Iowa Department of Human Services

Iowa State Innovation Model (SIM) Report to the Steering Committee

The recommendations included reflect the work of the stakeholder process (including workgroups and listening sessions) and may not reflect the position of the Governor's Office and the Department of Human Services.

October 2013

Contents

BACKGROUND AND OVERVIEW

Iowa has a history of demonstrated dedication to creating innovative health options for all Iowans. In keeping with this tradition, the State applied for and received a State Innovation Model (SIM) Design Award from the Centers for Medicare and Medicaid Services (CMS). Iowa received $1,350,711 to develop its plan for lowering costs and improving quality of care for its Medicare, Medicaid, and CHIP populations. The primary deliverable to CMS as part of the grant is a State Health Care Innovation Plan (SHIP). In addition, development of the SHIP will enable the State to apply for a Model Testing Grant which will provide additional money to implement and test components of the SHIP.[1]

As articulated in the grant application, the State is employing four strategies to meet the goals of improved quality and lower costs:

1. *Adopting and Adapting the Multi-Payer Accountable Care Organization (ACO) Model* developed by Wellmark Blue Cross Blue Shield, the state's largest commercial payer, and looking to lessons learned from the Medicare Shared Savings Plan and Pioneer ACOs operating in the State. Iowa's goal is to incorporate Medicaid and CHIP populations into ACOs over three years and to gain the participation of Medicare as a multi-payer partner. The State ACOs will use the same quality measures (the Value Index Scores) in use by Wellmark in order to align accountability and payment. In addition, the State will be adapting the model to encourage and reward the integration of long-term care supports and services and behavioral health care services.
2. *Incorporating Long-Term Care Services and Supports in the ACO Model* to reduce fragmented care and increase the use of home and community based services over more costly institutional services. All of the work done to integrate long term care into the ACOs will be coordinated with Iowa's Balancing Incentive Payment Program design and meet its requirements for a single point of entry system for services, standardized assessments, and conflict-free case management.
3. *Incorporating Behavioral Health Services in the ACO Model* and building off the Integrated Health Home (IHH) model implemented in July as well as the work done as part of the recent redesign of the State's mental health and disability system, which is shifting from a county-led to a regionally-led system.
4. *Promoting Good Health and Well-Being and Encouraging Individuals* to increase the use of preventative care and decrease the use of inappropriate emergency services. This goal will also help to support the Healthiest State Initiative.

The State has articulated specific cost-saving goals of reducing the growth rate of health care costs to the Consumer Price Index and for each ACO to reduce costs from projected trends by 5-8 percent within three years.

[1] In 2012, six model test states were awarded 42 month grants of between $33 and $45 million.

Vision for Iowa

As part of this work, the State has developed a vision for the transformed system in Iowa. The following are the primary goals and organizing principles of this transformation.

Goals

1. Achieve the triple aim: reduce the per capita cost of health care, improve the health of populations, and improve the patient experience of care (including quality and satisfaction)
2. Create a system that supports and encourages Iowans to participate in their own care
3. Align with the Governor's Healthiest State Initiative and support stakeholder participation in the process to transform Iowa's health care system into one that achieves the triple aim and supports Iowans in participating in their own care and in achieving improved health.

Organizing Principles

The new, transformed health care system will be a person-centered, value-based delivery system that makes Iowans healthier, and supports Iowans in actively participating in their care and the maintenance and improvement of their health and wellbeing. As part of the transformation, consistent and transparent standards and measures will be adopted that allow for demonstration of these improvements and the impacts of these improvements on Iowans' health. This system will have:

1. Dedicated and consistent leadership within all sectors including: public purchasers, private purchasers, providers, consumers, trade groups and associations, public health and other government entities.
2. Collaboration and open communication
3. Clarity in accountability
4. Transparency in data, dependable and secure connectivity with patient access to data, choices and rights
5. Alignment in measures and analytics

"As Is" State/Existing Efforts

"As Is" State of Iowa's Population Health and Health Care Systems

In 2012, Iowa was home to just over three million people. About 93 percent of Iowa residents are white (compared with 78 percent nationally), 3 percent are black (13 percent nationally), 0.5 percent are American Indian or Alaska Native (1.2 percent nationally), and 5.2 percent are Hispanic (17 percent nationally).[2] About 36 percent of Iowans live in rural areas, compared with only 21 percent nationally[3]. In terms of age, Iowans closely resemble national averages, with the exception of having a higher percentage of the population who are 55 years old or older.

Age of Iowans	Iowa	National
Population Age 0-18	25.6%	25.8%
Population Age 19-25	9.8%	9.8%
Population Age 26-44	23.4%	25.1%
Population Age 45-54	14.5%	14.6%
Population Age 55-64	12.4%	11.9%
Population Age 65+	14.3%	12.8%

According to the Iowa state health facts sheet produced by the Kaiser Commission on Medicaid and the Uninsured, in 2011, percentages of people living in poverty in Iowa were slightly lower than percentages nationally. For example, about 13 percent of Iowans were in poverty (below 100% percent of the Federal Poverty Level, or FPL), compared with 20 percent for the U.S.4.

Health of Iowans

According to an assessment done by the Commonwealth Fund, Iowa's overall health ranking was 2nd in the country, previously ranked 3rd by the same report. This report analyzed 35 total indicators of health, in the categories of access, prevention and treatment, avoidable hospital use and costs, equity, and healthy lives. Iowa has a relatively high rate of insurance comparatively, ranking 2nd in the nation of children insured and 6th in the nation of adults insured. However, Iowa has a relatively low percentage of their population accessing preventative health services, with only 42.9 percent of adults accessing recommended primary care and preventative services. Iowa also received a low ranking in the category of heath equity, with disparities especially high between income and racial and ethnic groups, with 68.5 percent of low-income adults not accessing recommended primary care, about 25 percent higher rate than the

[2] U.S. Census Bureau; American Community Survey. (2011). *Iowa State Quick Facts .*
[3] Ibid.
[4] Kaiser Family Foundation http://kff.org/other/state-indicator/distribution-by-fpl/

overall state total. However, according to this report, overall health in Iowa is improving, and the state's ranking for 28 of the 35 indicators either stayed the same or improved[5].

The percentage of adults in Iowa who are obese (29 percent) is slightly higher than the national average (27.8 percent), while the percentage of children is Iowa who are obese is slightly lower (10.2 percent compared to the national average of 13 percent). Adults in Iowa use tobacco at very slightly lower rates than the national rates (20.4 percent versus 21.1 percent), with youth tobacco use mirroring the national rate at 18.1 percent. Nearly 83 percent of adults in Iowa do not meet physical health recommendations (compared with 79 percent nationally), while only 48.5 percent of youth do not meet these recommendations (compared with 50.5 percent nationally).

In Iowa, more adults have a usual source of care than nationally, and more children have a medical home. Preventable hospital admissions are lower than the national average, for both adults and children, as are avoidable uses of the Emergency Room.

Enrollment and Expenditures

During State Fiscal Year 2013, the unduplicated Medicaid enrollment was 631,479, with 312,438 adults and 319,041 children. Using 2009 enrollment numbers, the Kaiser Family Foundation reported that about 55 percent of Iowans were covered by employer-based insurance, 14 percent were enrolled in Medicaid, 13 percent were enrolled in Medicare, 6 percent had individual insurance, and 1 percent had other public insurance. The remaining 11 percent were uninsured, which is lower than the national average of 15.8 percent. [6]

Iowa's spending on Medicare, which is $7,987 per person, is much lower than the national average, which is $9,477 per person. Although Iowa and the U.S. average spend a similar total amount per person for Medicaid, Iowa spends more on its aged and disabled populations, and less on its adult and child populations.

While children represent about 57 percent of the Medicaid enrollment, in 2012 spending on children was only 18 percent of total Medicaid spending. As with other states and nationally, aged and disabled populations account for a large percentage of Medicaid spending. While only 19 percent of those enrolled are disabled, 50 percent of Medicaid spending was dedicated to this population[7].

In terms of long term care, in FY 2010, Iowa spent close to $1.4 billion on long term supports and services. About 21 percent of the expenditures were for care for the 11,950 Medicaid enrollees in nursing facilities, while 38 percent was for care provided to

[5] Commonwealth Fund. (2009). *Scorecard on Health System Performance.* Commonwealth Fund.
[6] State Health Access Data Assistance Center , 2012 pg. 10
[7] Iowa Department of Health and Human Services. *Improving Iowa's Health Status.* Iowa Department of Health and Human Services, 2012, p. 2

the 25,624 Medicaid enrollees receiving care through a Home and Community Based Services Waiver. [8]

In terms of behavioral health care, about 4.9 percent of Iowans have a serious and persistent mental illness (SPMI), compared to the national average of 4.6 percent[9]. However, a lower percent of Iowans (30.6 percent) report having poor mental health, relative to the U.S. average of 35.8 percent. It is estimated that 25 percent of youth who need mental health services do not receive them.[10]

For commercial insurance, it is notable that, in comparison to the national average, Iowa's largest carrier, Wellmark Blue Cross Blue Shield, holds a high percentage of the market shares for:

- small group: 63.2 percent vs. 49.8 percent nationally
- large group: 77. percent vs. 58 percent nationally
- individual: 84.0 percent vs. 55.4 percent nationally

Health Care Delivery Systems in Iowa

Iowa's health care system is characterized by a relatively small number of large entities that are already working together. Three payers (Wellmark, Medicaid and Medicare) provide coverage to a vast majority of Iowans (86 percent) and a small number of very large integrated health systems deliver the majority of acute care services in the state.

The majority of Medicaid enrollees are served in a fee-for-service system for their physical health care. There is a capitated managed care option that currently serves individuals in 18 counties; (as of October 1, 2013, there are 19 counties with this option). In September 2013, there were 34,468 members eligible and served through this option. In addition, there is a primary care case management program (MediPass) that served about 375,000 enrollees; just under 100,000 people in 2012 were served through the medical home and health home programs.[11] There is a statewide Medicaid Behavioral Health Organization (BHO) (Magellan Health Services) that provides behavioral health services to the vast majority of Medicaid beneficiaries. The vast majority of long-term care supports and services (LTCSS) in the State are provided by Medicaid. .

Iowa's largest private insurance carrier, Wellmark Blue Cross Blue Shield, covers about 1.8 million Iowans. In 2011, Wellmark began developing ACO arrangements with three health systems and has increased the number of ACOs to five :

- UnityPoint Health (Cedar Rapids, Des Moines, Fort Dodge, Quad Cities, Waterloo)

[8] http://kff.org/state-category/medicaid-chip/?state=IA

[9] Substance Abuse and Mental Health Services Administration. (2011). *National Survey on Drug use and Health.*Washington: U.S. Dept. of Health and Human Services, p. 4

[10] Kaiser Family Foundation http://kff.org/state-category/health-status/

[11] Treo Solutions analysis of IME claims and enrollment data.

- Mercy Medical Center (Des Moines)
- Mercy Medical Center and University of Iowa (Cedar Rapids, Iowa City)
- Genesis Health Systems: (Davenport)
- Wheaton Franciscan Healthcare (Waterloo)

The ACOs share in savings or losses by a pre-selected percentage (50, 60 or 70 percent) and there are financial targets that trigger shares savings payment. There are incentive payments tied to provider performance on Value Index Scores (VIS) which measure seven core domains:

1. Member experience
2. Primary and secondary prevention
3. Tertiary prevention
4. Population health statues
5. Continuity of care
6. Chronic and follow-up care
7. Efficiency

In addition to the commercial ACOs, there are several Medicare ACOs operating in the State. These include:

- Trinity ACO (Fort Dodge area); this is a Pioneer ACO
- Accountable Care Clinical Services PC (Iowa)
- Alegent Health Partner, LLC (serving both Iowa and Nebraska)
- University of Iowa Affiliated Health Providers, LC (Linn, Benton, Jones, Cedar, Iowa, Johnson and Tama counties)
- Mercy ACO (Polk, Warrant and Dallas counties)
- Unity Point, LC (Cedar Rapids, Waterloo, Des Moines, Davenport, Bettendorf and Muscatine counties)

Related Initiatives

The State has made tremendous progress with several other initiatives (described below) that form the foundation upon which the ACOs will build their models of care. The State is not interested in dismantling these initiatives; rather they are building blocks for the larger transformation of the entire health care system.

Health Homes

Effective July 1, 2012, the State is operating a Health Home Medicaid program in 24 counties that enables providers to offer additional services for members with specific chronic conditions. A Health Home is a patient-centered, whole person approach to coordinated care for all stages of life and transitions of care; a model of care where Medicaid members with multiple or chronic conditions can receive help that integrates all their needs into a single plan of care. The State requires that providers meet specific standards and seek patient centered medical home (PCMH) recognition within 12 months of enrolling in the program. To facilitate a team-based, community focused

approach, providers participating as a Health Home must connect to the Iowa Health Information Network (IHIN).

The program is open to any full benefit Medicaid member, adult or child, with at least two chronic conditions from a list of conditions, or having one chronic condition and is at risk for developing a second from this conditions list. To support improved health and ensure more integrated, comprehensive care, the Health Home provides:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Support Services

The Health Homes are paid per-member- per- month (PMPM) rate based upon the number of chronic conditions of the member:

Tier	PMPM
Tier 1 (1-3 chronic conditions)	$12.80
Tier 2 (4-6 chronic conditions)	$25.60
Tier 3 (7-9 chronic conditions)	$51.21
Tier 4 (10 or more chronic conditions)	$76.81

Changes may be needed in the Health Home approach to align with future initiatives.

Integrated Health Homes for Individuals with Serious Mental Illness

Starting on July 1, 2013, the State began serving adults enrolled in Medicaid who meet the criteria for Serious Mental Illness (SMI) and children enrolled in Medicaid who meet the criteria for serious emotional disturbance (SED) through an Integrated Health Home (IHH). The IHH program started in five counties (providers are included in parentheses):

- Dubuque (University of Iowa – Child Health Specialty Clinic for children only)
- Linn (Four Oaks, Tanager Place, Abbe CMCH)
- Polk (Eyerly Ball Mental Health Center, Broadlawns)
- Warren (Eyerly Ball Mental Health Center, Broadlawns)
- Woodbury (Siouxland Mental Health Center)

Effective October 1, 2013, the program expanded to additional IHHs and even more will be added during 2014.

In the first phase, the State expects to serve 6,841 people; after the next two phases are implemented (in additional counties) nearly 25,000 people will be served in this program. After the third phase, the program will be statewide.

The IHH is a team of professionals working together to provide whole-person, patient-centered, coordinated care. The IHH is being administered by the Medicaid Behavioral Health Care Managed Care Organization (Magellan Behavioral Care of Iowa) and provided by community-based Integrated Health Homes. The Integrated Health Home providers must have the capability of forming a team of professionals required to provide comprehensive care coordination. This includes, but is not limited to, such entities as community mental health centers, federally qualified health centers, child health specialty clinics, etc An IHH provides case coordination through a team of professionals including access to family and peer support services. The IHH provides care coordination across all aspects of an individual's life, including coordination of physical health care and successful transition from inpatient and residential treatment. In general, workgroup members had positive things to say about the program and were optimistic it would achieve its goals.

Tier	PMPM
Tier 5 (Adult)	$177.79
Tier 6 (Child)	$153.38
Tier7 (Adult with Intensive Care Management)	$397.79
Tier 8 (Child with Intensive Care Management)	$373.38

The proposed SIM model design will build upon the IHH by utilizing lessons learned about how best to coordinate care for people with behavioral health needs, by leveraging relationships that are being developed and strengthened between behavioral health providers and physical health providers, and by replicating the successful care coordination strategies that are being using by the IHHs.

Iowa Health and Wellness Plan

In May of 2013 the Iowa Legislature passed the Iowa Health and Wellness Plan. The Iowa Health and Wellness Plan will implement three options that offer coverage to adults ages 19 through 64, with no dependent children who are not eligible for Medicaid under any other eligibility category and whose incomes do not exceed 133 percent of the FPL.

The three components, which will help the State promote private market coverage, capitalize on the efficiencies of the Marketplace, and mitigate the challenges of churn for those individuals most likely to become eligible for premium tax credits, are:

1. The Iowa Wellness Plan for eligible individuals with income up to and including 100 percent of the FPL and medically frail eligible individuals with income up to and including 133 percent of the FPL;
2. The Marketplace Choice Plan for non-medically frail individuals with income 101 percent of the FPL up to and including 133 percent of the FPL by offering premium assistance for eligible individuals to enroll in Qualified Health Plans (QHPs) through the health insurance marketplace (Marketplace); and

3. Premium assistance for individuals with income up to and including 133 percent of the FPL who have access to cost-effective employer sponsored insurance (ESI) coverage under Iowa's Health Insurance Premium Payment (HIPP) Program.

The Iowa Wellness Plan

The Iowa Wellness Plan uses delivery system innovation, care management, and quality approaches designed to realign the delivery system to focus on value, quality, and coordination of care. Through a phased implementation, the Iowa Wellness Plan promotes coordinated care through primary care physician coordination, managed care, and ACOs. The model will vary by geographic region and will depend on the delivery system readiness for ACOs and/or managed care. However, at a minimum, all members will have access to primary care that provides referrals and care coordination and focuses on quality outcomes. Over the course of the next several years, and as ACO development increases across Iowa, more Iowa Wellness Plan members will be covered by primary care physicians who are associated with ACOs. The Iowa Wellness Plan, by including ACOs where they are available, seeks to support the development of ACOs across the State in concert with the State Innovation Model goals.

The Iowa Wellness Plan will provide a comprehensive commercial-like benefit plan that ensures provision of the Essential Health Benefits (EHB) and is indexed to the State Employee Plan benefits with supplemental dental benefits. Behavioral health and dental benefits will be provided as carved out benefits on a contracted basis. Those found eligible for the Iowa Wellness Plan will be screened prior to enrollment (and later if there is a change in condition) to determine if they qualify for medically exempt status. Individuals who qualify as medically exempt will be defaulted to enrollment in the Medicaid State Plan where benefits are more appropriate to their needs; however, these individuals will have the opportunity to opt-out of Medicaid State Plan coverage and receive coverage on the Iowa Wellness Plan.

The Iowa Wellness Plan, as proposed, contains a unique incentive program that is intended to improve the use of preventive services and other healthy behaviors through the elimination of monthly financial contributions for those who complete preventive health service requirements. Members with income exceeding 50 percent of the FPL will be required to contribute financially toward their health care costs through monthly contributions. For the first year of enrollment in the Iowa Wellness Plan, all monthly financial contributions are waived. If members complete key health improvement behaviors in their first 12 months of enrollment, the required financial contributions are waived again for the next 12-month enrollment period. The required financial contributions are the only cost sharing required of Iowa Wellness Plan members other than copayments for non-emergency use of the emergency department, which apply to all members regardless of income level but are also waived in the initial demonstration year. Key health improvement behaviors may include items such as completion of preventive health care and health assessments, and such targeted behaviors will be defined by Iowa for each coverage year. Members who continue to complete health improvement behaviors in each 12-month period of enrollment will never be subject to the required monthly financial contribution.

Members will be enrolled in either the HMO or Medipass program. In Medipass, providers in the Iowa Wellness Plan will be reimbursed fee-for- service for the services provided. Primary care providers will also be paid a Per Member Per Month rate (currently anticipated to be $4.00) for each Iowa Wellness Plan member assigned to them. Primary care providers will have an opportunity to earn additional incentive payments including:

- A Physical Exam Bonus if at least 85 percent of members who have been attributed for at least six (6) months have received a physical exam during the Performance Year. The Physical Exam Bonus will be $10.00 per year per member that received the physical exam; and
- A Value Index Score (VIS) Medical Home Bonus of up to $4.00 per member per month (PMPM) based on performance in meeting measures aligned with core attributes of good primary care. These measures are: (1) person-focused care; (2) first contact with the health care system; (3) comprehensive, coordinated care and (4) transfer of information. The VIS is used by Wellmark.

These payments will be provided to the ACO directly for those primary care providers that are part of an ACO. ACOs are also eligible for an additional bonus payment (the ACO Incentive Payment) of an additional $4.00 PMPM for assisting in the transformation to a person centered delivery system. To receive this bonus the ACO will be required to: (1) provide Member education and outreach to ensure Iowa Wellness Plan members attributed to its PMs are aware of Iowa Wellness Plan benefits; (2) provide education and outreach to support members in adopting healthy behaviors; (3) provide education on the premiums for which members might be responsible; (4) provide resources to its PMs that include collection and evaluation of health risk assessment, support in providing after-hours care, and establishing urgent care centers and supporting efforts in ongoing member outreach and education

Marketplace Choice

By coordinating with the Marketplace Qualified Health Plans, the Marketplace Choice Plan creates a private market experience for members, assures access to care, and reduces churn between Medicaid and the Marketplace with the overall goals of increasing access and improving quality of care. The Marketplace Choice Plan targets individuals ages 19 through 64 who are not eligible for other categories of Medicaid or Medicare, have income at 101 percent of the FPL up to and including 133 percent of the FPL, are not medically frail, and do not have access to cost-effective ESI coverage. The Marketplace Choice Plan ensures the provision of Essential Health Benefits (EHB). In addition, dental benefits, similar to those provided on the Medicaid State Plan, will be provided as a supplement to the EHB benefits. The Marketplace Choice Plan contains an incentive program similar to that in the Iowa Wellness Plan.

Providers will be reimbursed according to the payment terms of the Qualified Health Plan in which the member is enrolled. Medically exempt individuals in the Marketplace Choice Plan will also be default enrolled in the Medicaid State Plan with the option to opt-out.

Like the Iowa Health and Wellness Plan, the proposed SIM model design will incorporate ACOs, support medical homes and encourage individuals to be active participants in staying, or becoming, healthy. Although only serving a sub-set of Iowa Medicaid enrollees, the implementation of this program will provide valuable lessons learned which will be incorporated into the larger program that will serve all Medicaid enrollees. As demonstrated below, the State is viewing this program as Phase I of this multi-year effort.

Balancing Incentives Payment Program

Effective July 1, 2012, the State is the recipient of a three-year Balancing Incentive Payment Program (BIPP) grant. BIPP is designed to "balance" states' spending on long term supports and services. The overarching goals of BIPP are to create coordinated access to long term care services through development of a statewide integrated system, expanded use of cost effective community based long term services and supports, and support and improve quality measurement and oversight. As of June 2013, Iowa spends approximately 8 percent of its Medicaid long term supports and services funds on home and community based services (HCBS); the goal is to achieve an even split of 50 percent spent on HCBS services, and 50% on institutional services. Through the BIPP grant, Iowa is receiving an enhanced match rate of 2 percent for non-institutional long term services and supports, for a total of $61.8 million.

The State is implementing three strategies to achieve these goals:

- A No Wrong Door/Single Entry Point system for Home and Community Based Services and Long Term Services and Supports
- Conflict free case management. Case managers work with individuals and families to develop a service plan, arrange for services and supports, and direct and monitor service delivery to assure the individual's needs are met and desired outcomes are achieved.
- Core Standardized Assessments. Standardized assessment tools identify eligibility for non-institutional services and supports and are used as a guide to develop person-centered service plans to address unique needs. The State will release an RFP in November 2013 requesting proposals to develop these assessment tools.

The work of the BIPP is in alignment with the work of the SIM, and the two grants and initiatives are mutually supportive. The work of the SIM includes a focus on the development of ACOs that have specific capabilities around improving care coordination and increasing the use of the most appropriate services in the most effective, appropriate, cost-effective, patient-centered settings, including increasing the use of home and community based services when this is most appropriate. Through the SIM work, ACOs will be held accountable for improving coordination of care and integration of services, and ensuring that individuals receive the most appropriate care and the most appropriate setting. The work of the BIPP to develop standardized assessments, no wrong door for services, and conflict-free case management standards and processes, supports these goals.

Governor's Healthiest State Initiative and the Blue Zones Project

The Healthiest State Initiative is a privately led public initiative which requires partnership between the public sector, individuals, families, businesses, faith-based organizations, and not-for-profits, to improve healthy behavior within communities. This is part of Governor Branstad's goal to make Iowans healthier and happier and to ensure Iowa is the healthiest state in the nation by 2016 by the standards of the Gallup-Healthways Well-Being Index. The Index measures Daily Pulse, Life Evaluation, Emotional Health, Physical Health, Healthy Behaviors, Work Environment, and Basic Access.

The Initiative's website: http://www.iowahealthieststate.com provides resources and suggestions for improving health, such as gardening at home and forming walking groups for exercise. There are also several core components such as the:

- The Healthy and Happy Outdoors (H2O) Iowa program, which is structured to encourage people to use outdoor space more frequently in order to improve health and reduce stress; and
- The Complete Streets policy initiative, which is meant to improve roads for all types of users - pedestrians, motorists, and bicyclists.

By using many of the same suggestions and goals, the Governor's Healthiest State Initiative is aligned with the Blue Zones Project, [12] a community-by-community well-being improvement initiative designed to make healthy choices easier through permanent changes to environment, policy, and social networks. The focus is to lead longer lives through good health practices. Currently Cedar Falls, Cedar Rapids, Mason City, Muscatine, Sioux City, Spencer and Waterloo are Blue Zones Communities. In addition, 19 Iowa communities have been selected to receive support from experts to become Blue Zone communities; more will be selected in the future.[13]

The SIM project will leverage these initiatives in several ways. First, ACOs will be required to develop and implement plans to engage the people they serve in prevention-related activities, and these resources will be an important part of the array of services to which ACOs will refer individuals they serve. Second, as Iowans begin to engage in more Blue Zone or Healthy Iowa activities, they will begin to take more ownership of their health, which will make them more likely to engage in preventive services provided by primary care providers and coordinated by ACOs. In these ways, the work of the SIM project and the work of these initiatives are mutually supportive.

Mental Health and Disability Redesign

The State is in the midst of a phased, multi-year effort to redesign the mental health and disability services (MHDS) system. Starting in 2011, multiple workgroups convened to develop recommendations and strategies to move the system to from one that is county-based to one that is regionally-based and has consistent, performance-based contracts. Workgroups covered topics including, but not limited to: children's disability services; Judicial; outcomes and performance measures; transition; adult mental health services, adult intellectual and developmental disability services, brain injury services and regions. There were also legislative interim committees in 2011 and 2012 to review workgroup recommendations and explore financial solutions for the MHDS system. Some of the workgroups met prior to the 2012 Legislative session which provided the Iowa legislature with recommendations and direction to move forward with significant MHDS redesign legislation. In 2012 the Iowa legislature passed Senate File 2315: the Mental Health and Disability System Redesign Legislation, legislation to make important changes to the mental health and disability system. This legislation continued the workgroup process with a focus on transition issues related to forming into a regional system and developing and system based on outcomes and performance measures which resulted in Iowa legislature passing additional legislation in 2013.

The goal of the Iowa legislature is to create consistency, continuity, effectiveness, efficiency and accountability in the MHDS system. This would be done through a regional mental health system that provides local access to services and supports, is regionally managed and measured through statewide standards.

[12] Additional information is available at http://www.bluezonesproject.com/.
[13] Healthiest State Initiative, "Programs: Blue Zones Project™," accessed June 4, 2013, http://www.iowahealthieststate.com/blue-zones.

In 2013, the State began work in earnest and is providing guidance to providers, developing service definitions, rules and reimbursement methodology, implementing the crisis stabilization pilot, and providing technical assistance to regions that have filed a letter of intent of formation.

There are 14 MHDS regions and one county meeting exemption requirements to regional formation that will be fully operational by July 1, 2014.

Medicaid Management Information System (MMIS)

The MMIS is a large, complex information technology system that supports all aspects of Medicaid administration. MMIS supports data processing and analysis and is a vital tool for the implementation of state Medicaid policy for policymakers. The MMIS processes over 33 million providers claims per year from over 38,000 providers; provides data for complex federal reporting requirements on a member/claim level of details; and addresses multiple benefit plans, dozens of reimbursement methods and tens of thousands of health care claims. The current MMIS system must be updated and federal funds are available. To change the way the State purchases health insurance and to allow for innovative delivery system and payment models, the State must update its 1970s era mainframe system. The State has released an RFP to select a vendor to provide these services. This new and up-dated MMIS will enable the State to be innovative in approach to providing health care services, as is being proposed in the SIM model design.

SIM Stakeholder Involvement

The State has undertaken an extensive and comprehensive approach to involving all stakeholders in the SIM design process. A communication plan was developed that included formal meetings, informal meetings and use of the IME website to provide information. In addition to this Steering Committee, the State has conducted the following activities.

Learning Sessions

As early as April, just weeks after the grant commenced, the State held an ACO learning session to describe the SIM process, the proposed ACO model, the different initiatives of focus (integration of behavioral health, long-term care supports and services and member engagement). Nearly 100 people attended this session. In June, the IME sponsored a learning session on the long-term care system here in Iowa. This was also well-attended and provided an important opportunity for people to understand the current system of long-term care supports and services and some of the initiatives underway.

Since the proposed ACO model that will be used statewide is aligned with the model in use by Wellmark, the IME posted on its website a webinar conducted by Treo Solutions and Wellmark. This provided background on the approach to shared savings as well as on the Value Index Scores (VIS) which will also be used with the Medicaid ACOs.

Workgroup Sessions

The State developed four workgroups built around the key strategies outlined in the original grant proposal. The goal was to use these Workgroups to focus on their individual strategy and the State would bring the goals and recommendations together in a cohesive plan.

These workgroups are:

- Metrics & Contracting: this workgroup was tasked with developing recommendations and goals around the structural arrangement of the ACOs, payment provisions and metrics and measures to use.
- Member Engagement: this workgroup was tasked with developing goals and recommendations about approaches to engaging members in their own care ad encouraging them to be active participants in becoming healthier. There was also discussion about how in 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.
- Behavioral Health Integration: this workgroup 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 current Iowa Plan and its additional services and focus on recovery.
- Long-term Care Supports and Services Integration: this workgroup 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.

Each workgroup met four times for two hours. The meetings were held every other week during the weeks of: July 22, August 5, August 19 and September 2. All workgroups had appointees but were open to the public. Supporting reading, agendas and minutes were all posted on the IME SIM website. Although the specific areas of focus differed, the workgroup meetings were arranged as follows:

- Workgroup meeting #1: Level setting with a focus on the entire project, the need for transformation and an introduction to the ACO concept.
- Workgroup meeting #2: Analysis and discussion of what works in the system of focus (LTC, BH, etc.), what doesn't work, and the goals and visions for a transformed system. From these workgroups, four summary documents of the key themes identified in each workgroup were developed.

- Workgroup meeting #3: Focus on developing 10 to 12 recommendations. These recommendations were then sent to the workgroups for them to identify and select their priorities. They were also asked to provide additional recommendations which might not have been mentioned. These priorities were then compiled into a summary document and shared prior to the fourth workgroup.
- Workgroup meeting #4: Focus on discussing and refining the recommendations, and soliciting any additional recommendations. Members were also asked to comment on priorities and discuss whether they would shift any of the priorities after further thought.

Workgroup members did not vote on any suggestions nor were they asked to come to consensus on adopting the suggestions. They did, however, prioritize the suggestions as a "1", "2", or "3". Many of these suggestions, as well as some others identified by the SIM team and those attending the listening sessions are reflected in the recommendations that appear later in this document. These reports and recommendations may not reflect the position of the Governor's Office and the Department of Human Services.

Additional reports summarize the discussions of each Workgroup, the background reading provided and the comments, concerns and recommendations articulated during the 16 workgroup meetings (four for each of the four workgroups) held from late July to early September of 2013. These reports and recommendations may not be adopted by the Governor's Office and the Department of Human Services.

The fifth workgroup is a consumer-focused workgroup that will meet on October 29 and October 30, 2013. During these meetings IME will provide an overview of the project, discuss the workgroup approach and present the recommendations and goals that will be/have been presented to the Steering Committee.

Listening Sessions

The State is committed to making sure that individuals not included in the workgroup process, as well as those in rural areas also had an opportunity to hear about the SIM process and to share their thoughts. Because the Iowa Health and Wellness Plan was a topic of great interest and because its planning and implementation is laying the foundation for the ACOs that will be put in place for all Medicaid enrollees during the SIM process, the State discussed both initiatives at these sessions. The Learning Sessions were held on the following dates in the following cities:

- August 13: Ottumwa
- August 16: Newton
- August 27: Council Bluffs
- September 17: Fort Dodge
- September 20: Waterloo
- September 27: Cedar Rapids

Website and Materials

Over the last six months, IME has been using the website to post presentations, reading materials, meeting agendas, meeting minutes, a schedule of events and background information about the State's SIM design proposal. This website is regularly updated to ensure that people can monitor progress and activities across all workgroups, meetings and events.

RECOMMENDATIONS/FUTURE STATE

Based on research, analysis, and stakeholder feedback, the following are the key areas for consideration for the development of ACOs and inclusion in the State Healthcare Innovation Plan:

- ACO model contracting and regions
- ACO provider relationships
- Ensuring accountability and alignment with other payers
- Increased transparency
- Reimbursement approach
- Approach to integrating behavioral health care services
- Approach to integrating long-term care supports and services
- Member engagement and approach to encouraging healthy behaviors
- Provider support and ensuring sufficient and appropriate workforce
- Creation of a reinvestment fund

These recommendations are described in greater detail below. At the end of the recommendations is a proposed, high-level timeline.

ACO Model: Contracting and Regions

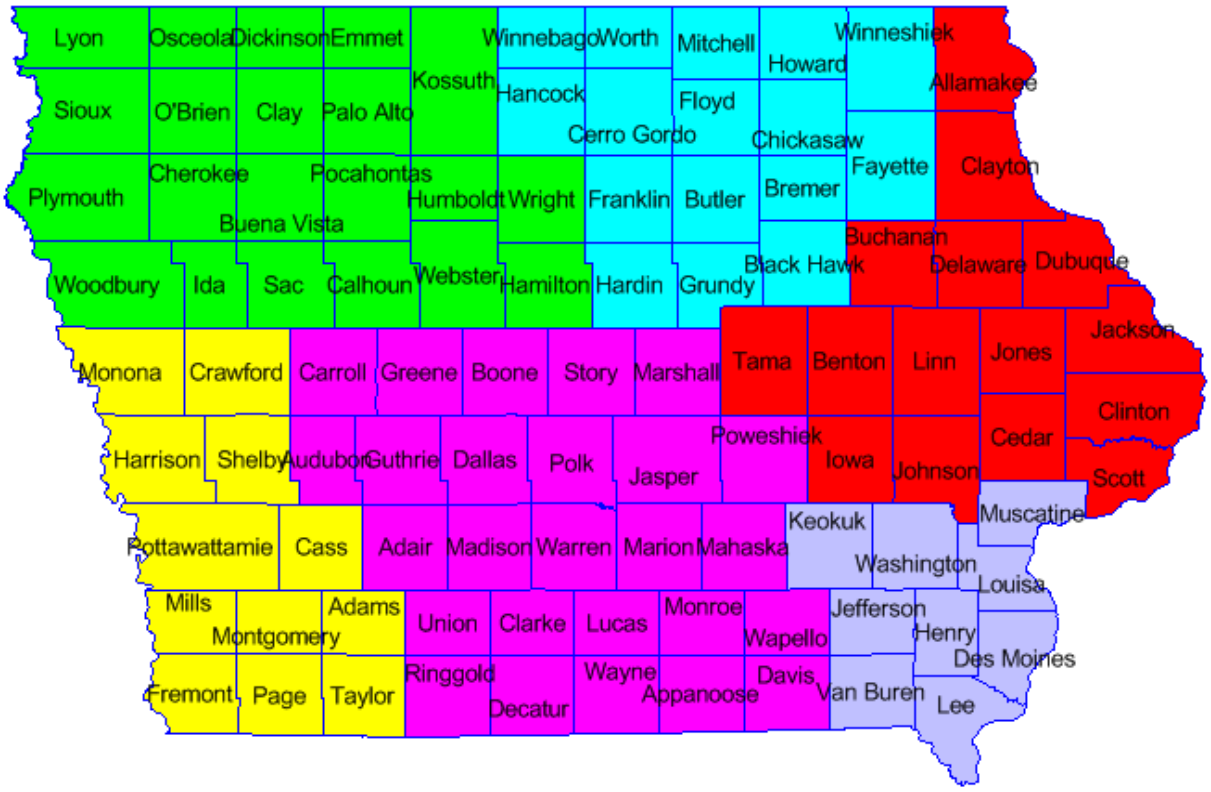
The ACO model provides an opportunity to transform Iowa Medicaid into a patient-centered system that provides better coordinated and integrated care, improves the patient experience of care, achieves better health outcomes, and reduces cost. Iowa's goal for the SIM project is to create delivery system change and payment reform that reduces the rate of growth in health care costs for the state as a whole to the Consumer Price Index within three years. Once the ACO model has been developed and implemented, the goals of the ACO organization(s) are more aggressive: to reduce costs by five to eight percent within three years.

All of the Workgroups discussed the approach to contracting and procurement for the ACOs. From these conversations and discussions, as well as research on approaches taken in other states, the State should consider developing the model and accompanying contracts with the ACOs in the following ways.

Regional Approach to ACOs

The State should use a competitive procurement process to award ACOs based on geographic regions. The ACO model provides an opportunity to provide better coordination of care, and to encourage and require enhanced accountability at all levels. Regionally-based ACO models provide even more opportunities in these areas because they are more attuned and responsive to local needs, existing community entities and partnerships, and gaps in care. It is recommended that ACOs be regionally-based, with full coverage by at least one ACO in every part of the state, to ensure that the entire state (including rural areas) receives the benefits of being part of an ACO. Iowa is a very locally-controlled state, with 99 counties and 101 local public health departments. Additionally, the state varies considerably from region to region in terms of the demographics of Iowans, and the existing health care systems, structures, organizations, and unmet needs. Regionally-based ACOs can be more attentive and responsive to these needs, and will be more aware of local resources that will be integral parts of effective care coordination. The ACO regions should be based on naturally-occurring practice and referral patterns, using existing claims data. ACO regions must be large enough to enable an ACO to have a significant volume of enrollees to have financial capacity to manage risk and to develop the infrastructure necessary to coordinate care, but small enough to allow for local approaches to care.

Data analyses conducted by Treo Solutions suggest the existence of six naturally-occurring regions (see map below). The regions were constructed by examining practice and referral patterns and noting where there were some natural concentrations of activity. For example, people who live in the nine southeastern counties of Iowa tend to have the same core set of primary care providers, and these providers refer patients to specialty providers, hospitals, and other health care entities within that region. These providers and these patients make up a naturally-occurring region. Rather than breaking up that region, it makes most sense to utilize and leverage that natural pattern. The data examined by Treo Solutions included a look at utilization and referral patterns for all Medicaid clients across the state, as well as examinations of subsets of clients, such as children, adolescents, older adults, and people with serious mental illness to see if different regions would emerge using only those data. The regions did not differ based on these subpopulations.


Lyon
Osceola
Dickinson
Emmet
Kossuth
Winnebago
Worth
Mitchell
Howard
Winneshiek
Allamakee
Sioux
O'Brien
Clay
Palo Alto
Hancock
Floyd
Cerro Gordo
Chickasaw
Fayette
Clayton
Plymouth
Cherokee
Pocahontas
Humboldt
Wright
Franklin
Butler
Bremer
Buena Vista
Buchanan
Woodbury
Ida
Sac
Calhoun
Webster
Hamilton
Hardin
Grundy
Black Hawk
Delaware
Dubuque
Jackson
Monona
Crawford
Carroll
Greene
Boone
Story
Marshall
Tama
Benton
Linn
Jones
Clinton
Harrison
Shelby
Audubon
Guthrie
Dallas
Polk
Jasper
Poweshiek
Iowa
Johnson
Cedar
Scott
Muscatine
Pottawattamie
Cass
Adair
Madison
Warren
Marion
Mahaska
Keokuk
Washington
Louisa
Mills
Montgomery
Adams
Union
Clarke
Lucas
Monroe
Wapello
Jefferson
Henry
Des Moines
Fremont
Page
Taylor
Ringgold
Decatur
Wayne
Appanoose
Davis
Van Buren
Lee

Contracting Approach to ACOs

The State should not dictate what type of entity can be an ACO nor should the State limit the opportunity to entities that are already operating as ACOs. The State should contract with whatever entity submits the best proposal for its region and can demonstrate its financial, organizational and clinical capacity to provide high-quality, coordinated care while reducing costs. The State should contract with ACOs that demonstrate a culture that encourages innovation and competition, and a commitment to using innovative strategies designed to engage the Medicaid population. This might be an existing ACO, a managed care plan, a new partnership, or a safety net provider based ACO. However, early in Phase I, when some Iowa Wellness Plan members will be enrolled in the ACOs starting January 1, 2014, the State may elect to contract only with currently operating ACOs due to the compressed implementation timeline. More ACOs can be added as they become operational.

The State is interested in having a collaborative approach to the contracting process. As such, IME staff have already met with ACOs currently operating as well as entities such as the Iowa Primary Care Association. To achieve this collaborative approach, the State should issue a Request for Information prior to issuing the formal Request for Proposals and finalizing the contract. Many other states take this approach.

ACO Provider Relationships

There are regional and county strengths and the ACOs should be encouraged to capitalize on those strengths in developing relationships with providers and social support organizations. The culture in Iowa is strongly rooted in the communities and the 99 counties; the approach to health care and the ACO model need to be able to adapt to those unique strengths and to develop an approach to supporting and growing areas of weakness and need. The State should set a clear expectation in the ACO contracts that ACOs should partner with existing providers of quality services to ensure that the individuals they serve have access to the providers they need and who provide services they currently utilize and value, including existing Integrated Health Homes, other behavioral health providers (including both mental health and substance use providers), and providers of long terms supports and services (including nursing facilities, other facility-based care, and home and community based providers). The State should not specify in the contract specific groups or entities with whom the ACO should contract to provide services and coordination activities, rather the ACO should be permitted to partner with quality providers and community organizations that will support the ACO in enhancing care coordination, reducing costs, ensuring access and changing the overall health care delivery system to one that is focused on outcomes.

Ensuring Accountability and Alignment with Other Payers

In order to hold ACOs accountable for quality of care, patient experience of care, health outcomes, and cost, a core set of measurements should be implemented across all ACOs in Iowa. It is recommended that the State adopt and require usage of a core set of measures for all ACOs in Iowa. This will ensure that measures across all payers in

Iowa are aligned to the degree possible and that practice change, as driven by performance, occurs across all payers. Specifically, it is recommended that the State use the Value Index Scores (VIS) being used by Wellmark and within the new Iowa Wellness Plan structure. Providers are familiar with these measures which measure progress toward the outcomes and goals that have been identified as part of the SHIP.

To support integration of behavioral health and long-term care services and recognizing that Medicaid enrollees have greater need for coordination of these services, in phases, the core set of measures should be augmented to include measures related to behavioral health and long term care supports and services. Behavioral health measures should include measures of members' access to and the quality of behavioral health care, as well as measures of the degree to which these services are coordinated and integrated with physical health services. Behavioral health measures should also focus on recovery and build off those articulated by the Mental Health and Disability Redesign Outcomes workgroup.

For long term care supports and services, measures should focus on the quality of these services, access to services, and the degree to which these services are coordinated and integrated with acute care services and behavioral health services. Potential measures related to long term care supports and services may be increased use of home and community based services as appropriate, and the degree to which care plans for individuals include both acute care and long term care services and supports.

To ensure the focus is not solely on those individuals with high costs and high needs, the State will also include in the VIS measures that focus on ensuring the needs of children are met which will result in longer-term savings.

ACOs should not be held accountable for costs associated with behavioral health and long term care supports and services in the first year, but this accountability should be added in the second or third year, as ACOs become more experienced at coordinating these services.

Increased Transparency

The State should develop standard analytics and model of distribution that provides the ACOs and their providers with access to the key metrics to which they are being held accountable as well as to patient level detail that is actionable. This centralized data function also serves a role as the third party verifier of actual performance and quality of care provided. These standard analytics can and should become the singular point for all parties to the accountable care model to use to access metrics that will evaluate overall program performance. The transparent use of data will improve the quality of health care and reduce costs. Moreover, standard risk-adjusted metrics provide a means to track performance, establish accountability, and fairly distribute incentive payments linked to performance.

A recent report from the Kaiser Family Foundation details the role the Statewide Data Analytics Coordinator (SDAC) plays in Colorado's accountable care model. In the report, they state that, "Data analytics are fundamental to accountable care. Accountable care models encourage and expect providers to work together and take responsibility for the entire population or area they serve. Common metrics, adjusted for risk, provide a means to track performance, establish accountability, and fairly distribute incentive payments linked to performance. Risk stratification allows care management resources to be targeted."

Reimbursement Approach

The State should hold the ACOs accountable to a Total Cost of Care calculation that is the cornerstone to any shared savings methodology. These methodologies should be risk adjusted and transparent in calculation with sufficient analytics and reporting to support ACOs. The State should also explore the possibility of using social determinates of health in the risk adjustment calculation (for example homelessness status or formerly incarcerated status) as these are strong predictors of the rate of utilization of health care services and the chronicity of the individual.

The reimbursement methodology should evolve such that the ACOs have more risk and greater accountability for Total Cost of Care. As the State moves into Phase II (Phase I is the implementation of the Iowa Wellness Plan), the statewide ACO model for Medicaid enrollees, the reimbursement should shift to one that includes greater risk, likely both up-side and down-side risk but that continues to use the VIS, along with additional metrics designed to measure performance related to LTCSS and BH services. The ultimate goal is to move to a fully capitated system within five years. There should be clear and specific triggers and timelines for these changes in payment methodology and increased Total Cost of Care accountability.

Approach to Integrating Behavioral Health Care Services

Across the country, there is a move to integrate behavioral health services more effectively with physical health services. This is being done by aligning measurement and payment; by simplifying care coordination; encouraging or requiring collaborative care plans and coordination of care across systems; developing ways to co-locate behavioral health and physical health services; developing health homes; and supporting other mechanisms for providing both behavioral health and physical health services to people in the environment that is most accessible, appropriate, and comfortable for them. There are initiatives underway in Iowa that are supportive of providing more integrated, patient-centered care, and the SIM work provides an excellent opportunity to build upon these initiatives. As part of the SIM work, all services to all populations, including those with serious and persistent mental illness and substance use disorders should be included in an integrated accountable care structure.

In 2013, Iowa began to implement the Integrated Health Homes project, described previously. The Integrated Health Homes provide care coordination through a team of

professionals including access to Family and Peer Support services, and will provide care coordination across all aspects of an individual's life, including coordination of physical health care and successful transitions from inpatient and other residential treatment. Providers include organizations like community mental health centers, federally qualified health centers, and child health specialty clinics.

A goal of the ACOs, relative to the provision of behavioral health services, should be to simplify care coordination for people with high behavioral health needs, and to ensure that care coordination is provided in the setting that is the most "natural fit" for the individual. It is recommended that ACOs be held accountable for ensuring that care coordination is simplified, provided in these most fitting and appropriate settings, addresses the recovery needs of the whole person and fosters the use of intensive community support services, evidence based practices and peer support.

As described above, quality measurements, including measures of patient experience of care, should be developed and implemented such that the ACOs recognize the value and contributions of the existing behavioral health system. Measures should demonstrate achievement of outcomes reflected in the MHDS Redesign workgroup reports.

Approach to Integrating Long Term Care Supports and Services

Many states are moving the delivery of Long Term Care Support Services (LTCSS) from a fee-for-service model that rewards volume of services to one that is more integrated and coordinated with primary care and behavioral health, rewards high-quality, and encourages the provision of LTCSS in non-institutional settings that allow people to live at home and be receive services in community based settings. With the move toward using an Accountable Care Organization framework for the Medicaid population, Iowa has an opportunity to improve care for the highest cost populations and impact expenditures by holding ACOs accountable for managing and coordinating services and for reducing unnecessary hospital admissions or re-admissions.

The state should use, and build on existing initiatives, such as the Balancing Incentives Payment Program (BIPP) to facilitate transformation of the LTCSS to one that includes BIPP required components such as: (1) No wrong door/single point of entry so that individuals can access services more quickly; (2) conflict free case management and integrated care coordination between primary care, behavioral health, and LTCSS; and (3) use of a core, standardized assessment instrument and require ACOs to have formal partnerships with entry-points.

In addition, the State should:

- Design contract metrics with ACOs that value and reward the use of home and community based services; develop metrics for nursing facilities that incentivize them to work with ACOs and to help institutionalized clients who would prefer to be in a home or community setting to find an appropriate, safe alternative

placement; and, develop metrics and incentives for nursing facilities to coordinate with ACOs and to reduce repeated and unnecessary hospitalizations.

- Support electronic connectivity and capacity for all provider organizations and LTCSS community-based providers to share information about individual patients. This can be accomplished through shared EMRs; connectivity through a statewide information exchange; or through a secure portal with access to an integrated care and treatment plan and integrated care coordination record. This is an identified area of high need as many LTCSS do not have EMRs and there are also family caregivers to consider.
- Incorporate best practices or evidence-based approaches to managing the LTC population that emerge from states or other national initiatives, including but not limited to the Center for Medicare & Medicaid Innovation's Core Measures which were designed to establish a consistent framework for performance measurement and quality improvement for evaluations across the Innovation Center and the overall impact of its initiatives on the health of populations, quality, and efficiency of care, and to compare the effectiveness of different models.

In light of the aging population in Iowa, the anticipated growing need for LTCSS, the workforce shortages in this area, the aging infrastructure of many of the facilities, and the fact that such a high percentage of all Medicaid expenditures are for individuals receiving LTCSS, the State should include the patients as well as the services in the ACO model as soon as possible. However, making significant changes to the LTC service delivery system should be done in a thoughtful, incremental fashion to ensure that for each step along the way, the most vulnerable and medically fragile individuals are best served and do not experience a disruption of service, or suffer from unintended consequences from policy changes or implementation of new designs. It is essential to allow adequate time in advance of implementing new, expanded or reconfigured LTCSS programs to allow for thoughtful planning and design, incorporation of stakeholder input, and implementation of safeguards to ensure a smooth transition to new service and payment models. In light of this, the State should phase-in the responsibilities and accountability for Total Cost of Care into the ACO model according to a pre-established timeline which will include readiness reviews of the ACOs.

In addition, the ACO model design needs to carefully consider the differing needs of long term care populations and the delivery systems that serve them. For example, the ACO will need to design a system for elderly persons that is likely to differ from the system that is needed to ensure persons with intellectual disabilities have their needs met. These differences need to be considered carefully with specific needs, goals and contexts in mind. The State should consider expanding the ACO model to serve elderly persons during a different phase than the expansion for intellectually disabled persons. .

Member Engagement and Approach to Encouraging Healthy Behaviors

In order to truly improve the quality of care provided and the health of all Iowans, as well as decrease health care costs, people must be active participants in making decisions

about their care and in taking steps to lead healthier lives and adopt healthier behaviors. In seeking to engage people the State should closely monitor the effectiveness of the Iowa Health and Wellness Plan and incorporate any best practices or strategies that work.

Additionally, as is being implemented in the Iowa Wellness Plan, the State should align the incentives for members who actively participate in becoming, and staying, healthy with the incentives for ACOs. This alignment will increase the effectiveness of member engagement activities.

Additional recommendations include:

- Ask the ACOs to describe, in their response to the RFP, how they will support members in adopting healthy behaviors and how they will support and provide education and training to providers so they can help their patients set, and achieve goals.
- Consider the use of healthy behavior accounts or use of other financial incentives.
- Allow the ACOs to establish relationships with community-based organizations, care coordination entities and other organizations or individuals that can help them engage members; the State should not be overly prescriptive in approach.
- The ACOs should be held accountable for innovative, in-depth member education and outreach to ensure individuals have the tools and information to be better consumers. This accountability could be measured by a new VIS measure, through a survey of members, or through other means.

Provider Support and Ensuring a Sufficient and Appropriate Workforce

The ACOs should be responsible for providing technical assistance and training and support to staff and providers to ensure they have the knowledge and skills to operate effectively in the new value-based system. Models of care provided through the ACO structure should be developed using a team-based approach to serving vulnerable or high needs/high cost populations. Just having more physicians will not improve access nor will it reduce total cost of care. Successful care coordination models use Integrated Care Teams that include the primary care physician, key specialty providers, a nurse care manager, social worker, health educator or community health worker, nutritionist, pharmacist and behavioral health specialists as needed. Many of the services and supports needed by complicated, complex patients are not medical services; affordable and safe housing, transportation, adequate meals, and access to community supports and activities can be just as important and impactful to a Medicaid client as a visit to the doctor. Moreover, re-thinking who provides the care (i.e. a social worker or nurse practitioner might be more adept at care coordination and identifying social supports than a doctor) has the potential to mitigate access to care challenges resulting from medical provide shortages.

In addition to re-thinking who provides care the State and ACO partners should continue to support and build on the multiple initiatives underway to address workforce challenges.

Creation of a Reinvestment Fund

During the last round of workgroup meetings, members expressed support for the idea of a reinvestment program, similar to the program currently in place as part of the Iowa Plan. With this program, the Medicaid Behavioral Health Care Managed Care Organization is required to set aside money to support innovation and priority objectives. It was recommended that the ACOs and the State be required to contribute some portion of any realized savings into a fund in order to make longer-term investments into the community. Although no specific uses of the money were articulated, there were suggestions that the focus be on making adjustments to longer-term cost drivers. For example, ensuring the health and proper development of children will have tremendous savings in a few decades (rather than a few years). Alternatively, the fund could be used to support innovation in the ACO delivery system.

Timing of Implementation

The SHIP is a five-year planning document. It will include specific dates and an implementation plan with "go no-go" triggers as well as mitigation strategies that will be employed as barriers emerge and plans are adjusted.

The following are the proposed high-level dates. These dates are not finalized and are subject to change but are designed to provide concrete milestones and ensure the ACO model is fully implemented.

- December 30, 2013: SHIP due to CMS
- January 1, 2014: Iowa Health and Wellness Plan members begin receiving services and Wellness Plan ACOs begin providing care.
- Spring/Summer 2014: State issues a Request for Information and assesses responses
- Fall 2014/Winter 2015: State issues Request for Proposals for ACOs that will provide physical health and behavioral health care services within a pre-established region
- Winter/Spring 2015: State selects regional ACOs and begins implementation planning
- January 2016: ACOs begin serving all Medicaid members (except for those with Developmental Disabilities)
- January 2017: ACOs assume cost of care responsibility for LTCSS and BH services
- State Fiscal Year 2020: ACOs are fully capitated.