MINUTES

INTEGRATED HEALTH CARE MODELS AND MULTI-PAYER DELIVERY SYSTEMS STUDY COMMITTEE

November 19, 2013

MEMBERS PRESENT:

Senator Amanda Ragan, Co-chairperson
Senator Jake Chapman
Senator Jack Hatch
Senator Janet Petersen
Senator Mark Segebart
Representative Linda Miller, Co-chairperson
Representative John Forbes
Representative Jo Oldson
Representative Walt Rogers
Representative Rob Taylor

MEETING IN BRIEF

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I. Procedural Business

Call to order. The integrated Health Care Models and Multi-payer Delivery Systems Study Committee was called to order by temporary Co-chairperson Miller at 10:00 a.m. on Tuesday, November 19, 2013, in Room 103 of the State Capitol. The meeting was adjourned for the day at 5:05 p.m. The meeting reconvened at 9:00 a.m. on Wednesday, November 20, 2013, in room 103 of the State Capitol. The meeting was adjourned at 3:06 p.m.

Election of permanent co-chairpersons. Members of the committee unanimously elected temporary Co-chairperson Ragan and temporary Co-chairperson Miller as permanent Co-chairpersons.

Adoption of rules. Members of the committee adopted procedural rules which are posted on the committee's internet site.

Committee charge. The Integrated Health Care Models and Multi-Payer Delivery Systems Study Committee was established by the Legislative Council for the 2013 Legislative Interim and authorized for two meeting days. The committee's charge is to review and make recommendations for the formation and operation of integrated care models in Iowa; review integrated care models adopted in other states that integrate both clinical services and nonclinical community and social supports utilizing patient-centered medical homes and community care teams; recommend the best means of incorporating into integrated care models nonprofit and public providers that care for vulnerable populations; review and make recommendations regarding development and implementation of a statewide medical home infrastructure to act as the foundation for integrated care models; review opportunities under the federal Affordable Care Act for development of integrated care models; address consumer protection, governance, performance standards, data reporting, health information exchange, patient attribution, and regulation issues relative to integrated care models; and perform other duties specified in the legislation. In addition, the committee is to serve as a legislative advisory council on multi-payer health care delivery systems to guide the development by the Department of Human Services of Iowa's design model and implementation plan for the State Innovation Models Initiative Grant awarded by the Centers for Medicare and Medicaid of the United States Department of Health and Human Services. The study committee may request that legislative leaders authorize supplementing the study committee membership to ensure there is a comprehensive review process and adequate stakeholder participation.

Welcome and Introductory Remarks. Co-chairpersons Miller and Ragan welcomed the members of the committee. Co-chairperson Ragan commented that the meeting will provide a great opportunity to learn about the changes that are occurring in health care.

II. Understanding the Evolution of the Health Care Delivery System

A. Mary Takach — National Academy for State Health Policy (NASHP)

Overview. Ms. Takach, Senior Program Director, NASHP, provided an overview of pathways to integrated health care delivery systems utilizing patient-centered medical homes, team-based care, accountable care organizations (ACOs) and accountable communities, and focusing on population health and multi-payer financing. Ms. Takach said that NASHP is a 26-year-old, nonprofit, nonpartisan organization that works with states, government branches, and agencies to advance, accelerate, and implement workable policy solutions that address major health issues.

Medical and health homes. NASHP has been focusing on new primary care models for Medicaid and the Children's Health Insurance Program (CHIP) and the use of medical homes. Medical homes address whole-patient care that is coordinated and accessible. A medical home can provide support for primary care practices by providing payments for ongoing medical home costs and incentives for performance, assisting with managed care contracts and adoption of best practices by providers, providing information to providers on their performance and patients, and providing funding and technical assistance for health information technology and health information exchanges.

Ms. Takach discussed various approaches to implementing integrated health systems. The key features of these models are high-performing primary care providers; an emphasis on coordination of providers in the system; shared goals and risks for a community of patients; population health management tools; health information technology and exchange; and an engaged patient population.

Multi-payer medical homes are often voluntarily created, payments may be aligned with practices achieving new medical home qualifications, practices may adopt transformation activities such as practice coaches, and may utilize data analytics to provide feedback on achievement of goals is key.

Vermont and Maine have adopted a shared practice team approach with multi-disciplinary teams that are shared among practices. Vermont's shared practice team model does not restrict patients based on insurance status; accepts referrals from practices and communities and focuses on prevention as well as chronic disease management. Maine's model focuses on high-risk insured patients and chronic disease management.

Ms. Takach explained the differences between a medical home and a health home. A medical home is designed for everyone, is led by a primary care provider with a primary care focus, and has no enhanced federal Medicaid match. A health home is designed under section 2703 of the Affordable Care Act for high-risk individuals with a serious mental illness or chronic physical condition, or both. The primary care provider is key, but not necessarily the leader. In a health home, there is a focus on linking primary care with behavioral health and long-term care, and increased reimbursement is provided to states in the form of an eight-quarter 90 percent federal medical assistance percentage match and a significant increase in financial support to participating providers.

Accountable Care Organizations (ACOs) and other models. ACOs are another model being implemented. ACOs are built on a strong primary care foundation with practice teams, quality improvements, and links between providers. ACOs are accountable for quality of care, patient care experiences, and total costs for a defined population of patients. Payments reinforce and reward high performance, and innovative payment methods and organizational models are used. There is monitoring, data feedback, and technical support for improvement.

Another model is the Coordinated Care Organization (CCO) which was authorized by the legislature in Oregon in 2012. CCOs receive a fixed global budget for physical, mental, and ultimately dental care, for each Medicaid enrollee. CCOs must have the capacity to assume risk and implement value-based alternatives to traditional fee-for-service methodologies. CCOs must have strategies to coordinate care and engage enrollees and providers in health promotion. CCOs must meet key quality measurements while reducing spending growth by two percent over two years or the state must repay federal funding received.

Various states are developing integrated health delivery models through the state innovation models (SIM) initiative created by the Center for Medicare and Medicaid Innovation Center. The SIM initiative is providing funding to states to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance and reduce costs. Projects focus on Medicare, Medicaid, and Children's Health Insurance Program enrollees. Grants may be awarded for model design, model pretesting, and model testing.

Colorado is implementing a SIM pretesting grant with three strategies for supporting integration of behavioral health into primary care by investing in data, measurement, and payment infrastructure; expanding and leveraging existing structures for learning and communication; and providing funding for practices to finance the cost of integration. Key stakeholders in Colorado have formed the Health Extension Service as a hub to support primary care redesign and collaboration.

Minnesota is implementing its SIM model testing grant in three phases. Phase I involves implementation of nine ACO contracts; Phase II involves awarding of a second round of contracts to expand the number of Medicaid enrollees and other populations served under the Medicaid Health Care Delivery System demonstration in alignment with other partners; Phase III involves continued testing of and infrastructure support for the ACOs. During the third phase, the 13 existing community care teams will be expanded to 15 accountable communities for health to bring together ACO providers and organizations representing a range of each community's population and service needs. Minnesota already has infrastructure in place because the state has a preponderance of large health practices and fewer small practices.

Vermont is using its SIM model testing grant to test three payment methods for population-based performance (shared savings by ACOs), coordination-based performance (bundled payments), and provider-based performance (pay-for-performance models).

Takeaways for promising strategies in achieving an integrated health care delivery system are: redesigning primary care to improve value in health care; using medical homes and ACOs to improve primary care; realizing that change is slow and requires upfront funding; multi-payer

financing is key to achieving system-wide change; early evaluations of medical homes are promising but significant short-term savings are unlikely; ACOs show promise in reducing costs, but the payment model is not sustainable; and the Affordable Care Act provides significant resources for achieving an integrated system.

B. Peter Damiano, DDS; Director, Public Policy Center; Director, Health Policy Research Program; and Professor, Preventive and Community Dentistry, University of Iowa

Overview. Dr. Damiano discussed the drivers of health care integration which are cost, access to, and quality of health care, and the evolution of the health care system from an acute care system to a community integrated system that focuses on population health and social determinants of health. Health care costs in the United States have been steadily outpacing those in other industrialized countries since the 1980s and it is estimated that one-third of health care spending in this country is wasteful. This situation is a challenge for employers who compete in a global market. The top one percent of health care users account for 27 percent of all costs so the focus of many reforms is on those users.

Access to care is a set of dimensions describing the fit between the patient and the health care system. Access constitutes not only financial access but other issues that impact access to care in rural and urban areas. It is estimated that 50 million people are uninsured, the majority of whom are lower income, but a growing number are underinsured, which becomes apparent when they have a catastrophic medical problem. Many bankruptcies are due to medical bills.

A historical look at insurance coverage starts with employer-provided insurance which began during World War II in response to wage and price freezes. Since that time public health coverage has expanded to fill gaps in coverage with the advent of Medicare and Medicaid in 1965 to cover seniors, the disabled, and mainly poor children; the Children's Health Insurance Program (CHIP) in 1997 to cover children of the working poor; and the Affordable Care Act (ACA) in 2010 to cover poor single adults, those with preexisting medical conditions, and those needing individual and small group insurance coverage.

Iowa Health and Wellness Plan. Iowa's Medicaid expansion program, the Iowa Health and Wellness Plan, is made up of two parts, the Iowa Wellness Plan and the Iowa Marketplace Choice Plan. Income eligibility for the program is determined by a new modified adjusted gross income (MAGI) methodology. About 52,000 people who were previously enrolled in IowaCare will be auto-enrolled in this new plan.

The Iowa Wellness Plan is for individuals with incomes not exceeding 100 percent of the federal poverty level (FPL). The payments are fee-for-service through any enrolled Medicaid provider. It is estimated that there will be 120,000 enrollees in this plan by 2016.

The Iowa Marketplace Choice Plan is for individuals with incomes from 101 percent but not exceeding 133 percent of the FPL (the income determination methodology has the effect of raising the limit to 138 percent of the FPL through application of a 5 percent disregard). These individuals may choose private health insurance coverage from the Health Insurance Marketplace.

Individuals considered medically frail with income not exceeding 133 percent of the FPL will receive coverage through Iowa's traditional fee-for-service Medicaid program.

Quality of health care involves not just technical quality but appropriateness of the care provided and outcomes, and their relationship to cost, both on a system-wide and personal level. For instance, the question is not just whether a medical procedure was done well, but whether the procedure was necessary or appropriate under the circumstances. Quality is driving the system now which is a major change from earlier health maintenance organizations (HMOs).

Evolution of health care. Changes in the health care system are also being driven by changing disease patterns. From 1850 to 1900, epidemics were the focus. Disease etiology was unknown and simple institutions existed to address health. It was the beginning of the public health era with the advent of clean water and sewers. From 1900 to 1940, the focus was acute infections. Science began to be used as a basis for addressing health, more complex institutions were formed, antibiotics became available, and the ability to treat individuals rather than populations became more prevalent. Beginning in 1940 and until the present day, chronic illness has been the focus. The use of science and technology has grown and more complex institutions have developed to address health. The majority of treatment is now based on improving quality of life rather than merely preventing death. Lifestyle-related illnesses including those related to smoking, exercise, nutrition, and automobile accidents are more prevalent.

The health care system has evolved based on differing goals. In the first era, yesterday, the goal was reducing death and the focus was acute and infectious disease, germ theory was prevalent, and medical care and insurance were newer concepts. In the second era, today, the goal is prolonging a disability-free life, and the focus is on chronic disease prevention and management, multiple risk factors are considered, and prepaid benefits are available. In the third era, tomorrow, the goal is optimal health for the whole population, and the focus is on complex systems and life course pathways, health relates to the overall lifespan, and population-based prevention is key.

Determinants of health. Health and health care are different concepts. Often, determinants of health are best addressed outside the system that directly delivers health care, and addressing health requires integration of a variety of community resources.

Determinants of health are lifestyle factors (51 percent), environmental factors (19 percent), human biology (20 percent), and health care delivery (10 percent), yet the United States invests 90 percent of its funding in health care delivery. Social determinants of health include early childhood development, education, employment and working conditions, food security, health services, housing, income and income distribution, social exclusion, the social safety net, and unemployment and job insecurity.

Portions of the ACA focus on the treatment of persons who are high-cost, high user patients, i.e., people with chronic physical or mental health conditions, to attempt to save money and improve the quality of health care. Under the ACA, Medicaid health homes can be established to coordinate care for people with chronic conditions. Other aspects of the ACA focus on prevention and population health. The Trinity-Pioneer ACO in Fort Dodge is a demonstration project under the ACA Medicare Shared Savings Program with a population health focus. While some ACOs

like the Trinity Pioneer ACO are population-based and community-focused, their increased prevalence may create a hypercompetitive private sector environment that hinders integration in some markets as various entities become involved such as private insurers like Wellmark.

C. Christopher Atchison, Associate Dean and Clinical Professor, The University of Iowa College of Public Health; Director, State Hygienic Laboratory, The University of Iowa

Iowa health reforms. Mr. Atchison discussed health reforms in Iowa over the decades, all focusing on cost, quality, and access, and the goal of promoting the optimal health status of both individuals and populations. Systems produce the results they are designed to produce. Our health care system is focused on acute care. Some have called it a "sick care," not a "health care" system. In an era of chronic disease we are missing opportunities. Health reform inevitably looks at economic models.

Different reform strategies have been employed over the years but Iowa has focused on more than cost. The Leadership Consortium on Health Care Reform (1990-1992) was convened by former Governor Ray, CEO at Blue Cross/Blue Shield, with a focus on health care coverage for all, cost management, improvement of health care quality and safety, equitable financing, and simplified administration.

The Iowa Health Reform Council (1993-1994) met to discuss long-term health care cost increases; a lack of understanding about quality; lack of personal responsibility by all parties; a complex and confusing health care system; and societal issues affecting health care for which reform alone cannot provide an answer. The council adopted a statement of principles based on access to a standard level of services for all; affordable care that balances cost, quality, and access; continuous improvement in quality and value; creating appropriate incentives to encourage accountability; facilitating the development of coordinated delivery systems; and payment of their fair share by government, employers, and individuals.

Iowa's Health Reform Transition Team (Final Report 1996) focused on structures for putting voluntary Health Insurance Purchasing Cooperatives (HIPC) and Organized Delivery Systems (ODS) in place; beginning small group and individual insurance market reform; initiating simplification of health care regulations; providing tax deductibility on 1996 income tax returns for the out-of-pocket premium costs of individuals; and recommending a State Health Expenditure Accounting System, research on status of the uninsured, and voluntary implementation of the community health management information system.

Current focus. In the last 10 years the Iowa General Assembly has enacted health reform legislation establishing the Safety Net Collaborative (2005), the Commission on Health Care Coverage for Families and Workplaces (2007), the Health Care Reform Act (2008), the Legislative Health Care Coverage Commission (2009), IowaCare expansion (2010), mental health redesign (2012), and the Iowa Health and Wellness Plan (2013).

The contemporary vision for health reform is the triple aim of better health for the population, better care for individuals, and lower cost through improvements. The goal is to promote optimal health

for everyone. Various models address the goal of optimal health. The chronic care model focuses on the creation of a primary care community made up of the community, health systems, prepared and proactive practice teams, and informed, activated patients. "Medical home" means a team approach to providing health care that originates in a primary care setting, fosters a partnership among the patient, personal provider and other health care professionals, utilizes the partnership to access all medical and nonmedical health-related services needed to achieve maximum health potential, and maintains a centralized, comprehensive record of all health-related services rendered to promote continuity of care. The ACO is an overarching structure within which other reforms can thrive. ACOs include accountability, performance measurement, and shared savings.

Public health intiatives must be highly adaptive since living conditions constantly change. Determinants of health include social and physical environment, genetic endowment, and individual responses based on biology and behavior. The goal of health reform is to find the "sweet spot" between access, cost, and quality.

III. Iowa's Health Care Delivery System and Opportunities for Further Integration

A. Medical Homes - Mary Takach, NASHP

Ms. Takach discussed the qualification standards for patient-centered medical homes and variations from state to state. Qualification standards provide assurance to payers and can be standardized to meet delivery system goals. Iowa is one of the states that aligns medical home payments with national or state-developed qualification standards, and 29 states are currently making payments for medical homes. There are national standards developed by the National Committee for Quality Assurance (NCQA), state standards developed by individual states including Oregon and New York, and hybrids of the two such as those developed by Maine, Missouri, and Massachusetts. The process of qualifying as a medical home is hard work. Qualification standards can be meaningful or just an exercise in paperwork. There are opportunities to customize the standards to meet a state's system delivery goals.

B. Prevention and Chronic Care Management/Medical Home (PCCM/MH) Advisory Council Update - Tom Evans, MD

Dr. Evans, President and CEO, Iowa Healthcare Collaborative, and chairperson of the Prevention and Chronic Care Management/Medical Home Advisory Council, explained that the Advisory Council is the result of merging the Medical Home and Prevention and Chronic Care Advisory Councils which were initiated in 2008 and merged in 2011. The legislative charge for the advisory councils was extensive and launched a robust statewide discussion of how to develop a plan for implementation of a statewide medical home system in Iowa. The progress of the groups to date includes adopting national standards as much as possible on a permissive, nonmandatory basis to foster Iowa's strengths in executing such standards. Medical home is a concept and a process, not a place, and requires the adoption of an additional skill set based on the joint principles of a primary care medical home to deliver improved outcomes and value-based care.

The advisory council is comprised of a highly engaged group of leaders and stakeholders who are making recommendations for Iowa-based solutions for population-based care. The advisory council is in the process of renaming itself the patient-centered health advisory council to more accurately reflect its focus and future goals.

C. A Medical Home in Practice, Lessons Learned, What's Next - Bery Engebretsen, MD; David Carlyle, MD.

Dr. Engebretsen. Dr. Engebretsen, Primary Health Care, Inc., Des Moines, discussed how to transform health care from the ground level. He said that health care has been transforming itself for several years, largely funded by the ACA, including increased use of electronic medical records, operation of ACOs, certification of family practitioners' practices as patient-centered medical homes (PCMHs), new and expanded roles for other health care team members, more patient involvement in their care, reform of the payment system, and use of data to improve care of populations, not just individuals. Such changes are difficult. Electronic medical records have slowed the office visit, but most would not want to go back to paper charts; providing preventive services takes time; and team care is very rewarding, but challenging due to the need to change the physician-driven culture to a team-based culture, data collection, records, and the lack of reimbursement for the additional time and resources required.

The key to transformation is putting a knowledgeable and empowered patient at the center of the care process. This requires a change in approach to acknowledge that social determinants of health such as poverty, domestic violence, and childhood adversity play a bigger role in human health than do health professionals, that a pill will not cure every human malady, and that critical elements of human behavior can be addressed by trained staff. The hardest part is fixing the payment system to shift resources from costly back-end consequences of poor health to front-end processes of keeping people well, coordinating their care, and creating teams. Rewards and reimbursement must change from rewarding volume of visits to rewarding quality outcomes. There is a reluctance to support infrastructure investments upfront, but the ACA has supported these.

Dr. Engebretsen took the first step in his practice 15 years ago by focusing on population health through the use of data systems, for example, focusing on the care of diabetics in his practice. The second step has been a team focus with inclusion of behavioral and mental health specialists, pharmacy services, nurse managers for HIV/AIDS patients, aggressive work with hospitals to prevent readmissions, OB checkups, and assistance with patients' long-term care, housing, and transportation issues.

Dr. Carlyle. Dr. Carlyle, McFarland Clinic, Ames, said that the holy grail of health reform is controlling costs while still providing access and quality. He opined that the key is care coordination, forms of which include PCMHs and ACOs. Dr. Carlyle has been involved with federal and state health coverage efforts for many years, chairing one of the legislative health commissions that developed the basis for the medical home system in Iowa. Dr. Carlyle is a practicing family physician, geriatrician, and hospice medical director whose clinic is a NCQA level 3 certified primary care medical home. Private sector primary care can be divided into employed

physicians of major hospital systems and the rest, including physicians in multi-specialty clinics, small groups, solo practitioners, and small-hospital affiliated physicians.

The essence of PCMH is a team approach for patient care with the patient, the primary care physician, and various members of the physician's clinic all vying to maintain and improve physical and behavioral health in a sustainable manner. The physician role is to create healing relationships and deal with tough diagnostic and therapeutic dilemmas. When PCMH is done well, it results in quality improvement and savings, and reduction in hospital and rehospitalization, emergency department visits, and cross-specialty consults. Team coaches in his practice have become certified application counselors who can assist patients in signing up for health insurance coverage through the health insurance marketplace. PCMHs cost money but the savings outweigh the costs.

Iowa was positioned three years ago for a multi-payer PCMH pilot but it did not come to fruition because Wellmark wanted to concentrate on the ACO model. CoOportunity Health has chosen instead to pilot a PCMH project using small physician groups in rural clinics, all members of the Heartland Rural Provider Alliance. In the future it would be helpful to have case managers on site for the most complicated patients and to have a point-of-service dashboard to view patients' claims data from the payer at the time of the patient visit.

There is a tension between the PCMH and ACO models involving how to divide work to accomplish care coordination and funding to accomplish care coordination, and the assumption of risk. Five questions going forward are how the cost of primary care medical home care coordinators will be acknowledged and maintained by a shared savings model; when risk assumption is the basis of the model, will the same dangers of HMOs return; can primary care groups assume risk; if the majority of savings can be achieved by primary care physicians, why would primary care physicians share the savings with hospitals and specialists; and when the shared savings is fully realized, how will the cost of care be computed?

The questions for state legislators are: will the large hospital systems be fair to rural county health care, and will there be room for independent physician groups in the Medicaid regional ACO model currently being developed? Dr. Carlyle's recommendations are to allow the free market to play out, to guard health care in rural areas, to make sure small physician groups that meet specified criteria are allowed to participate in future Medicaid models of health care delivery, and to emphasize care coordination and realistically negotiate risk throughout all parties including providers, payers, and patients.

D. Utilization of Medical Homes in Medicaid — Jennifer Vermeer, Iowa Medicaid Director

Ms. Vermeer, Iowa Medicaid Director, Department of Human Services, discussed the two types of medical homes being utilized by the Medicaid program: chronic condition health homes and integrated health homes.

A chronic condition health home is a designated provider offering whole-person, patient-centered, coordinated care for all situations in life and transitions of care for members with specific chronic

conditions. Iowa was one of the first states to implement this model, beginning in July 2012. Medicaid recipients assigned to such a health home must have two or more specific chronic conditions, or one condition and be at risk of developing a second. The conditions are mental health, substance use disorder, asthma, diabetes, heart disease, severe overweight/obesity, and hypertension. Improvements are planned for rollout in spring 2014, including provider supports and other improvements, aimed at increasing enrollment, maximizing improved member outcomes, and realizing savings targets. Participation in the program is voluntary for Medicaid providers and there are not yet enough participating providers to offer statewide coverage.

An integrated health home provides a similar team approach for the care of adults and children with serious mental illness. Integrated health homes are implemented through Magellan, a managed care mental health provider. A key lesson learned is that providers need a lot of support in caring for these patients. Phase 1 of this program began in July 2013, in five counties, Polk, Warren, Woodbury, Linn, and Dubuque, with intense provider supports and training. Phase 2 is targeted for spring 2014, in 29 additional counties with the goal of seeking and serving an additional 15,000 adults and children. Initial outcomes show decreased emergency room visits and psychiatric admissions for patients enrolled in the program.

IV. Accountable Care Organizations

A. State Roles in Supporting Accountable Care Organizations — Mary Takach, NASHP

Overview. Ms. Takach provided an overview of state roles in supporting ACOs including through purchasing, legislating, regulating, governing, and by providing technical assistance. States have identified a number of needs relating to ACOs including utilization of a strong primary care foundation for any ACO, the need for multi-payer ACOs, state-legislated certification of and accountability for ACOs, incorporation of public health and utilization of team-based care to provide linkages to community services, and the need for robust health information technology.

ACOs hold providers accountable for costs through payments that are linked to value. Some states define who can be an ACO. The federal government has supported ACO development through the Medicare Shared Savings Program and the Pioneer ACO. Medicare's Shared Savings Program has two tracks: in the shared savings-only model, ACOs can share in up to 50 percent of savings, based on quality performance, with no downside risk; in the two-sided risk model, ACOs can share in up to 60 percent of savings but also share in losses. Pioneer ACOs, funded through the CMS Innovations Center, have higher levels of shared savings and risk than the Shared Savings Program and allow ACOs that show sufficient savings after two years to move a substantial portion of their payments to a population-based model. There are hundreds of ACOs, both public and private, in the United States now. There are different ways to assign accountability. The shared savings process is the most popular because it provides a step-wise process of change. State-fostered ACO initiatives have the potential to support integration of services with public health.

ACOs in Medicaid. Under the MaineCare accountable care communities initiative, Medicaid provider contracts utilize a shared savings model based on attainment of quality benchmarks. Under New Jersey's ACO pilot, the ACO assumes the responsibility for Medicaid populations in a designated area. In Hawaii, some Medicaid managed care plans are participating in a virtual ACO formed by three federally qualified health centers. Minnesota's demonstration rewards groups of providers and integrated delivery systems that can achieve savings below a total cost of care target based on quality performance requirements. Illinois has launched Care Coordination entities, collaborations of providers and community agencies, governed by a lead entity that receives care coordination payments to provide care coordination services. Utah is negotiating contracts with Medicaid health plans in the state.

State certification of multi-payer accountable care entities. Texas is developing a certification process for health care collaboratives, composed of physicians and providers, who can enter into innovative payment arrangements with public and private payers to assume responsibility for a range of health care services. New York ACOs may enter into payment arrangements with one or more third-party payers to establish novel payment methodologies, including full or partial capitation. In Massachusetts, certified ACOs will be required to receive reimbursement or compensation from alternative payment methodologies, not only fee-for-service, and must be capable of coordinating financial payments among providers to improve quality and provide care coordination.

Coordinated Care Orgranizations. Oregon is developing a statewide network of Coordinated Care Organizations that provide integrated and coordinated health care for Oregon health plan enrollees under global budgets. Colorado has implemented seven Regional Care Collaborative organizations that are responsible for providing medical management, care coordination, and support to providers.

Assigning accountability. Some states are using active enrollment and others are using passive attribution in assigning accountability for patients to a provider or system.

Accountability for costs and quality. States are implementing payment mechanisms to reward value including pay-for-performance, shared savings, episode-based payment, and global payment. Shared savings is among the most popular models.

Incorporating public health. There is potential to support integration of services with public health in state-fostered accountable care initiatives. Maine's Accountable Communities must develop contractual or informal partnerships with public health entities. Oregon's coordinated care organizations must partner with local public health authorities and others to develop shared community health assets. Minnesota is using its State Innovation Model grant to expand its model to form accountable communities that integrate a range of services, including public health.

Key takeaways on ACOs. ACOs must have a strong primary care foundation. Team-based care models provide the needed linkages to community services. A robust health information technology and exchange system is essential. Shared savings is a transitional payment model that will need to evolve to global or full-risk payments to reach the goals of integrated care, multi-payer ACOs are nascent, and there are many roles that states can play in ACO development.

B. Commercial and Medicare Shared Savings Program ACOs

1. UnityPoint Health Partners ACOs — Aric Sharp

Mr. Sharp, Vice President, UnityPoint Health Partners, said that ACOs offer new ways to deliver care and new models for financing that care. The key components of an ACO are contracting, innovation, care management, and clinical integration. Governance of the ACO is critical and must achieve a balance between regional and system input in a partnership that hopefully results in optimal care. UnityPoint ACO currently has a network of 14 hospitals; 1,799 physicians including 789 primary care physicians and 1,010 specialists; and 43 unique entities. It is a robust network but there are still some gaps in safety net and community services. Standard quality metrics for services are employed. The UnityPoint ACO received shared savings from Wellmark for performance year 2012. Lessons learned so far are that the work is complex, it takes significant investment and resource allocation, there must be changes in management expertise and innovation discipline, and data is critical to the work.

2. University of Iowa Health Alliance — Dan Kueter

Mr. Kueter, Executive Director, University of Iowa Health Alliance, said that the alliance includes Mercy Health Network, University of Iowa Health Care, and Genesis Health System. Two of the state's highest performing community health centers are in Des Moines and Davenport. The alliance is working with the Iowa Medicaid Enterprise to implement an ACO. The alliance is working on a multi-payer ACO for Medicaid and a commercial carrier.

3. Mercy Health Network — Joe Levalley

Mr. Levalley, Senior Vice President for Planning and Advocacy, Mercy Health Network, said that nationally the Mercy Health Network is a joint operating agreement between Catholic Health Initiatives and Trinity Health which operates in 21 states. In Iowa, the Mercy Health Network operates 11 owned hospitals, 6 urban and 5 rural community hospitals; 1 joint venture surgical hospital; and employs 625 physicians. One initiative of the network tracks patients with congestive heart failure who are assigned a health coach, receive daily phone calls, and remotely record their vital signs. The program has reduced hospital admissions of such patients by 85 percent.

4. University of Iowa Hospitals and Clinics — Stacey Cyphert

Mr. Cyphert, Assistant Vice President for Health Policy, Senior Assistant Director, University of Iowa Hospitals and Clinics, said that UI Health Care participates in several ACOs. It is not possible to operate an ACO without sufficient volume, at least 5,000 members. The Medicare ACO was initially a one-sided model with fee-for-service and one-sided shared savings that will change to a two-sided risk model with shared savings and shared risk in 2016; the Wellmark ACO is also fee-for-service with one-sided sharing that changes to two-sided shared risk at year three; and the Iowa Wellness Plan is fee-for-service with performance incentives for two years and the possibility of capitation in the future. There are different quality metrics for different populations, such as children. Lessons learned include that there is a need to engage specialists, not just primary care providers; metrics must be designed carefully; there is a need to access all data, including mental health data, not just summaries of data; and electronic records greatly facilitate analysis, care coordination, and communication.

5. Genesis Health System — Ken Croken

Mr. Croken, Vice President, Corporate Communications and Business Development, Genesis Health System, said that the Genesis ACO (GACO), based in Davenport, was implemented in 2011-2013 and consists of over 100 primary care providers supported by NCQA-scored medical homes. The GACO governance board is 75 percent physician members, and includes a community member. GACO distributes quarterly scorecards to clinics and providers. The triple aims of improved population health, improved patient experience, and lower cost of care informs GACO's care guidelines, processes, choice of participating providers, and quality measures and incentive payment plan. GACO is working to find better ways to coordinate care with other community-based organizations. GACO has partnered with a federally qualified health center to assist with care of vulnerable populations. GACO began with management of chronic disease. Genesis has embarked on a broad-based program of inventorying its community's health needs and is working with community-based partners to address them.

Lessons learned include that Genesis is building its own health information exchange to link physician electronic medical records; clinical scorecards that are calculated at the ACO, clinic, and provider level are another way to show physicians that clinical integration is a powerful tool to improve care at the population level; and GACO's physician participation model is flexible to allow employed and independent physicians to integrate. Making the business model reflect the care model is a challenge.

6. Trinity Pioneer ACO — Pamela Halvorson

Ms. Halvorson, Regional Vice President, Clinic Operations, UnityPoint Clinic, Executive Sponsor, Trinity Pioneer ACO, provided an overview of the Trinity Pioneer ACO. The aim of the ACO is to leverage every aspect of the community to achieve the best outcome for every patient every time. They have strong strategic partners in local public health, the long-term care community, and with critical access hospitals. They have worked to integrate systems across the partners by using a common language. In the first year of the ACO, Webster County Health Department (WCHD) was formally invited to sit on the steering and work groups in the ACO and the WCHD provides the "population" input, guidance in providing a continuum of care for the clients, provides a standardized health assessment, home visitation, and existing services such as the Maternal and Child Health Title V program and smoking cessation programs. In the future, integration will continue between Trinity and public health to improve communication through interfacing software, tapping into, while not duplicating, services already offered through public health such as immunizations, and implementing the Tri-navigation Initiative to provide a primary care provider navigator, a mental health navigator, and a public health navigator.

Lessons learned include that the Pioneer ACO is not business as usual, but an evolutionary process. Continual analysis of the structure, capacity, workforce, and partners is needed. Communication is key and everyone should be informed of the vision and mission. The overarching goal is what is best for the patient or client. Silos are not allowed. The ACO is a structure with mutual accountability to the patient or client. The relationships needed for integration take time to form. Prescriptive and rigid rules kill innovation. Innovation is limited by

the resources at hand. There will still be those without insurance coverage and barriers to care. The Pioneer ACO provides a learning model for an integrated system.

In its first year, Trinity Pioneer ACO, based in Fort Dodge, had 7,000 members and was unable to include rural patients and in its second year is now at 10,000 members. Through a contract with Wellmark, Trinity Pioneer ACO has 23,000 members in eight counties. Trinity Pioneer ACO has a rural flavor that attempts to connect communities of patients wherever they are most comfortable.

V. Community Engagement

A. Integrating Social Determinants of Health Into Iowa Healthcare Systems — Chris Esperson

Ms. Esperson, Director of Quality, Primary Health Care, Inc., Des Moines, discussed the importance of integrating social determinants of health into the health care system. Federally qualified health centers (FQHCs) like Primary Health Care, Inc. have been addressing social determinants of health since their inception. Providing supportive services is an integral part of the FQHC model. Only 10 percent of health is determined by traditional medical services while the majority of health is determined by social determinants including genetics, the environment, and behaviors. Some examples of social determinants of health are income level, housing, access to healthy resources, job opportunities, access to health care, transportation, exposure to crime and violence, social support, language and literacy, culture, access to technology, and public safety. Determinants of health can amplify each other, and socioeconomic inequalities exacerbate disparities in health.

Transformation of the health care system must consider social determinants of health to improve health care as well as to lower costs. Through recognition of the factors that influence an individual's health and provision of care coordination and appropriate supports, individuals can realize sustained improvements in health outcomes. Primary Health Care, Inc. recognizes the need to quantify the impact of enhanced services on health outcomes. Taking personal responsibility is important and empowers patients but more importantly improvement comes via identification and amelioration of social determinants of health. Primary Health Care, Inc.'s care management program sees high-risk Medicaid patients and provides them with appropriate counseling and care coordination with the result that these patients have seen sustained improvement in their health outcomes. Their data indicate the urgency of incorporating infrastructure and support for addressing social determinants of health into the integrated health system.

B. The Importance of Disease Prevention, Health Promotion, and Population Health in an Integrated System — Julie McMahon

Ms. McMahon, Iowa Public Health Association, discussed why public health is an essential partner in an integrated health care delivery system. Public health focuses on population health and prevention which will result in shifting the cost curve by preventing more Iowans from developing chronic conditions in the first place. Public health brings a knowledge of the community and

population-based services, knowledge and experience with care coordination, and knowledge of available personal health services that may prevent or delay hospitalizations and the need for long-term care.

Challenges for public health include the lack of knowledge about and awareness of what public health does among policymakers, the community, and funders; the significant differences in public health services that exist from one community or county to another across the state; the lack of an integrated data system to measure outcomes of population health and what public health does for the community; and that funding for public health is often siloed lacking the flexibility to meet community needs resulting in fragmentation.

Ms. McMahon identified opportunities going forward to maximize the strengths of public health. In the future, the focus will shift to investing in and delivering population-based services such as primary prevention, health promotion, access to care, and chronic disease prevention and management. Public and private collaborations will increase. There will be a focus on community-centeredness and a health-in-all policies approach that brings the efforts of the public, communities, and stakeholders at all levels together. Effective measures of population health will be developed and implemented, and funding will be realigned to support coordination and sustainability.

Going forward, public health, in partnership with primary care, can contribute to shifting the cost curve and preventing more Iowans from developing chronic conditions in the first place. Public health is poised to play an even larger role in prevention and health.

C. Local Public Health — Utilizing Health Navigation — Peggy Stecklein

Ms. Stecklein, former community health coordinator, Dallas County Public Health, and currently program manager, Iowa Primary Care Association, discussed Dallas County Public Health's health navigation program which provides a resource for individuals to address social determinants of health through integration of existing community resources.

In 2008, there was only a patchwork of programs and resources with no central point of information or coordination. Social determinants of health were not recognized in connection to overall health, and so were not addressed. In 2009, the Dallas County Partnership for Health determined the need for an online resource directory and a health navigator.

The health navigation program provides residents of Dallas County with access to available resources in the county through one point of contact, resulting in increased efficiency, health equity, and improved quality. Referrals to the program can be made by a health care provider, agency, or individual who completes a short form and faxes the referral, contacts the client within three days, screens for additional information, provides referrals for resources, and completes the information loop to the provider if the client is referred by a provider. The health navigation role is to provide hands-on assistance with applications, paperwork, and translation; information, choice and support for the client to make decisions regarding needs; access to medication or to a medical payment source for medication; and access to other social/nonmedical services such as housing, heat assistance, childcare, food, and mental health/substance abuse services.

Health navigation is not emergency services, a primary care provider, a case manager/care coordinator/health coach, or discharge planner. Health navigation assists in all of these other roles, but is a shared community utility that helps integrate existing community resources. The benefits to patients, providers, and the community are access to payment sources and medications; help in addressing social determinants of health; decreased emergency department visits, hospital admissions and readmissions; and integration and maximization of community resources.

Ms. Stecklein provided lessons learned. One lesson learned is that a wide range of skills and knowledge are needed as is utilization of a team approach. Secondly, few referrals were made initially because providers are trained to focus on clinical status, not the underlying social determinants of health. The program used a community transformation grant to provide the technical assistance to reach out to providers. Four in five physicians say that unmet social needs are directly leading to worse health among all populations, not just those who are low-income, yet physicians are not confident in their capacity to address their patient's social needs. A third lesson learned is that data and information technology support are critical. They provide the web-based resource directory; the health navigation database; facilitate workflow of follow-up, team coordination, and updates to providers; track the numbers of individuals served and their demographics; and help to demonstrate utilization and effectiveness.

The 2012-2013 data provide that the program averaged 50 clients per month with 3.5 contacts on average per client. Referrals came from health care providers (30 percent), community partners (30 percent), and self/family (40 percent). The primary presenting issue was access to care (68 percent). A barrier identified was income (50 percent).

Ms. Stecklein also shared Maria's story. Maria was referred to the health navigation program by her health care provider. Maria, a 60-year-old woman, had problems being compliant with her diabetes treatment program which was exacerbated by financial issues and emotional stress. Through the program, Maria applied for and received assistance in paying for her medications, low-income heating assistance, supplemental food assistance for seniors, and a chronic disease self-management program which included transportation to the classes. The program reported Maria's progress back to her health care provider, and several months later, Maria's diabetes was well controlled and she had lost weight.

D. Community Transformation Grants — Kala Shipley

Ms. Shipley, Community Transformation Grant (CTG) Project, Iowa Department of Public Health, described the project, which is funded through a grant received from the federal Centers for Disease Control and Prevention in 2011. Overall, the CTG seeks to reduce the prevalence of heart disease and stroke and associated risk factors, so the target audiences are rural locations, people aged 45-50 and older, people with disabilities, and males. The Iowa project reflects the components of the national prevention strategy in focusing on tobacco-free living (focusing on multi-family residences), healthy eating (increasing available healthy options such as vouchers for farmers' markets), clinical and community prevention services, and safe and healthy physical environments (bike paths). The project has been implemented in 25 counties, has established

partnerships with local boards of health, and coordinates with state and local partners. The majority of the project's objectives are implemented through county boards of health and their community coalitions. County implementation varies based on the assets and gaps identified in local assessments and the readiness and strategy of the local community.

All participating counties are required to implement strategies in the required strategic directions and are required to use the same assessment tools in communities and worksites. The vision of the project is to improve statewide awareness of clinical prevention screenings and healthy lifestyle behaviors through consistent messaging in public health, primary health care, business, and community settings and to create community-based strategies for systems and environmental changes that improve access to healthy opportunities. Innovative strategies are needed in rural areas and small worksites. Program decisions are data-driven, and local flexibility is needed in program requirements.

E. Community Health Needs Assessments/Community Health Improvement Plans/Community Health Benefits — Jon Durbin

Mr. Durbin, Bureau of Communication and Planning, DPH, discussed the potential collaboration between public health and hospitals in utilizing community health needs assessments, community health improvement plans, and community health benefits planning to identify community needs and to craft strategies and long-term partnerships in statewide health planning. At least every five years local boards of health lead a community-wide discussion with stakeholders and residents about their community's health needs. The Community Health Needs Assessment (CHNA) and Health Improvement Plan (HIP) has been a fundamental element of statewide health planning for over 20 years. New federal requirements for tax-exempt hospitals to conduct community health needs assessments present an opportunity for hospitals and local boards of health and local public health agencies to join forces to identify community needs and craft strategies for meeting them. The focus is not just on disease but on social determinants of health.

The federal requirements present an opportunity for greater collaboration between hospitals and local public health agencies to set the stage for a long-term partnership in health promotion and disease prevention activities. DPH is encouraging a collaborative process in conducting a joint community health needs assessment by integrating Iowa's established community health needs assessment process for local boards of health with the federal requirements for tax-exempt hospitals and developing a community-wide HIP. There are four action steps proposed: sharing relevant data: hospitals can access health snapshots for every Iowa county on the DPH website to provide an overview of key health indicators for local communities; promoting efficiency in Iowa CHNA and HIP processes: Local boards of health report the results of their local CHNA and HIP processes to DPH for use in a statewide health needs assessment and HIP. Local boards of health that work with hospitals to develop a joint comprehensive CHNA and community-wide HIP may use the information from the joint CHNA and HIP to complete the required reports to DPH; sharing information: DPH encourages local boards of health and hospitals to share with each other any existing community needs assessments, health improvement plans, and annual reports; and facilitating a collaborative process: DPH will inform both hospitals and local boards of health about

tools, updates, and training related to CHNAs and health improvement planning on the DPH website.

F. The Iowa Collaborative Safety Net Provider Network and the Community Care Coordination Plan — Ted Boesen and Sarah Dixon Gale

Mr. Boesen, CEO, Iowa Primary Care Association, and Ms. Dixon Gale, Senior Program Director of Emerging Programs, Iowa Primary Care Association, discussed the opportunities for integrating safety net providers and their patients into a comprehensive, community-based integrated health care delivery system. They also discussed the community care coordination grants as an opportunity to develop regional community care coordination entities across Iowa to coordinate care for high-risk patients and to support primary care providers.

The safety net collaborative was created in 2005 to provide community care coordination across the state, increase access to health services to underserved populations, and increase health system integration and collaboration across the continuum of care with a focus on safety net services. The network includes child health specialty clinics, family planning agencies, federally qualified health centers, free clinics, local boards of health, maternal and child health clinics, rural health clinics, and others.

Policy considerations. The policy considerations expressed for integrating the health care system relative to the safety net providers include: while the safety net providers will become more integrated with the traditional health system, there will continue to be underserved populations post-reform as has been the experience in Massachusetts; the safety net providers started the journey of health care reform with unique characteristics such as having a mission and approach in alignment with the patient-centered medical home; safety net providers have significant infrastructure needs to become better integrated with the traditional delivery system such as health information technology, care management, and provider recruitment; payment methodologies must support delivery system change and be inclusive of nontraditional providers that impact health including public health, community action agencies, and legal aid; and any delivery system change should place the patient, family, and primary care team at the center. A comprehensive, community-based integrated health delivery system has at its core the patient and the patient's primary care medical home. Specialty care, behavioral health, long-term care services and supports, social services, substance abuse services, hospitals, public health, and health supportive community resources must also be integrated as part of the system.

Current activities. The General Assembly appropriated $1.1 million for FY 2013-2014 to the Iowa Collaborative Safety Net Provider Network to develop and implement a statewide regionally based network to provide an integrated approach to health care delivery through care coordination that supports primary care providers and links patients with community resources necessary to empower patients in addressing biomedical and social determinants of health to improve health outcomes. The goals of the initiative are to develop regional community care coordination capacity that becomes an extension of primary care teams; to provide assistance to local primary care providers to meet the unique needs of the highest risk patients; and to improve quality, population health, and cost of care at the local level. Activities to reach these goals include deploying care

coordinators and other support to assist practices in providing services for their patients such as targeted disease and care management, addressing gaps in care, self-management support, transitional care, providing a connection to community resources to link patients to support systems that address social and behavioral needs, pharmacy management, and behavioral health management. The initiative is focusing on fostering community innovation and building upon local champions and early adopters, and on demonstrating to payors the value of community care coordination and linkages to community resources in reaching the triple aim of improved population health, improved outcomes, and decreased cost.

Two communities, WCHD and Mercy Medical Center in Cerro Gordo County, were awarded grants on November 15, 2013, following an RFP process to implement the community care coordination initiative. At the state level, the initiative provides statewide program oversight, pharmacy technical assistance, behavioral health integration technical assistance, and evaluation and future expansion of the model.

SIM implementation. With regard to the SIM: there should be openness to all models and more than one entity in each state-prescribed region; there should be risk adjustment inclusive of clinical, social, economic, and other factors that affect health; the payment methodology should support the community care coordination infrastructure; and robust, timely, and actionable analytics and data should be available to all providers. Consideration in outcomes measures should include those outside of the value index score currently being considered.

There is interest in developing an operational plan and implementing a primary care/safety net-led care coordination entity due to the unique needs of the safety net population, recognition of the infrastructure needs of primary care providers and safety net providers, and the desire of safety net providers to remain true to their mission. The plan would guide development so that the network will be ready to take on risk through pay-for-performance, shared savings, or risk based contracts. The network has experience with supporting clinicians in the network and is familiar with the unique needs, including social determinants of health and other risk factors among the safety net population.

VI. Addressing Unique Populations and Determinants of Health in an Integrated System

A. Children's Health — Danielle Oswald-Thole and Mary Nelle Trefz, Vickie Miene, George Estle

At-risk children. Ms. Oswald-Thole and Ms. Trefz, Child and Family Policy Center, said their organization is a research and advocacy group with a special emphasis on at-risk children. If Iowa wants to be the healthiest state in the nation, it must raise the healthiest children. Approximately 96 percent of young children in Iowa have health care coverage due to the expansions under Medicaid and the hawk-i program and more than 90 percent have at least one well-child visit, in their early years to check developmental progress. This puts the health practitioner in the best position to address not only medical issues, but also to identify children whose health may be jeopardized because of their home and neighborhood environments. The potential return on

investment in children's health is huge in the long term, but the results may not be apparent in the short term. The 1st Five Healthy Mental Development Initiative, which received additional funding from the General Assembly last year, plays a key role in promoting primary care practices and linking families to services through care coordination, but is not yet statewide or comprehensive in scope.

Children with special health care needs. Ms. Miene, Executive Director, Center for Child Health Improvement and Innovations, Division of Community and Child Health, Department of Pediatrics, University of Iowa Carver College of Medicine, discussed integrated health care delivery models for children with special health care needs. There are an estimated 150,000 Iowa children with special health care needs who are at increased risk of a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services beyond those required by children generally. A specialized health home provides families with a team of professionals that work together to meet the needs of children with complex medical needs.

Mental health and physical health. Mr. Estle, CEO, Tanager Place, Cedar Rapids, explained that Tanager Place is a private nonprofit organization that has served at-risk children and families in Iowa since 1879. Tanager Place provides a full continuum of care, including inpatient treatment, an outpatient mental health clinic, community-based support services, prevention services, camp programs, pediatric integrated health care services, and research, and serves 4,000 children and their families each year. Tanager Place has a long history of development and implementation of innovative programs including being the first psychiatric medical institution for children (PMIC) in Iowa, building a comprehensive arts program, providing camps for children with hemophilia and diabetes, and developing neighborhood-specific, school-based prevention programs. Tanager Place also recognizes the importance of a research-driven practice and created the Tanager Research Center in 2012. Children with mental health issues are often an afterthought, and children with both a behavioral diagnosis and a chronic physical condition are often not considered in system design, even though this small population can result in significant costs.

In 1986, Tanager Place partnered with the medical community in Cedar Rapids to develop and implement the Tanager Place Diabetes Camp, and since that time, the camp has been a success. Through the camp, there was a recognition that children with type 1 diabetes express increased psychological morbidity, which is supported by data that 30 percent of children develop a mental health disorder within the first three months of initial diagnosis of diabetes. Over a 10-year period, psychiatric disorders in youth with diabetes was found to be approximately 47 percent. Additionally, depression and behavior problems are associated with an increased risk of multiple diabetes-related hospitalizations; there is an additional risk of increased mental health morbidity with other members of the immediate family; and higher mental health morbidity and higher family conflict are closely related to poor disease management.

Tanager Place formed a Diabetes Service Committee in 2009 and developed training to increase the competency of clinicians serving children with type 1 diabetes. This resulted in the development of a team of five clinicians who offer outpatient therapy and play therapy specialized for children with type 1 diabetes. In one case with an adolescent boy, through use of individual therapy to address the boy's anxiety disorder relative to changing his infusion set, the boy's blood

sugar stabilized and family functioning overall improved. This shows the need for integrating and coordinating care. Without the behavioral interventions, the physical outcomes would not have improved for the boy.

Children with type 1 diabetes are just one example of the numerous groups of children experiencing chronic physical health conditions coupled with higher risk for co-occurring mental health issues. Every child should have access to a system that can recognize and integrate responses to the co-occurring physical and behavioral health needs of children and deliver appropriate care. Policy implementation must build in the opportunity for critical assessments of the impact of policy and provide the opportunity for redesign, recalibration, and adjustment. Children with type 1 diabetes are an example of a population that benefits from an effective integrated health care policy.

B. Behavioral Health — Rick Schults

Mr. Schults, Division Administrator, Division of Mental Health and Disability Services, DHS, said that people with serious and persistent mental illness face many challenges. Mental health is one of the most important determinants of health. There is a need to integrate care for mental illness with other services such as weight loss, smoking cessation, regular checkups, and help in coordinating medications. Persons with mental illness need support, guidance, and coaching so that they share in health decisions and participate in their health care.

C. Older Iowans — Donna Harvey

Ms. Harvey, Director, Iowa Department on Aging, said that people 60 plus years of age will soon comprise over 20 percent of the state's population. There are over 600 agencies nationwide that serve the elderly providing services such as senior centers, congregate meals, and family care programs. It is important to build on existing systems using a consumer focus.

D. Dental Health — Bob Russell, DDS

Dr. Russell, State Public Health Dental Director, and Bureau Chief, Bureau of Oral and Health Delivery Systems, DPH, said there is a large unmet need for dental services as evidenced by the increasing number of dental-related visits to emergency rooms. Iowa Medicaid alone spends up to $7 million annually for dental-related ER visits. A study commissioned by United Health Care found that the provision of dental services yielded a cost savings on medical and pharmacy costs associated with other chronic medical conditions, especially for patients who were medically noncompliant. A person's overall health is impaired by unhealthy teeth because there is a connection between dental disease and other medical conditions due to unaddressed dental infections. As an indication of the magnitude of the unmet need in Iowa, in 2013 the Iowa dental Association held its first Iowa Mission of Mercy (IMOM) dental event in Des Moines. A total of 1,465 individuals sought dental care over the two days which is estimated to have provided over $1 million in free oral health care.

Dental ER visits and IMOM events cannot provide definitive and regular comprehensive dental care and cannot resolve dental needs unaddressed by the current fragmented system. The lack of

integrated care that includes dental care has a large cost impact on the state in ER costs but also in lost opportunity savings in the management of traditional chronic diseases. Greater integration of the system will also provide incentives to providers to address emergency room visits in a more appropriate and cost-effective way.

Dr. Russell also provided information regarding the increased prevalence of oral disease in patients with dementia.

E. Workforce Strategies to Ensure Access — J.D. Polk, D.O.

Dr. Polk, Dean, College of Osteopathic Medicine, Des Moines University, said that Des Moines University has changed its curriculum in response to the ACA to include more training relating to preventive medicine, quality and outcome measures, and electronic medical records. Des Moines University is also charting new educational pathways leading to a Master's of Science degree in Clinical Leadership and a Master's degree in Health Policy. In the future physicians may be board-certified in medical management so they can assume upper level management positions in health care organizations. Des Moines University College of Osteopathic Medicine has a dual mission of producing both primary care physicians and health care leaders. There has been bipartisan support from the General Assembly for the loan forgiveness program for physicians who choose to practice in rural Iowa.

VII. Health Information Technology and Data Analytics — Using Health Information Technology and Data to Integrate the System

A. Iowa Health Information Network — Kim Norby

Mr. Norby, State Health Information Technology (HIT) Coordinator and Executive Director, Iowa e-Health, discussed the three main services of Iowa HIT which consist of a directed exchange, a query-based exchange, and a state reporting exchange, and the importance of data exchange and quality measurement. A directed exchange exchanges information from provider to provider for referrals, from a provider to a registry for reporting purposes, and between a provider and a patient for personal health records. A query-based exchange provides a snapshot or summary of a patient's history and is a continuity-of-care document that provides information about demographics, allergies, medications, results, immunization history, family history, and procedures. A state reporting exchange provides automated support for receiving structured data from electronic health records to the Iowa Disease Surveillance System, the Immunization Registry Information System, the State Cancer Registry, and the IME Health Home Payment Program. Two other important exchange elements allow patient access to their own information via a patient portal and personal health record which is available wherever the patient is, and increased data elements for quality measures that are shared through health information exchanges to data repositories such as a data warehouse.

B. Iowa Public Health Tracking — Meghan Harris

Ms. Harris, Iowa Public Health Tracking Coordinator, DPH, provided an overview of the Iowa Public Health Tracking Program and the importance of the collection, integration, analysis,

interpretation, and dissemination of population health data in an integrated health system. For example, the tracking system can provide a health snapshot on a single county or multi-county basis to provide decision makers and county residents the opportunity to see how the county is doing as a whole or to provide a comprehensive picture of the health of local and surrounding communities. The primary focus of the snapshot is disease health indicators and the data in the report is population-based. There are multiple data sets that include births, deaths, inpatient data, behavioral risk factor surveillance, and census data. Expanded data sets may include water quality, air quality, poverty, birth defects, cancer, child blood lead, and numerous others. It is possible to create a map showing the frequency of a particular factor. Twenty-two other states are also involved in this project with federal funding and are working with the federal Centers for Disease Control and Prevention (CDC) to build dashboards for specific indicators.

DPH is making the transition from information consumer to information broker. Some of the issues to consider are: what system changes are needed for public health agencies to meet effectively the information needs of its community partners; how does Iowa keep pace with the growing demands to electronically exchange information with physicians, hospitals, and other public health agencies; and how does Iowa, within the public health agency, ensure the system is maximally collecting and utilizing data to provide the best community services?

C. Creating a Statewide Data Analytics Interface — Treo Solutions — Herb Filmore

Mr. Filmore, Vice President, Strategic Innovation, Treo Solutions, discussed the importance of having reliable, risk-adjusted data to buy value-based care. Treo Solutions is a private company that partners with providers and payers to provide data analytics that incorporate population health and that are a key part of transitioning to a more efficient health care system. Payers and providers need a common set of information to work from in setting up an ACO. Colorado has realized a $44 million savings by collecting data and creating a management platform for primary care practices in that state. Social determinants of health data is the next wave in data collection and analytics and Treo plans to add that data to their reports soon.

D. Using Data to Ensure Quality — Tom Evans, MD

Dr. Evans discussed the use of data for research, comparison and accountability, and improvement. He noted that the health care community in Iowa is very engaged in collecting and utilizing data to make sense of individual and population health. The use of data for measurement falls into three categories. Research data was used in evidence-based medicine in the 1990s to determine what data matters. Comparison or accountability data is used to create standardized efforts and measures. Such data can be used to define and manage populations to improve cost and quality of care delivery and for public reporting and transparency. Improvement data is real time, raw data with consistent definitions of what is being measured that can be used monthly rather than yearly like comparison data, to support rapid cycle changes and results. Improvement data is used to assist with better execution of health care delivery. The Iowa Healthcare Collaborative which involves only hospitals, collects data on over 100 measures using national standards.

E. Using Data to Address Population Health — Chris Espersen

Ms. Espersen provided an overview of the importance of health information technology and data analytics from a provider perspective. Data has helped Primary Health Care, Inc. make substantial improvements in population health, and only data that is timely, accessible, actionable, comprehensive, and accurate can be used to improve population health and decrease the cost of care. The first step in improving population health is understanding the root cause of poor outcomes. Traditional models focus on diagnosis and other clinical demographics, but do not include social determinants of health. Innovative risk adjustment models look beyond diagnosis to help providers identify which patients need extra resources to improve health. Social determinants of health can be as important as diagnosis in determining overall health and utilization patterns of patients and can help drive appropriate resource allocation. Providers need data that is easily accessible for use in their practices to allow the provider to look at the patient holistically.

F. Committee Discussion

Discussion included questions on how patient information that is collected is being safeguarded, what agencies have access to the information, and whether the data includes information that is identifiable with a patient name. There was also discussion about the use of performance standards and how the use of standards translates to standards of care.

VIII. Role of Medicaid in the Integrated System

A. Iowa Health and Wellness Plan Overview — Jennifer Vermeer

Ms. Vermeer provided an overview of the Iowa Health and Wellness Plan, which is Iowa's version of expansion of the Medicaid program to Iowans age 19-64 with incomes through 133 percent of the federal poverty level (FPL). The Iowa Wellness Plan will cover those through 100 percent of the FPL and the Marketplace Choice Plan will cover those from 101 to 133 percent of the FPL. The Iowa Health and Wellness Plan which begins coverage on January 1, 2014, was enacted to provide comprehensive health coverage to low-income adults. Sixty-three thousand IowaCare patients will be automatically enrolled in the new plans based on verified incomes. Persons enrolled in the Iowa Wellness Plan will receive Medicaid benefits with some program innovations including coordination of care for members through medical homes, provider accountability standards of quality and cost, and member incentives to engage in healthy behaviors. Persons enrolled in the Marketplace Choice Plan will select a commercial health plan available on the Health Insurance Marketplace. Medicaid will pay premiums directly to the commercial health plan on behalf of the member. The Iowa Health and Wellness Plan has not yet received a federal waiver due to its incentive requirements that may result in payment of premiums by members. Other issues relating to the waiver have already been resolved with CMS.

B. State Innovation Model (SIM) Initiative

1. Overview — Jennifer Vermeer

Ms. Vermeer provided an overview of the SIM report including metrics and contracting, member health engagement, long-term care, and mental health and substance abuse. SIM grants from the Centers for Medicare and Medicaid Innovation were made available to governors for either a design or testing track. Iowa's is a design track grant to develop the State Healthcare Innovation Plan (SHIP), a 5-year plan for system transformation that defines the current system and the desired system including barriers and opportunities, population health status measures and social impacts on health, and a timeline for transformation. DHS is pursuing a testing grant to continue the project, which will be awarded in January 2014. The goal of the plan is to lower costs and improve quality of care for the state's Medicare, Medicaid, and Children's Health Insurance Program (CHIP) populations.

Medicaid must have a role in delivery reform because it relies on the same health care system as all other payers to deliver care; uses similar payment and contracting methods; is impacted by the same costs and drivers as other payers; is the second largest payer in the state, behind Wellmark, covering 23 percent of all Iowans; and is the primary payer of long-term care services, not only for the elderly but for those with disabilities and behavioral health conditions.

The key strategies of the proposed SIM are to implement a multi-payer ACO methodology across Iowa's primary health care payers; expand the multi-payer ACO methodology to address integration of long-term care services and supports and behavioral health services; and incorporate population health, health promotion, and member incentives.

2. SIM Metrics and Contracting Workgroup — Tom Evans, MD

Dr. Evans, chair of the SIM Metrics and Contracting Workgroup, said that four workgroups were formed, one for each key strategy of the SHIP, to develop a framework for the ACO model. The Metrics and Contracting Workgroup was tasked with developing recommendations and goals around the structural arrangement of the ACO, payment provisions, and metrics and measures to use. Dr. Evans noted that as Iowa moves to the ACO model, much of Iowa is already organized to provide high-value, low-cost health care, and the state should not abandon existing structures which are working well.

3. SIM Member Engagement Workgroup — Chris Atchison

Mr. Atchison, chair of the SIM Member Engagement Workgroup, explained that this workgroup was tasked with developing goals and recommendations about approaches to engaging members in their own care and encouraging them to be active participants in becoming healthier. The workgroup also discussed how to include and incorporate the strengths of the public health system in order to address population health and achieve the Governor's Healthiest State Initiative. In looking at other states, Indiana has penalties and Florida offers enhanced benefits as incentives for healthy behaviors. The question is what enables people to make personal decisions for good health and wellness. Member engagement is about providing the necessary tools and resources to make health care available and accessible.

4. SIM Long-term Care Supports and Services Integration Workgroup and Behavioral Health Integration Workgroup — Jennifer Vermeer

Ms. Vermeer said that the SIM Long-term Care Supports and Services Integration Workgroup has focused on the best approach to integrating these important services into the ACO model, what care coordination should look like, and what types of measures will encourage and support increased use of home and community- based services. The Behavioral Health Integration Workgroup has discussed measures that should be used to ensure accountability for behavioral health care needs, considerations for including the safety net providers in any ACO arrangement, and the importance of building upon the strengths of the Integrated Health Home and the Iowa Health and Wellness Plan and its additional services and focus on prevention.

Ms. Vermeer explained that long-term care and behavioral health issues require different goals and philosophies than some other types of health care because these are situations where the problem cannot be fixed, instead the goal is to help people live their lives as best they can and avoid early death due to preventable causes. Long-term care represents about one-half of the entire Medicaid budget. Most people would choose support at home instead of institutional care and those desires must be balanced. It is important to provide information so that people can obtain the support needed to keep a loved one at home.

Ms. Vermeer opined that DHS has a good chance of obtaining more federal funds for testing but will probably go forward even without those funds. Money for testing is needed to support actuaries and other types of services that are not usually supported by Medicaid funds. Private insurers and ACOs do not deal with the same long-term care issues as Medicaid because they do not cover long-term care costs.

IX. Investing in Quality — Using Payment to Incentivize an Integrated System

A. Overview — Mary Takach, NASHP

Ms. Takach discussed financing health care delivery system reform through value-based reimbursement methodologies that reward value and quality by creating financial incentives for providers. States are currently implementing a variety of payment models including per member per month care management payments; performance incentives; shared savings/shared risk payments; bundled/episodic payments; and global payments. There is an emphasis on payment methods that include a quality component.

For example, Missouri is utilizing the health home approach under section 2703 of the ACA to pay for behavioral health home teams and physical health primary care health homes for Medicaid enrollees. Health home teams receive a per member per month payment and additional payments fund care management, care coordination, behavioral health, and administration. Massachusetts is using a comprehensive primary care payment which provides higher payments based on the level of behavioral health services provided. Arkansas is basing multi-payer payments on episodes of care with risk and gain sharing depending on average costs of care per episode and

achievement of quality indicators. Colorado's accountable care collaborative consists of seven regions with three core components of primary care medical providers, regional care collaborative organizations, and a statewide data analytics contractor and a focus on three outcome measures which are emergency room visits, hospital readmissions, and outpatient service utilization. Minnesota is using the Medicare shared savings model and allowing Medicaid providers to form ACOs responsible for the total cost of care of their Medicaid populations with smaller providers operating under a shared savings model and larger systems using a shared risk and shared savings model. Oregon has implemented Coordinated Care Organizations that have the capacity to assume risk and receive a fixed global budget for physical, mental, and dental services. The CCOs must meet key quality measurements while reducing growth in spending by two percent over the next two years.

The basis of integrated care models begins with strong primary care (medical homes). Practice training, data analytics, expanded care teams, patient engagement, and community linkages, including public health, are fundamental to success. The potential for meeting cost and quality targets in an integrated model is significant and shifting the health care system will ultimately depend on integrating public health into these models.

B. Medicaid Reimbursement Policies — Jennifer Vermeer

Ms. Vermeer noted the importance of the multi-payer integrated system that is being developed through the SIM. The SIM is being used to bring payment strategies together on a broader scale. Workgroups and listening sessions suggest that Medicaid should use a competitive process to award ACOs based on geographic regions; ACOs chosen must encourage innovation and competition; ACOs are expected to have an understanding of the needs of the Medicaid population; the state should be open to contracting with any organization or business structure; the state should expect and require that ACOs develop strong relationships and collaborate with quality partners in their region and communities to enhance care coordination, reduce costs, ensure access, and change the overall health care system to one focused on outcomes; ACOs should be held accountable for outcomes; the state will initially use Value Index Scores, currently used by Wellmark and proposed in the Iowa Health and Wellness Plan, as a standard measure of quality for all payers but should augment the core set of quality measures for physical health with additional measures including behavioral health and long-term care supports and services over time; and there should be a long-term goal to include other payers such as CHIP and Marketplace Choice health plans.

C. Private Health Insurance Reforms — Nick Gerhart

Mr. Gerhart, Commissioner of Insurance, noted that the ACA focuses on requiring insurance plans to cover preventive services. There is also a focus on patient-centered medical homes to incentivize primary care. There is not one definition of an ACO and there are several models being implemented. The Insurance Division regulates entities when performance risk, the rate of utilization of services, and their quality and availability, crosses the line to insurance risk. An insurance company is an important partner in an ACO because the insurer has IT infrastructure, data analysis, actuarial, payment, and administrative capabilities. Some issues for legislators to

consider relative to ACOs and similar types of arrangements are those of physician self-referral, anti-kickback rules for referrals, and antitrust considerations.

D. Focusing on Paying for Value in the Private Insurance Market — Mike Fay and David Lyons

Mr. Fay, Vice President of Health Networks, Wellmark Blue Cross and Blue Shield, noted that insurers are not ACOs, but merely enable the provider organizations that constitute ACOs to function. Mr. Fay defined an ACO as a local health care organization that assumes accountability for the quality and cost of care delivered to a defined population. An ACO has effective primary care at its core; requires member attribution to a primary care physician; works best with health care organizations that have a significant number of members; involves multi-year agreements and total cost of care agreements; may involve shared savings and losses; and has quality targets and incentives and risk adjustment. Wellmark has had agreements with hospital ACOs since 2012, and agreements with clinics may be next. It is not necessary for all providers to be in an ACO. Any provider can manage costs and increase the use of best practices and quality measures.

Mr. Lyons, Founding Director and CEO, CoOportunity Health, stated that cooperatives are different in that being an ACO is an inherent part of their structure. Patients are in medical homes and that fact is integrated into all payments made by the cooperative. Iowa is in a leadership position with the formation of CoOportunity Health which will operate in Iowa and Nebraska. It is important to measure value through the consumer's eyes. Consumers want seamlessness between public and private payers, between physical and behavioral health care, and between clinic and pharmacy services. There are opportunities to innovate in coordination of care and technology. Deductibles in new health coverage products should not become a new barrier to access and system integration.

E. Committee Discussion

Questions and discussion centered on whether cost-sharing and the ACO model are transitional phases in how health care will be paid for and delivered in the future. Cost-sharing may change based on what it rewards or may change to penalize as well as reward providers. Under a full capitation system, carriers will just process claims. The need for and size of insurers' reserves may change. Cost-sharing may or may not be transitional. Insurers are not ready to administer a capitated system and providers are not ready to practice under that type of system either. The earlier deployment of capitation in HMOs did not work. There is a lot to learn before moving to a capitated payment system. By removing the preexisting conditions barrier, the ACA has made it easier to change plans. The consumer has the choice to select a plan with a smaller network and save money or to choose a plan with a larger provider network that is more costly. New models encourage consumers to become more active purchasers of health insurance and health care. Consumers are becoming more well-informed but need support in getting information to make informed choices.

X. Workforce and Delivery Strategies to Ensure Access

A. Carver (College of Medicine's) Rural Iowa Scholars Program — Victoria Sharp, MD

Dr. Sharp, Director, Carver (College of Medicine's) Rural Iowa Scholars Program (CRISP), provided information about the program which is designed to attract, educate, and inspire future physicians to meet medical needs in rural areas of the state through mentorship, shadowing, field experience, clinical experience, electives, clerkships, and community orientation. In exchange for practicing in a rural area of Iowa for at least five years after completing residency in Iowa, the student receives $20,000 in January of their intern year and $16,000 per year for five years of practice in Iowa. Currently, there are eight mentors in the program who are located in Clarion, Manchester, Anamosa, Muscatine, Iowa City, Mount Pleasant, Fort Madison, and Oskaloosa. Criteria for admission into the program include prior exposure to rural life, commitment to practice medicine in Iowa, understanding of the roles and responsibilities of a rural physician, and personal characteristics important in the practice of rural medicine. The first group of students was admitted into the program in fall 2012.

B. Iowa Physician Supply vs. Population — Chris Cooper, MD

Dr. Cooper, Associate Dean, Office of Student Affairs and Curriculum, University of Iowa Carver College of Medicine, discussed retaining medical students in Iowa and the need to focus on quality in training. Increasing physician supply in the state is not just a matter of increasing the number of medical students because residency positions are not increasing and there are not enough positions to train additional medical school graduates. In 2013, there were 230 open positions in the state for primary care physicians to practice in family medicine, general internal medicine (office-based), and pediatrics. As of 2012, approximately 49.4 percent of practicing physicians in the state had received their medical education or training through the University of Iowa. In 2013, 54 percent of the graduating class was beginning a residency in primary care: internal medicine, family medicine, pediatrics, OB/GYN, or general surgery. The likelihood of a physician entering Iowa practice after residency training in Iowa is much higher than if the physician trained outside the state. Iowa does not have enough residency training slots. Having more residencies in the state is key to increasing the number of MDs practicing in the state.

C. Rural Health Delivery — Eric Tempelis

Mr. Tempelis, JD, MPA, Director of Government Relations, Gundersen Health System, and member, Iowa Rural Health Association Board of Directors, explained that the Gundersen Health System is an integrated delivery system operating in Wisconsin, Illinois, and Iowa with over 50 clinical locations, three critical access hospitals, and a fellowship/residency and medical education program. Gundersen is a member of the Iowa Rural Health Association which was established in 1993 with the mission of ensuring optimal health for all Iowans, particularly those in rural areas. Outside of Iowa's metropolitan areas, 77 of 99 Iowa counties are rural. There are shortages of health professionals in rural Iowa. It is difficult to place physicians in rural areas. Gundersen also participates in The Healthcare Quality Coalition, along with The Iowa Clinic and the McFarland

Clinic, which is working to shift from fee-for-service to value-based reimbursement. Ensuring rural access to an integrated health system includes shifting from a fee-for-services to a value-based system; promoting interstate regulatory harmonization including through interstate compacts and adoption of equivalency in regulation; mental health redesign; use of Iowa Physician orders for treatment, and licensing and credentialing; protecting and promoting critical access hospital and rural health clinic designations; ensuring access of all clinics and hospitals, whether rural or urban, to participate in medical homes and ACOs; and improving telemedicine access.

D. Integration of Public Health Services Into the Pioneer ACO — Community Care Coordination Grant — Kari Prescott, Webster County Public Health

Ms. Prescott said that the Pioneer ACO is comprised of an eight county service area in northwest central Iowa. The WCHD is not contractually part of the ACO but has undergone a three-year integration into the ACO. The focus is to have an integrated regional model but also retain the separate integrity of county public health. The questions for public health agencies involved were: what does each public health agency already provide in this regional Pioneer ACO area; and can public health departments "braid" our services together and be integrated into the Pioneer ACO and focus on population health and community services. The "triple aim" goals are better care for individuals, better health for populations, and reduced health care expenditures. The overriding goal is to leverage every aspect of the community to achieve the best outcome for every patient every time. The primary drivers of the effort are to promote and maintain health, prevent illness and disability, provide a coordinated care experience, manage population health, and support health, through the lifespan, from preconception through old age.

In integrating with the Pioneer ACO, the health departments diagrammed the various services and supports provided by public health under the primary drivers; and tried to mirror the maternal and child health program in determining the structure, services already coordinated, relationships already established, the capacity to provide additional services, and the existing and future opportunities for future alliances for services. They identified public health services that could be integrated into the ACO, developed a common language to be used in standardized assessments and approaches, to provide for transitions and coordination, and to provide the population health input.

Webster County Public Health was awarded one of the community care coordination grants by the Iowa Collaborative Safety Net Organization. The Your Community Care Team project establishes a comprehensive trinavigational model (physical, mental, and public/social needs) to coordinate and mobilize health care and community resources for the most vulnerable. The effort is a collaboration between six independently governed public health agencies to implement a regional population health strategy in Calhoun, Hamilton, Humboldt, Pocahontas, Webster, and Wright counties. The overarching goals of the project are to positively impact the health and wellness of vulnerable individuals by identifying needs, filling existing gaps in services without duplication, and opening channels of communication between service providers to more effectively and efficiently serve the public.

Aside from public health agencies, 100 percent of primary care providers in the area have agreed to participate in the ACO project. Numerous community partners including social services, area schools, prisons, and maternal and child health contractors also participate. Additional participating stakeholders are behavioral health providers, dentists, and pharmacists. Overall, 37 organizations submitted letters of commitment in support of the project.

Your Community Care Team will provide care coordination services to roughly 2,400 residents with medically complex conditions and at-risk children. The project will provide appropriate medical homes with distinct supports tailored to the individual and their primary needs — public health, primary care, or behavioral health. The model wraps around the patient to provide all-inclusive assessments and services regardless of where they present, their primary health need, or their required supportive services. The model provides for collaboration with the individual's trusted provider and extends the reach of the patient's primary care provider. The team acts as an extension of the primary care medical home for the targeted population and will participate in the development of individualized care plans and health and psycho-social assessments, assist patients with scheduling and appointments, support health literacy efforts and self-management, and identify and track referrals to community resources. Health care professionals may be dispatched to homes to assess patients and families in their environments, and will also address medication reconciliation, food and nutrition, and mobility issues.

XI. Areas for Additional Discussion

Members of the committee identified the following areas for additional discussion:

- Data collection and sharing should be implemented in a way to ensure privacy protections.
- Rural and small practices should be integrated into the system.
- Public health has expertise with local populations, especially in promoting prevention and wellness, and this expertise should be extended throughout the state.
- Individuals that are high utilizers should be a focus and must have buy-in to participate in the system.
- Pharmacy services should be a focus and pharmacists should be utilized more fully in the system.
- Electronic medical records are very beneficial to coordinating an individual's care, especially during transitions.
- Public health and the safety net providers are important components of the system, especially for those with cultural and social constraints. It is necessary to focus on social determinants of health in addition to clinical care.
- Coordination of care is an essential component of an integrated system.
- The focus should not only be on rural areas, but also on urban areas with high incidences of poor health.
- With the shortage of physicians, other providers should be utilized in an integrated system to provide the services needed. There should be further review of how to integrate other professionals to provide care coordination and other elements of care.

- Iowa needs to define medical homes, health homes, and ACOs to ensure accountability and positive outcomes.
- Challenges will remain with providers and patients who are not part of the integrated system.

XII. Materials Filed With the Legislative Services Agency

The following materials were distributed at or in connection with the meetings and are filed with the Legislative Services Agency. The materials may be accessed from the "Committee Documents" link on the committee's Internet site:

www.legis.iowa.gov/committees/meetings/documents?committee=19051&ga=ALL

1. Integrated Health Care Models and Multi-payer Delivery Systems Study Committee Briefing - Distributed by LSA Legal Services Division
2. Community Integrated Health - 3.0 A New Operating System for Public Health - Distributed by LSA Legal Services Division
3. U.S. Health Care Delivery Evolution diagrams - Distributed by LSA Legal Services Division
4. Health Care's Blind Side - Distributed by LSA Legal Services Division
5. Triple Aim diagram - Distributed by LSA Legal Services Division
6. The U.S. Health Care System and the Role for Integration - Peter Damiano, University of Iowa Public Policy Center
7. Health Reform in Iowa - Continuing Improvement - Comprehensive Strategies - Christopher Atchison, University of Iowa College of Public Health
8. Pathways to an Integrated System - Mary Takach, NASHP
9. Medical Home Standards - Mary Takach, NASHP
10. Prevention and Chronic Care Management/Medical Home Advisory Council - Tom Evans
11. Medicaid: Medical and Health Homes - Jennifer Vermeer, DHS
12. UnityPoint Health ACO - Aric Sharp
13. Genesis ACO - Ken Croken
14. Trinity Pioneer ACO - Pam Halvorson
15. Public Health Services Integration/Community Care Team - Kari Prescott, Webster Co. Public Health
16. Public Health in an Integrated System - Julie McMahon (IPHA)
17. Local Public Health - Health Navigation, Dallas Co. Public Health

18. DPH CHNA HIP Fact Sheet - Jon Durbin, DPH
19. DPH CTG Fact Sheet - Kala Shipley, DPH
20. DPH CTG PowerPoint - Kala Shipley, DPH
21. Safety Net Integration - IA Primary Care Assoc. (IPCA)
22. Safety Net - Policy Considerations (IPCA)
23. Integrated Services for Children - Child and Family Policy Center (CFPC)
24. Integrated Health for Children with Special Health Care Needs - U of I Center for Child Health Improvement & Innovation
25. Research Driven Integrated Health for Children - George Estle, Tanager Place
26. SIM Steering Committee - Final Report, DHS
27. SIM Steering Committee - Recommendations, DHS
28. SIM Metrics and Contracting Workgroup Report, DHS
29. SIM Long Term Care Integration Workgroup Report, DHS
30. SIM Behavioral Health Integration Workgroup Report, DHS
31. SIM Member Engagement Workgroup Report, DHS
32. Iowa Health and Wellness Plan - Jennifer Vermeer, DHS
33. SIM Summary - Jennifer Vermeer, DHS
34. Medicaid ACO Agreement, DHS
35. Paying for Value - Mike Fay, Wellmark Blue Cross and Blue Shield
36. CRISP - Victoria Sharp
37. Rural Health Delivery - Eric Tempelis, Gundersen Health System
38. Investing in Quality - Private Health Insurance Reforms - Nick Gerhart, Insurance Commissioner
39. 1st Five Evaluation Summary - CFPC
40. Community Transformation Grants Briefing - DPH
41. Using Data to Ensure Quality - Tom Evans
42. Iowa Health Information Network - DPH
43. Patient-centered Medical Home - David Carlyle
44. ACO - University of Iowa Health Care
45. Integrated Health Care for Children with Special Needs - U of I Center for Child Health Improvement and Innovation

46. ACO - Mercy Health Network
47. The Importance of Data and HIT in an Integrated System - Chris Espersen
48. Integrating Social Determinants of Health into an Integrated Health System - Chris Espersen
49. State Roles in Supporting ACOs - Mary Takach, NASHP
50. Value-based Reimbursement for Delivery System Reform - Mary Takach, NASHP
51. Patient-centered Medical Home Implementation - Mary Takach, NASHP
52. Health Information Technology Evolution - Christopher Atchison
53. Iowa Health Information Network - Update - DPH
54. Iowa Health Information Network presentation - Kim Norby, DPH
55. Data Resources for Public Health - Healthcare Integration - Meg Harris, DPH
56. Oral health and Alzheimer's Connection - DPH
57. Dental health - Bob Russell, DPH

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