- if we didn’t do that, they just wouldn’t have gotten services, but that was, that was a nightmare in terms of tracking and making sure that we were getting paid what we needed to get paid, that we were, you know, getting services billed that needed to be billed to IME which, it was just a nightmare. Um, but we did it because if we hadn’t done it, then those patients wouldn’t have had access to lab and radiology.

Communication with administration

In general, respondents were very happy with the level and quality of communication between the clinics and the Iowa Medicaid Enterprise (IME). Clinic staff were thankful for the role that the Iowa Primary Care Association (IPCA) played in facilitating good communication.

Respondents felt like IME staff members were available if clinics had questions. According to one respondent:

I think communication between us was good because we did it one-on-one if there were questions. Um it, I think, I early on learned certain people, certain numbers that I think are communication between us was good because we did it one on one if there were questions.
The weekly calls with IPCA and IME were cited by most clinics as an invaluable resource for negotiating the challenges:

We did have a weekly call it’s, you know, all the FQHCs in the, in the state as well as our primary care association, and so that was where we kind of went with all of our questions, comments, concerns, that kind of thing was, we basically facilitated it all through our PCA and they would follow up with IME with our questions and then, you know, we discussed it on our weekly calls.

However, communication between the hospitals and the clinics presented a significant challenge. One respondent tried to explain the communication issues between the clinics and the hospitals:

… [there] were some very serious uh-- well lack of communication, uh institutions going their separate ways, devising policies around the program um that weren’t in my opinion necessarily um it, it was left up to the organizations to try and figure out systems or non-systems whatever you want to term it, um without specific IME guidance.

**Care coordination**

Respondents gave their assessments of the process of making patient referrals in light of program guidelines and restrictions. Many respondents described challenges related to obtaining and coordinating specialty care for patients with UIHC or Broadlawns, including challenges related to the communication between practices and these institutions.

Because referrals are a large portion of the care coordination process, some clinics reported how difficult referrals were to make and track:

… We’ve worked so hard on trying to make our referral process better, you know, making sure that we are doing our job getting the information to the next person, following up on that patient, making sure they followed through, so, um, I th- we’ve, we’ve really worked hard on that, so I, I think, we’re, we’re ahead of a lot of places, I feel good about that, um, we still have to improve our phone system, you know, of just patients calling in or specialists calling in, you know, returning those phone calls in a timely manner, that’s the other thing for our improvement processes, that, that we’re really trying to work on to improve that care. Um, but I think, I think we’re sitting pretty good with that, I do.

All clinic respondents reported that the level of care coordination increased as a result of IowaCare participation, and most believe that clinic capacity to coordinate care had improved because of the IowaCare experience. However, there were challenges to care coordination, especially related to referrals for specialty care services:

… getting patients in for specialty care seemed to take a little longer than it maybe should have for them. Umm and then I don’t know if the University is planning on adding additional staff with, with the expansion and all of these changes, but I know that some specialty referrals, I mean it, it’s normal to wait maybe you know a month or two but I know that some of the specialty departments, they were scheduling out anywhere
The care coordination piece is especially hard to complete successfully when timely referrals are not available.

...one of the things that stand out are like stress tests, um, you know when you have somebody that you think has angina that’s not so acute that you just need it today, it could take months and months um before y- you know, you would be able to order a stress test, I’ve had positive hemocults that took over a year before I was able to get somebody in to get their colonoscopy, so I think it’s just that, you know, the big demand, trying to get a person in and them having to wait...and then as a primary care provider, you’re on the other end having to spend part of your visit with just a frustrated patient and they’re frustrated with the system, and so you just feel like you’re spinning your wheels going nowhere

Additionally, clinics reported that care coordination was obstructed when primary care providers at clinics did not receive timely information back from specialists related to patient care and treatment:

Um… receiving reports back from specialists, I think that’s the other big hole, you know, eventually you get the r- the report from the specialist, but then if they did anything, you never got the result of what they did, you know, you always have to call and get that, if they ordered labs, it’s not included in, in the, in the, in the report. And so you’re constantly having to make that phone call to say, okay, you did the biopsy, now t- you know, where’re the biopsy results, so just that kind of breakdown in communication.

Coordinating patient care at the time of hospital discharge was also challenging:

...when they’re hospitalized and discharged and then trying to get the accurate information, you know, before they get to their appointment and, y- you know, t- trying to keep that continuity of care going um I think it’s pretty difficult, and vice versa, y- y- you know, here I am, the primary care person, sending my person down to, to, you know, to a specialty care, and somehow the information that I want them to get, they don’t get, so (laughs) it’s that black hole (laughs) where, you know, that exchange of information somehow didn’t happen, um, so, I, I think across the board that’s, that’s frustrating.

Based on the IowaCare experience, some clinics will be hiring more care coordinators.

**III. Financial and payment issues**

**Lack of clarity in payment system**

In many cases, respondents reported tensions or conflict resulting from disagreements over which party was liable for coverage of a given service, including disputes over who was the responsible party and questions about reimbursements and billing. Respondents expressed confusion and frustration at unclear or changing payment structures; one clinic administrator summed it up as, “you know when, when it came down to
anything that...basically what the real issue was, were our uncovered services, that was the issue.”

Challenges related to patient care were mentioned as a consequence of these inconsistencies related to payment and coverage structures. Confusion over which party was responsible for a given payment often hindered patient diagnosis and treatment, and in some cases delayed patients receiving necessary specialty care:

Um, we were assured going in that um Medicaid would be covering services that were already being covered, and-but one of the problems that I had, was concerned about was then so what happens with x-ray and what happens with laboratory services because, and the laboratory service arrangement that people had is we contract with a private entity, they have, or private entity, they have their people here, they’re doing the tests; they do it at a discounted rate. However, according to the Medicaid rule, since people did not own that and since that entity was not named as an IowaCare provider, the department could not reimburse for those laboratory tests. And so what we were finding then that um as the new patient population was coming in, they’re very, very sick, they needed tremendous work-ups and then they also needed to have fairly extensive workups before they could be accepted or would be accepted by the University of Iowa specialty-um specialty practices.

Other respondents noted the burden that increased billing and administrative requirements placed on individual clinics:

Um, this year, the challenging-- I would say is the billing portion of it since the funds, the pool funds that were established for IowaCare patients, to pay you know the hospitals for the claims, that went away January one of 2013; it has been, uh, a pretty huge impact on the billing side for the help centers, having to file the claims and submit weekly reports to Iowa Medicaid and pay those out…

Clinic staff were not the only ones confused about payment rules. Respondents reported the difficulty of relaying information to patients and other clinics about what would or would not be covered by IowaCare:

I think a lot of the challenges were not only helping the patients understand what IowaCare covered and didn’t cover, but even, you know, like the outside entities, the outside, you know, medical places, um, that didn’t understand, you know, the full um realm of what IowaCare would cover and what they wouldn’t cover …

Resource demands

Many respondents described having inadequate access to resources to meet the resource demands of IowaCare enrollees, especially given the complex healthcare needs of this patient population and their lack of alternative resources. Respondents described several instances where the demand for services offered by the IowaCare program exceeded clinic resources. The demand for laboratory and radiology services and durable medical equipment was especially problematic for many clinics:

We don’t really have any simple access to durable medical equipment.
Um, so, lab and X-ray both ran and the money ran out at a certain time during the year, and so there was, I don’t know, eight to six weeks, um, when things weren’t covered…

And money was a fundamental problem, there wasn’t enough money in the specialty care pool, there wasn’t enough money in the hospital pool, um, there wasn’t enough money in the help center lab and radiology pool, and all the providers would run out of money.

Other areas of concern included coverage for medications, transportation, and home healthcare:

…the fact that, you know, there wasn’t reimbursement for pharmaceuticals, um, that there wasn’t reimbursement for transportation, um, those were significant barriers, um, to our patients.

…home health, uh, because there, there wasn’t capacity to get people in, there wasn’t enough money in those pools to pay for it.

One respondent described the many complications and barriers involved with trying to provide treatment to IowaCare patients given the financial constraints and lack of resources available:

…people are just, I, are dismissed like from the hospitals and they go home and I mean with no home health coverage it’s like, you know even to find a secure oxygen for a patient, it’s, it’s challenging because you know you have to call around and find somebody that will just maybe do it as a charitable or work with the patient to see if they could set up a payment plan to try to uh pay for that, um so that was always a challenge for me was that the patient that was discharged from the hospital had to do their um, their in home or home health care that was, that was an issue. Um another one was you know these people would come in and they would do a sleep study, so they would have to travel to Iowa City for their overnight sleep study and they would, you know, be diagnosed with the sleep apnea and then there was nothing to, to buy the machine. It was like, well you have it but now you know there’s no coverage for your sleep apnea machine…

**IV. Patient care**

**Medications**

Responses were mixed when it came to handling issues related to affordability and availability of medications for patients. Some clinics, by drawing on existing clinic infrastructure and resources, were able to offer medications at a reasonable cost for IowaCare patients:

Well, we offered the same program that we offer to all our uninsured patients, um, which is basically that we purchase the medication through the 340B program.

Another respondent said:

Okay, so probably the biggest thing that we helped patients with were, were medications and so we had a pharmacy on site and at least a quar- it was a pricing structure, is that we were able to help with a lot of
medications, um, for… for little money um, we couldn’t give it away free, but we really worked on the funding part where we could help them with medication, so sometimes in, you know, with a certain funding steam, we could offer chronic care medicine, a three month supply for just three dollars, um, we definitely helped with patient assistant programs so we help, um, our, our patients get on those programs when needed.

Others reported challenges with trying to connect patients with medications. The following respondent noted how the issue of medication expense came up when trying to coordinate specialty care with one of the hospital partners, with the care team at the hospital prescribing or recommending medications unavailable at low-cost to the patient:

One of the disjoints we found in trying to work with the University was that what patients were maybe discharged with or were recommended to be on, um were drugs that weren’t in our formularies, so we really weren’t able to fill those prescriptions coming out of our pharmacy. Uh, so there was a lot of discussion back and forth, trying to reach the University providers to ascertain to whether the, our primary care providers could use a substitute, um if there was any other resource maybe. Um, and that became um a little bit of a culture shock I think between the two, whereas out in the field, you know we’re always cognizant that, that people don’t have money for medication and yet as people were being discharged from the University, they were being told oh just go to your medical home and they will get this- and-and I know one of them was Plavix. it’s a great medicine, it’s wonderful, it’s not in our formulary, um and it takes a while to, to get a charity care um pharmaceutical program enrollment going and so patients were left without a resource in order to get, to get this medication and that was a big concern to our providers.

**Emergency care**

IowaCare rules resulted in changes to emergency care-seeking behavior by some patients. Administrators reported that since the IowaCare program only covered emergency care at hospital partners in Des Moines and Iowa City, many patients were hesitant to seek emergency care at their local hospitals—even when primary care providers strongly urged them to seek emergency services:

*R:* Oh, oh emergency room visits, that was another [challenge]. Umm, because it wasn’t covered for local emergency room visits, umm patients were actually hesitant to go to the emergency room when they really needed to.

*I:* So like if they had shown up at your clinic and you said ‘oh, oh no, no you need to go to the emergency room,’ they didn’t want to go then?

*R:* Right, right. They always ask, you know, ‘am I gonna get a bill?’ You’d be like ‘ok, just worry about that after the fact, you need to get to the emergency room,’ and, umm, we found multiple times where they just wouldn’t go. And the problem would just get exponentially worse.

**Patient satisfaction**

Despite the financial and logistical challenges of enrollment in the
IowaCare program, respondents described how nevertheless a multitude of patients were extremely grateful for services rendered or access to low-cost services as a result of the program.

Some respondents noted how patients were happy for the opportunity to receive primary care within their community instead of driving long distances to Iowa City or Des Moines:

> but umm once we got added Dubuque county umm December of last year, which all of our local umm stations, they were really happy with the change, that way they were able to come here now umm for local care and it would be covered with the IowaCare. So they were really happy with it.

Many patients were grateful just to be seen, especially those who had not received healthcare in many years. According to one respondent, “Uh, we, of course we have a lot of testimonial, we have the people who just were so happy that they could get in, that they could get care. Uh, so that, that always is good.” Patients were appreciative of the chance to finally address medical issues at a more comprehensive level than in the past:

> So there was a lot of very postive comments that people felt like finally somebody cared and somebody really wanted to help me address my issues, um unfortunately you found some very serious illnesses because you know people had ignored them. So I, I mean I think that that was, that was a good thing too, that people felt like they, that somebody did care and that they could address their medical issues, that was nice.

Administrators described the satisfaction that clinic staff and providers felt at being able to treat IowaCare patients and make a difference in their lives:

> …talking to the large majority of our patients, they don’t want to go somewhere else because they’re very happy here with our providers and the care that they’ve gotten, so, it really from a patient satisfaction aspect, and that’s what’s really the most important to me, uh, that’s been huge for us, is the fact that our patients are happy and want to stay here even when they can choose to go someplace else.

> Oh th- I… I, I think just that the gratitude of, of patients who um came to our, our satellite clinic…[w]alked in and um this man, and he just was so um happy that the door wasn’t shut in his face. He said, you know, I’ve gone other places to try to get medical care and they’ve shut the door in my face, they haven’t given me an opportunity um being, you know and we treated him like an, a human being and um he, he was just so grateful and it just made me feel so good to know that we, you know, were able to tough that person’s life as, make them feel worthwhile.

**Fulfillment of services gaps**

The IowaCare program covered inpatient and outpatient hospital visits, physician care, limited dental services, and annual physicals for all enrollees. IowaCare also allocated pools to help offset the cost to clinics of laboratory and radiology services and durable medical equipment.5

Beyond these areas, though, many clinics were left to cover other services,
such as vision, podiatry, durable medical equipment, mental health, and health education using their own resources. Respondents described several areas of care provision needed by patients that clinics successfully filled during the program:

So we used to have a podiatrist that came in umm once a month that they would be on the sliding fees scale umm well it’s just a, just an office visit, she said they would pay him. And also umm our eye doctor would do the retinopathy exams for our diabetic patients umm so they wouldn’t have to travel all the way to the University for that. Umm let me think, what else. Our pharmacy services umm those are, that’s a service that all of our patients get to utilize at no charge.

…not necessarily that we provided but, uh, we have a MOU with our local hospital and so like for um diabetic education: they could go to our local hospitals and just pay three dollars for a two hundred and fifty dollar diabetic education class.

one of those things that we did offer was we do have a MOU with our, um, local mental health provider so, you know, if somebody that was on IowaCare needed mental health services, you know, they could pay little, a little amount of money and go see a mental health specialist, so…Really, um, we don’t have a lot of resources here for the vision screening, um, you know the one thing that we would do is if they were diabetic, you know, we could get ‘em that once a year screening at Broadlawns or, um, you know, if you get their diabetic guy to stamp it, otherwise there’s just a routine vision exam. We don’t have a lot of resources other than… you know our local Wal-Mart, that is, you know, pretty reasonable cost.

**Transportation**

Although the expansion of IowaCare to incorporate regional FQHCs within its provider network was intended to offset the burden of transportation on patients, issues were nevertheless commonly expressed by or observed among patients related to transportation. Many patients faced traveling long distances to obtain primary and specialty care or lacked access to adequate transportation across the state.

Even though regional access to primary care was provided to IowaCare enrollees as a result of the establishment of these medical homes, some patients still had transportation to their primary care provider:

I would say for our patients that we have due to transportation cause we do cover such a large area um so the challenge of getting them here for their visits um as far as you know like simple colds or just simple appointments all the way to the complicated ones, um, trying to find transportation or that finding transportation and then us referring them on um and then them having the same issues of trying to find the transportation to get to these appointments to be treated.

Enrollees were still required to receive specialty or emergency services at Broadlawns Medical Center in Des Moines or at the University of Iowa Hospitals and Clinics in Iowa City, placing a burden on many patients:

So transportation was a big [challenge]...Umm one of the major one’s
because patients were provided access a little closer umm they still had to
go to the University for specialty care and it, sometimes it was hard for
them to even get here, let alone getting all the way to the University. So
that was, that was a major major one.

…the referral pattern, that they have to drive those few hours to get to, for
specialty care, so when you take an underserved population and then they
don’t have much money and then you’re asking them to, you know, head
so far away for specialty care, that’s been really difficult too.

Health outcomes

Many clinic administrators observed improvements in health outcomes
for patients as a result of participation in IowaCare. The general
consensus of interview respondents was that imperfect coverage was an
improvement over no care at all, and that IowaCare offered much needed
access and services to patients who had long-neglected health issues:

…we have seen so many people that have not had any access to health
care prior to having IowaCare, so, yes, there are tons of challenges, but,
just being able to offer them even primary care, that they only have to pay
three dollars for an office visit and actually get to see a doctor, and, giving
them access to, some people, where transportation isn’t an issue, it’s huge
for them to be able to see a specialist and not have to pay out of pocket for
it. Um, so that’s been, been really, uh, a, a success, I think, is just access
to health care even if it’s imperfect access.

Um and the number of patients that we were, people that we were able to
um provide the medical care that they needed, um all the way from, you
know just uh physical to all the way to um you know, the, um, the cancer
diagnosis the saving of the diabetic’s toes, the, I mean just, there’s so
many stories out there of the people’s lives that we touched, now, that we
probably wouldn’t have if IowaCare wouldn’t have been around.

I think [our clinic] did fairly well in um improving um standard of care for
people who had not had um regular medical care, services. Uh, I think we
did um an acceptable job in improving health as far as um improving um
hemoglobin A1C for diabetics…

Some respondents offered narratives related to how IowaCare had
allowed clinics to hone in on preventive care:

You know I think that we um, we with the IowaCares you know we
really focused on colonoscopies and pap smears and uh, you know, kind
of went out and made phone calls and made sure that that was part of
whenever we could get anybody in here to be seen, that that was always
a priority, that they had to have that checked. And I think probably um,
you know the pap smears was probably a success because you, even if you
identified one and I know there were more than that, identified you know
an abnorm- an abnormality with that and, and treatment, and treatment
was given um you know that’s, that’s huge because that’s a pre-runner
to, pre-supposing to you know, much greater things and a huge expense
when you have to start you know chemotherapy or something that if it
wasn’t addressed in the early stages. And I think a lot of the IowaCare
people, had they not had their IowaCare and their access to the clinic then
they probably wouldn’t have even ever had a pap smear done.

**Chronic illness and patient severity**

Patients with chronic illnesses who had lacked routine primary care in the past presented a challenge to many clinics. A majority of respondents recalled the overwhelming influx of IowaCare enrollees after the designation of their clinics as a medical home, and how many of these patients came in with long-untreated chronic conditions:

Right um the complexity is amazing. (Laughs) Um, I’m really hoping that through IowaCare that some of that first wave of really, really sick people is kind of…we, we kind of addressed some of that. Um I don’t know how many more folks are out there like that but um it’s not at all unusual for us to see someone who has um 3 or 4 chronic illness and then something acute going on too and um…. So that’s what people are dealing with and it’s a lot of behavioral based things. . It’s the um either tobacco use or in these populations um obesity, that leads to the heart disease, diabetes, um kidney illnesses, those, those kinds of things that really require the patient to make major changes in their lifestyle to try and improve that, because medication isn’t gonna take care of everything.

Um they had completely ignored their um, completely ignored their medical conditions. Unbelievable, but you run into people that are diabetic that haven’t had their insulin for years because A, they didn’t go to a doctor because they couldn’t afford it and then they couldn’t afford their medicine.

Some respondents offered lessons learned or changes in clinic flow as a result of caring for these patients:

*I: What do you think that you all might have learned from the IowaCare population about this idea of pent up demand as far as, you know, people who like you’ve said have had chronic illnesses and haven’t accessed health care in a long time, what do you all think you’ve learned?*

*R: Um, you know, really just making the provider available, scheduling those patients for a longer block with the providers…instead of, you know, a normal fifteen minute follow up appointment, you know, scheduling it for a thirty or forty-five minute session with the provider to really help the patient.*

Related to chronic illness, IowaCare medical homes were often the first point of contact for the initial wave of sick patients who moved into system before ACA implementation. These patients often came to the clinics with serious medical concerns beyond the scope of typical primary care practice:

*And then the first patients that we started seeing were, you know, a young patient who was a diabetic who was losing his toes. You know, just the severity of, of their um chronic diseases was overwhelming. Um, I honestly um can’t remember um… the um, the hard um… the um, amount of cancer patients you know, the amount of diagnoses of cancer. I mean it was just, I would say the first year of it was so overwhelming just on how many patients it touched.*
I think, I mean, I think so, you know our biggest thing was just when we brought in the IowaCare patients, yeah they had a lot of medical issues that were, they’d gone so long without being treated.

V. Moving forward

ACA impact

The interview guide asked administrators to speculate about expected shifts or changes in patient population as a result of the ongoing implementation of the Affordable Care Act in Iowa. Respondents identified how the expiration of the IowaCare program at the end of 2013 would impact their patient base and divide former IowaCare patients into differential levels of coverage; as one respondent summed up, “… with IowaCare going away and some of our patients, some of them have qualified for straight Medicaid, some of them have qualified for the, the Iowa Health and Wellness Plan, and some of them have qualified for the Marketplace Choice Plan.”

Respondents were asked if they expected to see a change in their patient population as a result of IowaCare’s expiration and the implementation of broader coverage eligibility under the Affordable Care Act. Many expressed hopes that IowaCare had successfully begun the process of addressing the most serious or neglected patient cases, and that the wave of new patients seeking care under the ACA would feature fewer complicated and/or severe cases:

Uh and, I, I feel pretty good actually now going into the ACA that we at least have maybe got some of the first wave of the sickest people coming, coming through and worked into the system.

Some expressed optimism about being less overwhelmed because the numbers would be smaller and the providers might have the opportunity to provide well care.

I don’t know that our numbers will be as big as what we had with IowaCare at first, but um, but I think we’re gonna have, you know, at times a lot of requests for appointments. I’m hop- and I’m hoping it’s um more of the well care more so than the um chronic acuity care. Yeah. It’ll be a change for our doctors!

Others disagreed, venturing that the initial ACA patient population would be medically similar to IowaCare patients:

You know, I think um everybody is envi- envisioning a new population of patients that haven’t had health care access, and now they’re going to have that so they’re gonna be a lot like the IowaCare’s patients with the chronic diseases, a lot of health issues untreated.

Many speculated on whether IowaCare patients would remain at the medical home assigned to them under IowaCare, or use the choice afforded them by ACA coverage to find a new provider closer to home:

R: With the Affordable Care Act, you know, it’s been a very big topic for us here at the health center and trying to establish our budget for next year, and whether or not the IowaCare claims, um, patients are gonna stay with us and we hope and we project that a majority of our current
patients will stay with us for the care we have provided them but we are realistic and know that the ones that live, you know, a hundred to two to four hundred miles away are probably gonna access that care closer to home to be more, you know, helpful for them.

I: Mm hm. So do you v- envision your numbers overall going down or will ther- other new people come and replace them?

R: We hope that other new people will come and replace them… a lot of those patients are now gonna be either on you know the Iowa Health and Wellness Plan or one of the um other plans out there. We’re hoping to keep them with us.

I’m expecting that our payer mix will shift, but as far as the population is, that we serve, um, I don’t expect that to change, like I said a lot of our IowaCare patients have told us that they’re going to stay with us or would like to stay with us. You know we still have our patients that are undocumented that are gonna be on our sliding fee scale, we still have, um, you know our patients that are on the sliding fee scale that don’t file taxes so they can’t be responsible for the tax penalty or shared responsibility payment, whatever you wanna call it. Um, and so they’re gonna continue to be on our sliding fee scale because they don’t want to put in their information to the system, let people know where they are, all that kind of stuff, so we’ll still have them. Um, you know it’s, it’s, our patients just may be with a different payer source.

Some respondents believed that participation in IowaCare had better prepared clinics to face the challenges expected to arise from taking on the next wave of patients covered under the ACA:

I think it’s prepared our staff to understand um…the complexity of the people who we’re going to be seeing; adults who have not had regular insurance coverage. Um, and I think that’s a ne-uh a good understanding, I think it’s also um required us to get much more sophisticated in how we provide services to patients in group settings. Um using, uh non-position personnel, managers, uh health educators, health coaches, all of, all of that kind of thing in trying to get people to improve, or ha- give them the resources they need to improve their health.

Others touched on larger social and market forces related to ACA implementation, describing how changes in the healthcare system will affect patient access and care-seeking behaviors:

I mean in private practice they cap the number of Medicaid patients they have and stuff and I think quickly with a lot of the patients on the Health and Wellness Program, they’re high needs patients, and it’s very to take care of a high needs patient in a private practice population, they just w- require so many things, and so I think eventually they’ll probably put a cap on that, um, I think… you know, even though our patients now will have I think better insurance coverage, it still doesn’t change their social situation, and… y- y- you know, it’s still that population that, y- you know it’s, it’s, it’s a lot more than just saying okay here’s your medicine, you know, you really have to help them with their own social structure so they can help take better care of themselves.
Some respondents expressed concern that there will still be people who do not access insurance or seek care because of cost:

Um, so, I-I think there are gonna be, I think that thing that scares me...we still have our patient population whose chose to um, get on the computer on their own and um not qualify for the Health and Wellness but, but they move on to the next bracket and then they see what their copay is, um, what their um premiums are, and they stop right there and don’t continue, they don’t get to the, and oh by the way you’ll get a tax credit to help you, and they see what high deductibles are on their insurance plan and say no, and that to me is probably the biggest scariest group is gonna be that, because I think, trying to get that buy in for that group of people, is, I think is gonna be a little bit difficult, if I have to pay for this and then I have, you know, I have a five thousand dollar deductible; it’s just not worth me having insurance. So I think we’re all gonna struggle with that patient population.

Continuing gaps in service

Respondents were asked what additional healthcare service coverage they believe this patient population needs going forward. Gaps in coverage commonly identified by respondents included vision care, health and nutrition education, mental and behavioral health services, podiatry, home health services, and durable medical equipment.

- Vision care

  ...but I think what comes mostly to mind is uh once again vision services...

- Health and nutrition education

  ...working out the, okay I was diagnosed with heart disease, that was probably another thing, I was diagnosed with heart disease and now I’ve had my cabbage, um, and now you’re working on trying to get them healthier, and you don’t have access to the physical therapy, you don’t have access to now I need to improve my health with exercise and stuff, and so really broadening those type of support services um, you know, somehow incorporating that mental health

  Well I, I think uh nutrition services, those are certainly important because once again I’m thinking again about you know uh obesity...

- Mental and behavioral health

  ...but I mean all of this that we’re trying to do with medical home and so forth that, it’s really the behavior things that, you know, and those I can tell you story after story of, you know, people that, these real issues, you know, are not the medical conditions but, you know a lot of it goes ba-you know I can just draw you one huge category, you know, population, (inaudible) population, um, of people that have PTSD for example, and their ability to function normally within society is, is really compromised and the, and the ability to take care of themselves is compromised, and, you know, we d- we don’t address those things well, we, you know, we often don’t even identify them as issues, um, and, and if this whole, you know, this whole reform is going to, uh, is going to happen, you know,
just organize the nation and the health care systems, we gotta figure out how to better manage those issues.

- **Podiatry**

  ...podiatry, uh, foot care is something, especially because we have so many diabetic patients um that have not been able to take the opportunity of having podiatry care.

- **Home health and long term care**

  Um I think a home health care, I think the long term care, um because I, we noticed that with our IowaCare population that it was, I think that because we, in fact we have um, um we also serve the homeless population, so we, I think, and which, we noticed that with IowaCare was you know kind of that they didn’t need to be in the hospital but they couldn’t go home yet. And just that, you know, in between care with you know with nursing homes and, and um, um, you know, just home health and I really think um that’s going to explode with um patients needing it in our area and um we don’t, I mean, we don’t offer home care and we don’t offer you know like long term, kind of the in between out of the hospital. So, I, I really think in our area that i- that’s gonna be huge.

  Uh yeah that, that certainly is an issue um home care became an issue, um and, and home care from the aspect of some pretty involved processes like IV, antibiotic therapy, enteric feedings, those kind of things that, actually we were not able to provide and um didn’t have a lot of success in getting the local agencies to provide free of charge either.

- **Durable medical equipment**

  Uh no, uh we did not have any durable medical equipment. Uh there were at times where we received some donated supplies for some of those things like splints for example and things th- uh, that I recall. Very few of those small supplies that we were able to um offer to patients.
Discussion

This study was conducted in order to understand the experiences of FQHCs participating in IowaCare. Respondents included administrators, care coordinators, health care providers, and billing managers. The following research questions addressed by respondents are listed below.

What were the general experiences (including challenges and successes) of clinics related to participation in the IowaCare provider network?

Respondents provided information about the challenges and successes of being part of the IowaCare provider network. Most responses were mixed, citing several challenges related to IowaCare participation along with successes like enhanced clinic capacity and patient gratitude.

The four most salient challenges are listed below.

- The overwhelming number of IowaCare enrollees, which placed organizational and financial strains on clinics--especially at the beginning of the program.
- The medical complexity and severity of IowaCare enrollees, many of whom had not had adequate access to healthcare services for a long time before enrollment in IowaCare.
- The gaps in services and equipment not covered by IowaCare, especially with regard to patient transportation and certain ancillary diagnostic and treatment services.
- Issues in communication between clinics and UIHC.

The most important success cited by respondents was the provision of care to many people who were in serious need of medical attention. Respondents said that while IowaCare was flawed, it nevertheless had provided a much-needed and appreciated resource to low-income Iowans who had been without sufficient healthcare for a long time.

Certain changes to clinic and provider practices were also viewed as successes of IowaCare participation, including the adoption of a more holistic or whole-person approach to treating patients. Most respondents remarked on improved organizational capacity of clinics in response to status as an IowaCare provider, including the hiring of additional staff, implementation of more efficient administrative and clinical processes, management of a larger patient load featuring more medically complex patients, and a push for administrators to reflect on the needs of their patient population.

How was communication between clinic staff and the Iowa Medicaid Enterprise/the IowaCare program characterized?

Communication is an important component of any program and is particularly vital to the effective care coordination of medically complex patients. Respondents characterized communication with the Iowa Medicaid Enterprise (IME) staff, staff at the Iowa Department of Human Services, other FQHCs, and the Iowa Primary Care Association as very
positive. Program staff were described by respondents as helpful and responsive. The Primary Care Association played a key role in facilitating weekly calls and providing a foundation for open communication.

How was care coordination between clinics and the participating medical centers characterized?

Though care coordination was seen as a major challenge, all of the clinic respondents reported that their care coordination efforts had improved greatly throughout the process of treating IowaCare enrollees. The challenge of care coordination was compounded by the large number of patients and their high degree of medical complexity. Over time, though, clinics identified more resources in their communities, partnered with new agencies to provide needed services, and developed innovative strategies for filling patient needs. Some clinics resented the extra cost they were forced to absorb in order to provide patients with services or equipment, especially when the clinics felt like the label ‘medical home’ was really a designation for ‘you are responsible for paying for all of the services this person needs.’ Because of the important role care coordination played in patient management, many clinics reported wanting to hire more care coordinators to facilitate this process.

Communication between clinics and UIHC was described as problematic at best. Communication challenges were evident both at the individual patient level and at the administrative level. Clinic providers and care coordinators reported that providers at UIHC did not communicate patient results, respond in a timely manner to requests for appointments or information, and/or provide patients with treatment plans that were appropriate to the constraints of the IowaCare program. At the administrative level, many respondents believed that UIHC was not consistently following the policies determined by IME, and was not working collaboratively with IowaCare program staff and clinic staff at FQHCs.

Have there been changes in health outcomes of IowaCare enrollees as a result of participation in the program?

While most respondents did not have data available to demonstrate evidence of changes in the health outcomes of IowaCare enrollees, all of the clinics shared moving stories about the impact of providing treatment to individuals who had not had sufficient medical care in many years—decades, in some cases. Respondents described how breast cancer was detected and successfully treated in female enrollees, patients with heart disease were given care, and diabetic patients who had been without insulin were provided with much-needed medicine and education. Some respondents discussed their efforts to work with their patient panel to improve Hemoglobin A1C test results in diabetics and to increase cancer screening rates. Clinic staff reported that many of the IowaCare enrollees were incredibly grateful to be cared for with respect and dignity by providers and staff, and greatly appreciated the medical care available to them because of the IowaCare program.

How did clinics handle any gaps in coverage as a result of services needed or sought by patients that were not covered by the IowaCare
program?

IowaCare, as a limited-coverage insurance program, was not responsible for coverage of many additional services, leaving it up to clinics to fulfill these unmet patient needs. The list of services and resources commonly mentioned by respondents that were needed but not covered by IowaCare are listed below.

- Laboratory
- Imaging/radiology
- Mental and behavioral health
- Health education and nutrition education
- Durable medical equipment
- Home health care
- Long-term care
- Vision
- Dental
- CPAP masks/machines
- IV medication
- Pharmaceuticals
- Emergency care
- Podiatry
- Transportation

Transportation and prescription drugs were issues mentioned by every clinic. While some clinics were able to obtain coverage for these services through other funding sources or programs, others had to pass the cost on to their patients or find a local partner to provide the service at little or no cost.

What impact has IowaCare participation had on present or future clinic capacity to address any changes in patient population that may result from ongoing implementation of the Affordable Care Act?

All clinic respondents believed that the IowaCare experience had prepared them for the upcoming implementation of the Affordable Care Act (ACA). While clinics did not all agree about how their patient population might change as a result of ACA implementation in Iowa, all of them believed that lessons learned from IowaCare participation would help them in important ways. Some described how their experience with IowaCare had prepared them to manage the increase in patient load expected as a result of the ACA. Others believed that the medical complexity of new patients would be similar to that observed among the IowaCare population. These clinics described lessons learned as a result of their experience with IowaCare patients, such as the need to increase
the time allotted for initial new patient visits given the high degree of complexity and/or severity of these patient cases. Others cited their ability to coordinate care and their experience utilizing community resources as assets gained through the IowaCare experience that will be of use with the new patient population under the ACA. Most clinics indicated that this process brought them closer to the ideal of the medical home model. However, concerns remain among clinics about meeting the demands of these new patients and how needed services will be found and paid for.
Appendix A

Telephone script protocol

Hello, my name is XXXXX. I am calling from the Public Policy Center at the University of Iowa. We are calling to speak with you about the IowaCare program and to explore changes related to access, quality, improved health status and prevention efforts as a result of medical home model pilot implementation at your practice. We are also interested in how these experiences have prepared your clinic to face the changing health care system.

[READ INFORMED CONSENT DOCUMENT FOR VERBAL CONSENT]

Thank you. Over the next 30 minutes I will ask you questions about characteristics of your practice as related to different domains of the patient-centered medical home model and experiences with the IowaCare insurance program and its enrollees. Please be specific in your responses to open-ended questions and provide as much relevant information as possible. When answering these questions, please consider your answers in light of how your practice may have changed since the implementation of the patient-centered medical home pilot.

First we have some brief general questions:

Can you tell me a little bit about your institution's experiences with IowaCare over the last two years?

What have been the greatest challenges? (probe for specifics, can you give me an example?)

What have been the greatest successes? (probe for specifics, can you give me an example?)

Describe the quality of communication between your practice and the IowaCare program.

Has your practice seen an improvement in health outcomes for IowaCare enrollees since implementation of medical home pilot? Example?

Are there any services that are not covered by IowaCare that your institution is offering IowaCare patients at no or little cost to the patient? What are they? (probe for...Generic prescription drugs, Durable medical equipment, Laboratory services, X-ray services, other?)

We are also interested in how your experiences with IowaCare may have helped you think about or address some of the issues facing your clinic because of changes related to the Affordable Care Act.

Will the population your clinic serves change based on the ACA? If so, how?
If it will be different- do you think the IowaCare experience has prepared the clinic for the new challenges? If yes, how?

What do you think you might have learned about how your clinic’s population will remain similar or change compared to today?

What do you think you have learned about the services needed by this population? (What services that your clinic currently doesn’t offer will be most needed as healthcare reform is taking place?)

Based on your experiences with IowaCare- what do you gauge your clinics’ ability to make referrals?

What do you think you have learned about pent-up demand or need or gaps?

Based on your experiences with IowaCare- what do you gauge as your clinic’s ability to coordinate care?