MINUTES

Health Policy Oversight Committee

Second Meeting of the 2021 Interim

Monday, December 20, 2021

MEMBERS PRESENT

Senator Jeff Edler, Co-chairperson
Senator Joe Bolkcom
Senator Mark Costello
Senator Mike Klimesh
Senator Amanda Ragan

Representative Joel Fry, Co-chairperson
Representative John Forbes
Representative Shannon Lundgren
Representative Ann Meyer

LSA CONTACTS: Organization staffing provided and minutes prepared by: Patty Funaro, Sr. Legal Counsel, 515.281.3040

CONTENTS

I. Procedural Business

The second meeting of the Health Policy Oversight Committee for the 2021 interim was called to order at 12:30 p.m. on Monday, December 20, 2021, and was adjourned at 2:35 p.m. The meeting was held by videoconference.

II. Value-Based Contracting

A. Iowa Total Care and IowaHealth+ Partnership

Mr. Aaron Todd, CEO, Iowa Primary Care Association (IPCA) and Mr. Mitch Wasden, President and CEO, Iowa Total Care (ITC), provided an overview of value-based (VB) contracting.

Mr. Wasden began by describing the historical development of VB contracting and pay for performance (P4P), including the relationship between Iowa Total Care and IPCA/Iowa Health+ (IH+). He noted that for decades, the health care system had been dominated by fee-for-service administration but going forward the health care system needs to recognize and reward quality of care and other factors besides volume of care. As one of the new managed care organizations (MCOs) in the market, ITC created a plan so that the majority of its members could be covered under a VB arrangement. Today, approximately 85 percent of ITC's members go to a primary care provider who has a VB arrangement with ITC. The VB arrangement provides P4P incentives, rewarding providers for reaching certain outcomes based on individual quality metrics. Mr. Wasden reviewed a document demonstrating the kinds of measures for which providers are rewarded such as breast cancer screenings, cardiac blood pressure control, cervical cancer screenings, follow-up after an emergency room visit for mental health at 7 days and 30 days, and others. ITC began with an initial list of 12 measures. In reviewing the 2020 versus projected 2021 rates, there has been progress in all 12 of the quality measures over the prior year. Providers are paid based on how high the percentile is at which they perform. Some of the notable increases among the 12 measures listed include breast cancer screenings increasing 9.7 percent, cervical cancer screenings increasing 12 percent, child immunizations increasing 9.3 percent, and adolescent immunizations increasing by 24 percent. Having data available to providers and creating processes for the providers and payors keeps everyone aligned and focused on the best health of ITC and Medicaid members. In 2022, ITC is starting new VB programs for home- and community-based services (HCBS) providers and behavioral health (BH) providers.

Mr. Todd provided a provider perspective in working with VB care and a P4P arrangement. Mr. Todd began by explaining that IH+ is a voluntary business venture involving 11 of the 13 Iowa community health centers in Iowa and the IPCA, forming an integrated primary care network. IH+ is dedicated to providing VB care while furthering the mission of community health centers. IH+ was initially created in 2011 to apply for a Medicare Accountable Care Organization (ACO) opportunity, and was then repurposed for the Medicaid expansion ACO in 2014. IH+ began serving as a Medicaid ACO in 2016 under managed care with all of the MCOs, and will join the Medicare shared savings ACO program in 2022. In 2020, IH+ served over 194,000 patients and over 81,000 attributed Medicaid lives across the MCOs. The intention is to move across the continuum of VB purchasing and to partner with the Medicaid MCOs to transform health care delivery within their system in partnership with payors and other provider groups across the state.

The IPCA is the primary association that employs all of the staff. IPCA, along with InConcertCare and IH+, operationalize their services as one company comprised of three interconnected organizations working in tandem to support a VB system of care statewide on behalf of their community health centers. InConcertCare provides the health information technology utilized within IH+ to support

electronic health records as well as the analytics infrastructure that powers the work they do from a population health management perspective; and IH+ managed by the IPCA on behalf of its members performs the daily VB care work. Mr. Todd reviewed a diagram depicting how the organizations work together and their specific functions and services. He described the IH+ journey on the VB care spectrum as aligning with the national dialogue on VB care. He reviewed a slide depicting the alternative payment methodology (APM) framework, categories 1 through 4, that supports the national dialogue on VB care. The categories represent the move from traditional fee-for-service payment to a fully-capitated population health management system. IH+ is currently in category 2. As the MCO system has evolved and matured in the state over time, IH+ has been able to mature along with the MCOs and is moving toward category 4. IH+ is progressing in partnership with the MCOs and the Iowa Medicaid enterprise (IME) across the spectrum of VB care, but it takes time and thought, and dialogue and partnership. It is not a one-size-fits-all journey. IH+ is exploring a subcapitated payment structure relating to primary care and behavioral health care in partnership with the MCOs and IME to develop a payment structure that works well in the outpatient integrated care space for community health centers. Mr. Todd reviewed the IH+ model of care slide that depicts how IH+ thinks about the delivery of services and differentiates its work from other providers in terms of the integrated model of care they provide from an outpatient-based service delivery model including primary care, behavioral health, oral care, and pharmacy services on site. The model addresses access to care and reducing barriers to access for their patients; transitions of care from emergency rooms and other patient settings; high-risk care coordination and interfacing with provision of care coordination by the MCOs; how to continuously improve the quality of care and metrics; and social determinants of health which have finally gained national prominence in the dialogue about how to move the metrics and help people overcome barriers to improve their own personal outcomes. All of this is supported by health information data and analytics so that decisions and the work are data-informed and patients are engaged and take ownership over their own health care decisions and outcomes.

Mr. Todd reviewed a slide on investments in VB care, depicting how they have invested the resources available through the VB care contract. They have a transformation collaborative which is an IPCA interdisciplinary team that supports the community health centers in their daily work. They also bring the centers together to understand best practices so as to not duplicate efforts as practices expand statewide. There is a lot of inertia in the health delivery system and change is challenging. There are a lot of perverse incentives in the health care delivery system, so they have focused on and invested a lot in leadership and change management as they move forward.

Mr. Todd next reviewed a slide depicting the IH+ partnership with ITC in 2021, and how IH+ earns its P4P. They do need resources up front to invest in the infrastructure to make change happen. There are two ways the partnership is resourced. The first is through the Care Coordination Fund that recognizes the need to support the care coordination and data analytics infrastructure necessary to engage with patients and ensure patients have access to the resources necessary for them to be compliant with screenings, well checks, and other services. The other way the partnership is resourced is by recognizing and providing incentives for good performance by meeting P4P measures. As they accomplish specified metrics or benchmarks in the partnership, a share of the available pool of financial resources applicable to meeting those metrics is provided.

Mr. Todd highlighted some of the successes from the partnership between IH+ and ITC. ITC has been highly collaborative and responsive, which is necessary in developing the structure to move forward in VB care and to do higher quality work. IH+ has done particularly well in follow-up after hospitalizations for mental health and has shared best practices with ITC and other partners. IH+ and ITC partnered

on a reattribution project to more accurately assign patients to the correct health care system which is very important in VB care and is a challenge nationwide. ITC has been working to expand the data sets available to IH+ which are essential to preparing for risk-based agreements.

Mr. Todd stated that next steps include continued relationship building and strategic alignment with IME and the MCOs; leveling up the health information technology infrastructure to empower population health and health equity improvement initiatives, most likely moving to a shared infrastructure for electronic health records and the analytics infrastructure for community health centers statewide which would make Iowa one of the first states to accomplish this; increasingly collecting data on social determinants of health for their patients; continuing progress on quality and performance improvement and on the VB pay spectrum of the APM framework, developing a culture of continuous improvement across the network; securing additional payor partnerships beyond Medicaid so that the system is payor agnostic, i.e., the patient's payor source does not matter as far as receiving the same quality of service; and supporting leadership development and enhancing change management capacity which has often been lacking or under-resourced.

Finally, Mr. Todd reviewed some of the VB care hallmarks that, from the perspective of a safety net provider, are important to a robust VB care system, and that the General Assembly can help support and resource. Some of these include strong, high-functioning MCO operations including claims payment and credentialing; incentives and programs focused on health equity and social determinants of health because over 60 percent of patient outcomes are related to other factors in the full context of a person, such as their living environment and the work they do; patient attribution/assignment that closely reflects patient choice and includes a collaborative data sharing process to understand utilization patterns especially as providers take on more risk; upfront investment in operational, data, and analytics infrastructure which is especially important for safety net organizations that have virtually no profit margin; alignment of quality, cost, and other metrics that stretch goals, but are realistic; coordination across systems, including the IME, MCOs, and providers so they can work in alignment and patients understand where to go to get their care and providers can provide care at a reasonable cost; investment in patient-sought, cost-effective strategies such as telehealth, remote patient monitoring, and 340B drug program involvement; providing access to all available real-time clinical claims data; and promoting multi-payor alignment and reduction of administrative burden, recognizing variation in provider types and VB frameworks that will best respond to the variation.

IH+ has spent a lot of time understanding the management structures, motivation, and business imperative at each of the MCOs so they can work as closely together as possible to accomplish shared goals.

Co-chairperson Fry stated that a few years ago, IH+ shared with the General Assembly that they had received shared savings of about $600,000, and wondered if similar shared savings has been received since then. Mr. Todd responded that IH+ had received funding, but their contract with ITC is still in the P4P stage so it is not a shared savings partnership yet. However, ITC and IH+ are in discussions to move into a shared savings realm. IH+ is in a shared savings arrangement with Amerigroup (AG), has had good outcomes in the last few years, and has received significant resources as a result.

B. Amerigroup and Community Pharmacist Enhanced Services Network (CPESN) Partnership

Mr. Jeffrey Jones, President, Amerigroup (AG) and Ms. Lindsey Ludwig, Executive Director, CPESN, provided an overview of the VB partnership between AG and CPESN.

Mr. Jones stated the presentation would demonstrate VB purchasing through the lens of retail pharmacy. He noted that Ms. Ludwig had been the executive director of CPESN since 2018. CPESN is a high-functioning network of pharmacies throughout the state that is committed to the health and well-being of the Iowans they serve. There have been conversations in the past about making sure members are receiving the right care, at the right place, at the right time. Pharmacy case management supports this goal, and CPESN has a lot of experience with pharmacy case management. Increasingly, the MCOs are rewarding pharmacists for the ever-expanding role they play in keeping members healthy.

Ms. Ludwig reviewed a document providing an overview of CPESN, noting that CPESN is America's first accountable pharmacy organization. CPESN is a clinically integrated network of community pharmacies across the state, and is performance-based and willing to be held accountable to drive outcomes. CPESN is uniquely focused on patient outcomes and provides a consistent core service set and service delivery across all practice sites. She referred to a map that depicts the statewide network of 122 participating pharmacies across the state that adhere to CPESN quality and service standards. CPESN is considered the second largest chain of pharmacies in the state. Their network was selected last winter by Iowa's Department of Public Health (DPH) as one of two statewide pharmacy partners to receive early access to the COVID-19 vaccine for administration to Iowans. They were also selected by DPH to distribute the antiviral medication once the medication is more widely available. The local pharmacies in the network have longstanding local roots, local relationships with doctors and others, and local engagement in the communities they serve. CPESN has also worked to develop relationships with AG local care managers, because these relationships help in identifying the needs of AG members in the community and in addressing the health disparities and social determinants of health that may be preventing members from optimizing their medication outcomes. The pharmacies have the opportunity to engage patients and members where they are and because of the expansive network across the state the pharmacies have administered more than a quarter of a million COVID-19 vaccines, countless COVID-19 tests, and a few locations across the state serve as antibody administration sites. They are working tirelessly to make sure members who are homebound have access to critical services and if a member does not have transportation access, the pharmacy can go to them to provide critical services.

Ms. Ludwig noted that on average a patient has 3.5 primary care visits per year, but has 35 pharmacy visits per year. Pharmacies can leverage these frequent patient touches to improve medication management, optimize patient outcomes, provide continuity, and ensure patient needs are met. The pharmacies focus not only on filling prescriptions but on providing medication optimization activities and enhanced patient services, collaborating with the extended care team such as the case managers to improve patient health, and focusing on interventions that change patient behavior and lead to better health.

Because of all of the services CPESN has provided in the past, they began discussing with AG how CPESN could utilize its local approach in enhancing member experiences and delivering outcomes. By partnering together, they are hoping to improve the unique needs of AG members through a program CPESN developed and focus on those members who, based on medical and pharmacy claims, are deemed to be at high risk within four clinical categories. In mid-August of 2021, CPESN and AG launched a new program with 18 initial pharmacies participating, 60 percent of which are located in rural communities. Under the program, approximately 400 Medicaid members will be actively served, receiving an initial screening, an assessment based on their identified clinical conditions, and action/referral to a provider based on the screening and assessment, along with monthly or periodic follow-ups as needed and identified by the pharmacist. Ms. Ludwig shared a slide depicting the 18 initial, diverse participating pharmacies throughout the state. There are four clinical service program

categories: behavioral health (anxiety, depression, and mental health), asthma/COPD, opioid use disorder, and opioid management. These categories were chosen due to an identified unmet need based on population health data and the health outcome goals of the Medicaid program. The three core objectives of the program are to support Medicaid members in managing four clinical categories; driving the costs of care savings for Medicaid plans; and addressing health disparities and health challenges for local populations. The program focuses on what services are available in the community and how the pharmacist can direct members to the available services. The success measures are similar to those for other providers: decreasing hospital stays, decreasing emergency room visits, increasing medication adherence, decreasing inhaler use, decreasing morphine milligram equivalents for opioid prescriptions, and increasing the number of members engaged and the interventions completed.

Ms. Ludwig stated that early findings indicate progress. A number of pharmacists have utilized the state standing order authority to prescribe tobacco cessation products to members. They have been able to identify medication administration errors and inhaler misuse, and have educated members relating to opioid issues. Ms. Ludwig demonstrated the progress made through member story examples. She shared a story she received from a pharmacist about a member who was initially identified as a behavioral health member. However, following an assessment it was determined the member was having side effects from the member's medications. The member also was behind on immunizations. Working with the local prescriber, the pharmacists was able to reduce the dose of the medication and resolve all of the side effects. The pharmacist has also worked with the member to catch up on the vaccination gaps. In the most recent follow-up this month, the member was screened again for his behavioral health status. The screening demonstrated a significant improvement in the member's status. The member stated he had been in incredible pain, had been unable to find a dentist, and so had been extracting his own teeth. The pharmacist contacted and worked with Webster County public health to obtain an appointment with a local dentist and worked with AG to help the member get transportation to the appointment. Pharmacists have utilized AG case managers to ensure coordination of care and utilization of all member resources. They are finding that members need resources, but are not always sure how to access them. So, having the closed loop process to keep everyone informed should help ensure utilization of the services available and address the care gaps that have been occurring.

Even though it is still early in the program, Ms. Ludwig indicated that she is thrilled with the progress to date. The level of service being provided by the pharmacies in the network is incredible and CPESN hopes to work with other MCOs in the state on these enhanced pharmacy services.

Social Determinants of Health. Ms. Elizabeth Matney, Medicaid Director, Mr. Wasden, and Mr. Jones provided an overview of social determinants of health (SDOH) data being collected and provided in a public dashboard.

Director Matney began by demonstrating the new SDOH dashboard that will be available on the Department of Human Services' (DHS) website and will include information collected in the health risk assessments the MCOs are performing. There is a subset of 13 SDOHs in the assessment that the MCOs have been collecting over the span of a few years, and the Medicaid team is now compiling the data into a public dashboard. Director Matney stated that the dashboard is a bit confusing at first, but reviewed the dashboard with the committee, making suggestions to help in navigating the dashboard and understanding the data. As an example, she reviewed the data collected based on a question regarding housing. She noted that members' responses are completely voluntary. If there are fewer than 20 responses per county, to address federal Health Insurance Portability and Accountability Act

(HIPAA) privacy concerns, the dashboard states there were fewer than 20 responses. Director Matney offered to walk committee members through the dashboard at any point in the future.

Mr. Jones provided that one of the most important uses of the data collection is as a triggering event that demonstrates what needs a member has. This in turn triggers a referral to a case manager and community-based teams to identify what the member's challenges might be and what community organizations might be available to support them. He noted that a member's answer does not always identify the underlying need. In one case, a member indicated they were concerned about their housing. When AG engaged with the family of nine, they found the housing risk was tied to an employment risk and the employment risk was tied to the father needing four new tires for his vehicle to get to work so he could make the income to pay for the housing. Through a community partner, AG was able to provide the member with the tires so he could continue to work and pay for housing. Mr. Jones shared a document entitled "Amerigroup About Us" that demonstrates the breadth of the community partnerships. The data collected helps, but a lot of the work is investigative work diving more deeply into what a member's needs might be. He provided an example of a program that grew out of the derecho effort when AG was providing food bank support and he noticed there was always free produce available at every food bank and food pantry. AG investigated where the fresh produce was coming from and how to augment the system throughout the state to address food insecurity and make sure the system continues. Through these efforts, AG found the Iowa State University community garden program. AG began to support this program both from a funding and a volunteer perspective. Another example is the first electronic breast pump program for members in the state launched by AG last year to make sure expecting and new mothers had access to these breast pumps. Approximately 1,250 electronic breast pumps have been issued so far in 2021. Lastly, Mr. Jones noted the community health worker training program supports community health workers who act as an important connector between a local community's available resources and members with specific needs. Along with the chronic care consortium, AG funded 100 training enrollment seats in partnership with Des Moines Area Community College. To date, 85 of these seats have been filled.

Mr. Wasden began by recognizing that there is a lot of complexity with SDOHs. ITC has focused on SDOH analytics. There are many ways to find out about SDOHs including through surveys, case managers, and providers. ITC is working with providers to make sure they are using Z-codes which providers can use to indicate there are SDOHs involved with a member. ITC has worked with Broadlawns, UnityPoint, the Iowa Primary Care Association, and recently did a presentation with the 14 CEOs of the mental health and disability services (MHDS) regions to work with providers to recognize that while SDOH data is interesting it also needs to be useful in identifying and targeting specific populations to address their needs. The MCOs have housing specialists, case managers, and others and can direct resources to members when needs are identified. But, every intervention on SDOH has two levels: an air campaign and a ground campaign. An example of an air campaign is a literacy campaign. It is important to do, but it will be difficult to quantify the difference it makes. The ITC literacy campaign partnered ITC with 100 schools, providing 70,000 activity books and $50,000 in resources to improve their libraries. This is important, and it is an SDOH issue, but it is not something for which a result might ever be proven. A ground campaign is different. One of the tenets of SDOH is that a person's zip code determines their health. ITC identified seven zip codes in the Des Moines area in which low birth weight babies are born. Going forward in 2022, ITC will be providing doulas as a value-added benefit to provide an extra layer of support to the pregnant women in these zip codes to determine if the extra layer of support actually improves birth weight outcomes. This type of work takes the SDOH data from being interesting to being useful. Nationwide, people are still trying to figure out

how to use SDOH data and what interventions actually work. Mr. Wasden said that one program that has worked is the “my health pays” program. As members use the health care system and get their vaccinations, preventive services, and well-child checks, they earn money which they can then spend on SDOH issues like education, utilities, child care, rent, food, and clothing. Each year ITC awards over $1 million under this program. Since its inception, the members involved have doubled in number. As the MCOs get better at utilizing the SDOH data, they need to use it to scale to help the most members.

Co-chairperson Fry wondered how the presenters would use the SDOH data to drive the big picture in health care. Director Matney responded that there really is not one answer. The data looks at things at the macro and individual levels. A person can look at the data and determine if there are areas of the state where individuals might be at greater risk of food or housing insecurity, and then work with the MCOs to develop a campaign or work with local school districts or housing authorities to address the need. At the individual level, the data provides trigger points with an individual to ask for additional information and make sure that community-based connections are being made for that individual. Mr. Wasden agreed and stated that part of what ITC is doing is trying to determine which interventions make an impact. Some interventions are a hit while others are a miss. Mr. Jones added that when the social factors of members are connected to their health outcomes, commonalities and disparities can be identified. Co-chairperson Edler asked if the MCOs and IME are able to identify and address overlaps between health and other factors. For example, if there is a health concern that is impeding someone from working, are the MCOs and IME able to work on the health side to get the person back into employment? Mr. Jones responded that they are effective in doing this on a micro or individual level now, but they would like to get to the macro level. These are exactly the connectivities they are making now, engaging families that have identified a need and then having conversations and determining the intersections between health and other issues. Mr. Wasden added that when they provide data to providers, the data is cut by chronic conditions so the provider can see if the SDOH needs are affected by having a chronic condition and if targeted outreach is needed. The MCO can work to address the SDOHs and the provider can address the chronic condition.

III. MCO Updates — Workforce Status in Light of COVID-19 Vaccine Requirements

ITC. Mr. Wasden reported that 91.7 percent of the ITC employees are vaccinated. ITC employees are categorized as member-facing and non-member-facing. Right now, only about six member-facing employees have not been vaccinated and they have been assigned to non-member-facing work, leaving only vaccinated member-facing staff. There are about 40 employees with religious or medical exemptions, but these employees are not doing member-facing work. No ITC employee has been terminated based on the ITC vaccination policy. Some of the success in the high vaccination rate is due to ITC having town halls featuring their medical director to provide education and address concerns. ITC has a turnover rate of about 14 percent. The pre-COVID-19 level of turnover was 11 percent. In terms of COVID-19 outreach to members, ITC has done a lot including donating personal protective equipment (PPE), and providing phone calls and text alerts to members with only a 6 percent text alert opt-out rate. ITC has worked with the Iowa Immunization Registry to get updated vaccine information for members to know who to target with information, and did some automated phone campaigns to notify members when the vaccine became available for children 12 years of age and older. Given the worker shortages, ITC employees have been volunteering at vaccine clinics. ITC had about 10,000 members who were at very high risk during the pandemic, and ITC focused outreach on informing these members about where to get the vaccine.

With regard to non-COVID updates, Mr. Wasden reported that ITC had a barrier removal fund to help providers in making their locations more accessible. ITC provided $168,000 worth of grants to providers to, for example, purchase weighted blankets or noise-canceling headphones or to install automated entrance doors. Another very successful initiative ITC hopes to continue is their partnership with Babylon, their telehealth vendor, with whom they have worked for over a year. ITC used Babylon in working with Broadlawns because Broadlawns' emergency room was being flooded with people who were not requiring emergency level of care for behavioral health visits. Babylon is an appointment module available 24 hours a day, seven days a week. It is free to ITC members and about one-half of the visits end up being related to behavioral health and one-half are general medicine. ITC has about 15,000 registered users of Babylon now and the number continues to grow monthly. A behavioral health appointment is usually available in five business days. Users have rated Babylon as a 4.9 out of 5, so it is a good experience. About 30 percent of those who used it say it helped them avoid a hospital emergency room visit. Additionally, using telehealth dramatically reduces the no-show rate, which is often the result of transportation issues.

AG. Mr. Jones reported with regard to COVID-19 that AG has taken many steps to comply with state and federal laws and to ensure the safety of AG associates, members, and providers. One change was allowing associates to work remotely. AG did have requirements for case managers who work face-to-face with members, but AG has not had a single termination related to these requirements. AG has actually created some new positions within the plan for associates who were member-facing and did not want to become vaccinated in order to leverage their talents and expertise in the long-term services and supports (LTSS) population and identify new opportunities. AG continues to try to work as efficiently as possible and provide flexibility. One of AG's key roles during the pandemic has been around education and outreach. Vaccine outreach has been nonstop since the vaccines were introduced and they have transitioned at each new phase. They have partnered with local clinics and local public health departments, supported volunteer efforts, provided publicity for efforts across the state, and provided educational webinars. They have addressed health equity program design and partnerships with a health equity grant to address disparities related to the vaccine. AG has also leveraged all available data to determine which members are and are not vaccinated. The primary concern regarding workforce has been the safety of AG associates and the members with whom they interact. One new position is an LTSS concierge position. This position supports and augments the LTSS program footprint for those who do not want to be vaccinated or do face-to-face work. Another new position is as a member of the advance placement team. The team will identify critical resources to focus on the most complex cases and community transitions.

Mr. Jones also shared quality and clinical outcomes of AG value-based arrangements depicted in a document provided to committee members. The outcomes focused on marked improvement rates of adolescent immunizations, follow-up for emergency department visits for mental illness, improvement for comprehensive diabetes care blood pressure, childhood immunizations, and improvement in controlling high blood pressure.

A focus of AG in 2021 has been refreshing their population health strategy using all available data to ensure that the strategy is working to eliminate health disparities. This work has informed several key initiatives relating to population health including those involving behavioral health and substance use disorders, antidepressant medication adherence rates, initiation and engagement rates for treatment and follow-up post-hospitalization, low birth rates, prenatal and postnatal timeliness of care, diabetes testing compliance, medication adherence for those with asthma, and disparities in COVID-19 vaccination rates.

With regard to National Committee for Quality Assurance (NCQA) accreditation, Mr. Jones provided that AG did achieve its reaccreditation this year and was also recognized with multi-cultural and LTSS distinctions.

Mr. Jones concluded with a success story of a 25-year-old member who was served through the intellectual disability (ID) waiver. The member was residing in a 15-bed facility with 24-hour supported community living services. He was able to secure his own transportation and could spend time in the community on his own. He was employed at the local Walmart for several years with the help of a job coach. When the pandemic hit, the facility restricted employment to keep all residents safe. This created stress and hardship for this member both financially and socially. The member's mother, who is also his guardian, worked with his care team including his job coach and his case manager to find him his own apartment, work with his employer to go back to work after he had moved, and set up reliable transportation to and from work. They also found new providers of supported community living services to replace those he had employed previously. Today he is still living in his own apartment, works at Walmart, and has other interests.

IV. Member Questions

Senator Bolkcom asked the MCO representatives to respond to the Department of Justice (DOJ) report on Glenwood and Woodward which suggested the state did not verify the data provided by the MCOs and the state has no plans to use the data provided by the MCOs. The report also indicated that the state delegated the responsibility of developing the community-based provider network to the MCOs and virtually nothing has happened. Senator Bolkcom asked whether the MCOs agreed with the report, where they thought their efforts should be focused to address these concerns, and specifically what the MCOs are doing to help with workforce development.

Mr. Wasden responded that the MCOs are working closely with DHS on the response and on the plan. Since the time frame the report covers is a two-year span, a lot of work has been done during the two years and progress has been made. Mr. Wasden stated that they are all in the "fix-it" mode and are excited to resolve any issues. Mr. Jones reiterated that the work to resolve issues did not just start with the release of the report, but that the work has been underway for some time. The MCOs are a key component to ensure there is a working system in the future. On the community integration piece, efforts have already been made to expand capacity including identifying border state providers that might have capacity to expand into Iowa. AG has also reserved some philanthropic funding to help attract providers who want to expand services into the community services area space.

Senator Bolkcom stated that the state remains in a relatively uncontrolled pandemic with only about 55.2 percent of the population being vaccinated. He asked if the MCOs are tracking the percentage of their members who are vaccinated. Mr. Wasden responded that they do track this by age category and by product, although the timing of the data lags behind, with the most recent data being from November 2021. Given the very recent onboarding of the 12-year-old plus age group and the fact that the majority of Medicaid members are younger individuals, even though the 65-plus age group is 77 percent vaccinated and the 46-64 age group is 60 percent vaccinated, the low numbers of vaccinated youth brings the average down. Mr. Jones added that this data was consistent with his data.

Senator Bolkcom asked if the increase in childhood vaccination rates to which the MCOs referred was for the standard childhood vaccinations. The MCOs confirmed this.

Senator Bolkcom asked if the MCOs had claims and cost data available relating to Medicaid member hospitalizations relating to COVID-19. He noted that there are currently 800 people in the hospital with COVID-19. Mr. Wasden said ITC has run this data in the past, but he did not have it available for the meeting. Both Mr. Wasden and Mr. Jones agreed that this data could be made available.

Senator Bolkcom asked how the pandemic is affecting the business side of the MCOs since the pandemic has continued to result in more cost to the health care system. Mr. Wasden responded that ITC's decision to allow the majority of their employees to work from home provided a level of stability and protection. Employees had concerns about their safety in coming back in person, so ITC allowed them to work from home thereby stabilizing their workforce. At this point, ITC is not concerned about the stability of the operation. In terms of what utilization will look like in the future, he said that it is anybody's guess and they will continue to be surprised. Mr. Jones responded that flexibility and education have been very critical. The education is ongoing because the situation is ever-changing.

Representative Meyer thanked the MCOs and IME for their outreach to her community during the summer. She asked when breaking down hospitalizations by diagnoses, if the data could also include body mass index, smoking, and exercise. She stated that many health conditions are the result of what people do to themselves.

V. Public Comment

There was no public comment before the committee.

VI. Committee Discussion

Senator Bolkcom again expressed his concerns about the issues with data as specified in the DOJ report. He understands that the state hired expertise through use of federal American Rescue Act funds to help with some of the data work, but the state computer systems are not very sophisticated. He is interested in whether there will be investments in these areas to provide good data on which to make decisions. He stated that there is a lot to take in and the one day of oversight is not enough. He expressed some frustration with the format of the meeting and effort, but acknowledged that with an uncontrolled pandemic the committee has to do things in a slightly different way.

Co-chairperson Fry stated that he thought Senator Bolkcom was saying that he was not sure enough oversight was provided on certain topics, but at least from the perspective of the members of the House of Representatives there is ongoing oversight of the budget and Medicaid. Additionally, both the House and Senate have oversight committees to probe into certain areas. The committee agenda was set to provide clarity and input on certain topics. Senator Bolkcom appreciated the response and stated that he hoped the Senate would join the House in holding budget subcommittee meetings in the coming legislative session. He added that he thought it was a mistake for the Senate not to participate in these.

Representative Forbes stated that it was not a normal day for him at his pharmacy because one of his pharmacists was absent due to a sick child. He wanted to touch on the presentation that was given by CPESN. He stated that his pharmacy is a participating pharmacy of CPESN and his pharmacy is seeing some very positive results from the program. He is hopeful the program can be expanded in the future to more pharmacies across the state to increase quality of care. He stated that being in the health care field, he had some concerns with where the state is going with COVID-19. He is getting more calls with concerns about the new variants and whether the vaccines are going to work or not. He said that currently it looks like the vaccines are working, but the concern is what the next variant is going

to be like and where the state will be in a month or three from now. He said we need to work hard as a state to get as many people vaccinated as possible. Vaccines do reduce the transmission of COVID-19 and if a person becomes sick they do not end up in the hospital. He is hopeful the two antiviral drugs released in the next few weeks will have an impact on patient hospitalizations. Pharmacies are going to play a vital role in the dispensing of these medications, and pharmacists will be able to test and treat with the antivirals. Representative Forbes stated that a concern is what the General Assembly will look like during the upcoming session. Will clerks and interns be there? The concern is that based on the current approach the General Assembly might have to pause the session. He said he hoped people would take the pandemic seriously and get their vaccine and mask up. People need to get serious again about wearing masks in public. He said he had been on and off the meeting trying to run his pharmacy and give COVID-19 vaccines at the same time.

Co-chairperson Edler thanked Co-chairperson Fry for stepping up and hosting the second meeting since he had issues with his broadband capacity. He also addressed Senator Bolkcom's concern with the limited oversight. Co-chairperson Edler responded that he looks at the oversight as an everyday event, addressing constituent and provider concerns which is a part of oversight as well as budgeting. He said that while the meetings might have been somewhat limited, there are other avenues available. Things can always be improved but there are adequate channels for oversight. He also stated that there had been a lot of focus on the vaccine, but he had not heard any discussion about natural immunity which is a piece of herd immunity that should be discussed. The co-chairpersons thanked everyone for their participation and wished everyone happy holidays and good health.

VII. Materials Filed with the Legislative Services Agency

The following materials listed were distributed at or in connection with the meeting and are filed with the Legislative Services Agency. The materials may be accessed from the link on the committee's website www.legis.iowa.gov/committees/meetings/documents?committee=24165&ga=ALL:

1. Iowa Value-Based Purchasing, submitted by Amerigroup
2. Iowa Total Care Community Investment, submitted by Iowa Total Care
3. Amerigroup About Us, submitted by Amerigroup
4. Value-Based Contracting — Community Pharmacist Enhanced Services Network (CPESN), submitted by CPESN
5. Value-Based Contracting and Pay-for-Performance Incentive, submitted by Iowa Total Care
6. IowaHealth+ and Iowa Total Care Value-Based Care Partnership, submitted by IowaHealth+