Iowa Department of Human Services

Iowa State Innovation Model (SIM) Behavioral Health Integration Workgroup Summary of Suggestions and Discussions

The recommendations included reflect the work of the Behavioral Health Workgroup and may not reflect the position of the Governor's Office and the Department of Human Services.

October 2013

Table of Contents

Executive Summary

The State of Iowa has been developing a State Health Care Innovation (SHIP) - the multi-year plan that ensures the State achieves its goals of lowering health care costs, improving the quality of health care for Iowans, and improving health outcomes for Iowans. Stakeholder engagement and involvement are core tenets of the State Innovation Model (SIM) grant that the State received from the Centers for Medicare and Medicaid Innovation and the State has undertaken an extensive and comprehensive approach to involving all stakeholders in the SIM design process.

In order to ensure attention and feedback on the key strategies outlined in the original grant proposal and to support the State in developing a framework for the Accountable Care Organization (ACO) model, the State developed four workgroups, one for each key strategy. These workgroups are: Metrics and Contracting; Behavioral Health Integration; Long Term Care Supports and Services Integration; and Member Engagement. All workgroup meetings were open to the public and agendas and minutes were posted to the DHS website, as were other supporting resources.

Each workgroup met four times for two hours, over the course of two months. The first meeting was primarily focused on providing information to workgroup members about the project, the context and their roles. The next three meetings were focused on discussing and developing recommendations for transforming Iowa's health care system that would be considered for inclusion in state's SHIP.

This report provides a summary of the original reference report provided to the Behavioral Health Integration Workgroup, and details about questions that were discussed in the meetings. Additionally, recommendations and suggestions generated by the workgroup members and meeting attendees are included in this report.

Overview of Approach

The State of Iowa has been developing a State Health Care Innovation (SHIP) - the multi-year plan that ensures the State achieves its goals of lowering health care costs, improving the quality of health care for Iowans, and improving health outcomes for Iowans. Stakeholder engagement and involvement are core tenets of the State Innovation Model (SIM) grant that the State received from the Centers for Medicare and Medicaid Innovation and the State has undertaken an extensive and comprehensive approach to involving all stakeholders in the SIM design process.

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These workgroups are:

- *Metrics & Contracting*: Chaired by Tom Evans, this workgroup was tasked with developing recommendations and goals around the structural arrangement of the ACOs, payment provisions and metrics and measures to use.
- *Behavioral Health Integration:* Chaired by Rick Schults, 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*: Chaired by Donna Harvey, 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.
- *Member Engagement*: Chaired by Chris Atchinson, this workgroup was tasked with developing goals and recommendations about approaches to engaging members in their own care and encouraging them to be active participants in becoming healthier. There was also discussion about how to include and incorporate the strengths of the public health system in order to address population health and achieve the Governor's Healthiest State Initiative.

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. Meeting materials were posted on the IME SIM website, including reading materials for work group members to read before meetings, meeting agendas and meeting minutes. 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, an introduction to the ACO concept, an overview of the regional approach which will be part of the ACO model, and use of a competitive procurement process which will included multiple steps, including a Request for Information and Request for Proposals

- Workgroup meeting #2: Analysis and discussion of what works in the system of focus (LTC, BH, etc.), what does not 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.

Prior to the first meeting, the SIM team developed a reference report for each workgroup. The Behavioral Health Integration paper provides an overview of the current state of Behavioral Health (BH) in Iowa, the preferred future state, key considerations based on lessons learned from other states, and examples of approach other states are using. At the end of the reference report there were a series of questions that guided the discussions during workgroup meetings 2, 3 and 4.

Report Purpose

This Behavioral Health Integration Workgroup report summarizes the original reference report as well as the workgroup discussions and suggestions. The recommendations included reflect the work of the Behavioral Health Integration Workgroup and may not reflect the position of the Governor's Office and the Department of Human Services.

Overarching Principles and Goal

The Accountable Care Organization model provides an opportunity to transform Iowa Medicaid into a patient-centered system that provides more coordinated and integrated care, improves the patient experience of care, achieves better health outcomes, and reduces cost by coordinating care, providing services in the right place at the right time and reducing rates of inappropriate utilization (for example, non-emergent use of emergency rooms and avoidable hospital readmissions). IME's overall vision is to implement a multi-payer ACO methodology across Iowa's primary health care payers.

It is critical to the success of an ACO model that the model is able to integrate and coordinate care across systems of care, including behavioral health and physical health care services. The inclusion of behavioral health services into the ACO value-based framework will help increase this coordination and integration, help improve communications between physical health and behavioral health care providers, and help ensure that Iowans are getting both the physical health care and behavioral health care services they need.

In developing the ACO model, the State's goals relative to behavioral health services are to:

- Increase integration of behavioral health and physical health care services, using the ACO model:

- This integration will result in more patient-centered care, improved patient experience of care, and better health outcomes, and reduced cost.
- This integration will also result in improved care coordination for patients and improved communication between different providers, resulting in better care and better health outcomes.

- Continue to solicit stakeholder input throughout all phases, including planning design, development, implementation and on-going monitoring

Current ("As Is") State

The current system for Medicaid enrollees, called "the Iowa Plan" uses a statewide Medicaid Behavioral Health Organization (BHO) model with Magellan Health Services as the provider of behavioral health services to almost all Medicaid beneficiaries. Behavioral health care services are "carved out," meaning they are provided separately from physical health care services through a different network of providers. This behavioral health "carve-out" is operated under a 1915(b) waiver, with mandatory enrollment for Medicaid beneficiaries.[1] Services provided under the plan include: ambulance, clinic services, detoxification, home health, inpatient mental health, inpatient treatment for substance use disorders, laboratory, mental health outpatient, outpatient treatment for substance use disorders, and X-ray. Magellan also manages substance abuse services. There are about 30,000 adults in Iowa with serious and persistent mental illness (SPMI) and about 16,000 children and youth with a diagnosis of seriously emotionally disturbed (SED) statewide.[2]

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

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[1] The sections of Title XIX of the Social Security Act that were waived are: 1902(a)(10)(B) Amount, Duration and Scope; 1902(a)(23) Freedom of Choice; 1902(a)(4) Proper and Efficient Administration of the State Plan.

[2] SPMI is defined by the following diagnosis categories: psychotic disorders, schizophrenia, schizoaffective disorder, major depression, bipolar disorder, delusional disorder, obsessive-compulsive disorder. Serious emotion disturbance (SED) means a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet DSM diagnostic criteria.

Another aspect of the behavioral health care system in Iowa is the Integrated Health Homes project. Starting on July 1, 2013, Integrated Health Homes became available for adults who meet the criteria for serious mental illness (SMI) or children who meet the criteria for a SED. Health homes were initially rolled out in five Iowa counties: Linn, Polk, Warren, Woodbury and Dubuque for children (adults in Dubuque will begin January 1, 2014). The remaining Iowa counties are being phased in over the next 12 to 18 months; an expansion occurred effective October 1, 2013. The Integrated Health Homes provide care coordination through a team of professionals including access to Family and Peer Support services, and 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, child health specialty clinics, etc.

Future State ("To Be" State)

The State is developing ACOs that will be multi-payer and be modeled after Wellmark's new program for commercially-insured individuals. Wellmark is currently working with health systems across the state and makes payments to the ACOs that are in addition to Fee for Service (FFS) payments. The additional payments and are comprised of a shared savings component and a quality incentive payment. To qualify for any shared savings payment opportunity, certain measures must be equal to or better than the target. Measures that trigger the shared savings opportunity are in the Value Index Scores (VIS). Shared savings are not applicable until year three.

The quality measures are in seven 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

The State will use this value-based framework as the foundation for all services and will expand it to integrate BH. All Medicaid members will be enrolled in the ACO program - only those individuals with intellectual disabilities will be excluded initially. It is possible the State will consider phasing-in ACO responsibility for BH service costs over time. As part of the ACO model, the State will augment the VIS with measures that will support care coordination of all services (including medical and behavioral) and a comprehensive whole-person approach to caring for individuals needing behavioral health services. In addition, the State envisions that payment and contracting structures will support and encourage improved coordination of service delivery across behavioral and physical health, and also with long term care supports and services.

The model implemented will build upon the IHH structures and will align with the current efforts and activities to redesign the MHDS system.

Key Considerations in Integrating BH

Many states, counties, regions, and systems have implemented or piloted methods of integration of behavioral health and physical health, with improved coordination between all of those entities. These pilots have demonstrated that any selected option needs to address the following core elements, many or all of which can be enforced by state purchasing contracts include:

- aligned financial incentives across physical and behavioral health systems
- real-time information sharing across systems to ensure that relevant information is available to all members of a care team
- multidisciplinary care teams that are accountable for coordinating the full range of medical, behavioral, and long-term care supports and services, as needed
- competent and adequate provider networks
- mechanisms for assessing and rewarding high-quality care.

Additionally, these pilots of integration and increased coordination of care have demonstrated that the following are essential elements for clinical integration of behavioral/physical health at the point of care:

- comprehensive physical and behavioral health screening
- beneficiary engagement
- shared development of care plans by the beneficiary, caregivers, and all providers
- care coordination and navigation support for clients in navigating the different health care systems.

Options to Create an Integrated System

To create a system that integrates behavioral health and physical health, it is important to consider ways to integrate both the delivery of care (delivery system reform) and the payment for services (payment reform). Some models for integration focus on integrating one or the other, while some focus on both.

Generally, methods of integration fall into one of the following categories, and some of these have been tested widely enough that we have some solid lessons learned and some indications of their level of promise to meet the goals of improving health outcomes, patient experience of care, and patient access, while also reducing cost or improving efficiency.

Option 1: Add Management of Behavioral Health Services to an Existing MCO

One model is to add the management of behavioral health services to existing Managed Care Organization contracts that have typically only managed physical health services. In the new contracts, the Managed Care Organizations would be paid for managing behavioral health services also, and would be required to ensure that these services are provided. While this type of integration focuses primarily on a payment reform approach, a goal of the payment reform is to better integrate services. This can be a good option for states that have behavioral health services “carved out” and have managed care organizations that are functioning well and have capacity to add behavioral health services to their scope of services.

There is less experience with this model for people with SPMI than for people with fewer behavioral health needs. One benefit of using this model is that the same organization is responsible for and accountable for a more comprehensive set of benefits for the client, which

can result in greater integration and coordination. This type of integration can be achieved by integrating benefits within existing MCOs or by contracting with "specialized" MCOs that have capacity to provide the necessary behavioral health services to SPMI populations.

This model does not utilize Accountable Care Organizations. Rather, MCOs begin to manage both physical health care and behavioral health care services.

Examples

Several states have implemented this model in some counties or regions, primarily on a pilot basis. In Tennessee, for example, the TennCare model is fully integrated, with all clients mandatorily enrolled in an MCO. In Washington State, the Washington Medicaid Integrated Partnership (WMIP) was implemented in Snohomish County in 2005, integrating physical health services with chemical dependency services, with mental health services and long-term care services integrated within a year. This pilot calls for voluntary enrollment of clients. In Minnesota, the Minnesota Preferred Integrated Network Program (PIN) is a partnership between a special needs plan (SNP) for dual eligibles with disabilities (Medica) and a county (Dakota County) to integrate Medicaid and Medicare primary care and behavioral health services.

Relevance for Iowa

This option may not be in alignment with IME's long term goals and plans because of the move toward an ACO structure of service delivery.

Option 2: Use Primary Care Case Management to Integrate Care

In this model, better integration of services is promoted and incentivized through a payment reform model that provides additional funding to primary care providers (PCP) that is used to provide better care coordination and care management functions, focusing on ensuring that behavioral health services and physical health care services are better integrated.

Part of the model includes supporting the development of community-based care teams to extend the reach of primary care provides. To make the model successful, an investment in health information technology is typically required, to support efficient and real-time exchanges of information, access to information about population health, and access to information about performance measures. An important part of the model is also the development of financial incentives that support integration.

This model can exist without an ACO, with the state essentially performing the functions that an ACO would provide. The state would provide enhanced funding to PCPs and require that these PCPs provide more care coordination and, therefore, better integration of behavioral health and physical health care services. However, in addition, the state would need to provide support to the PCPs by supporting their care coordination and integration efforts, helping to build new connections across systems of care, collecting and utilizing data, and supporting their efforts to be more accountable for quality, utilization, and cost.

Examples

North Carolina
North Carolina's Community Care of North Carolina (CCNC) is an example of a PCCM program and an integrated care entity. Since 2010, North Carolina has utilized an enhanced per member per month (PMPM) payment to support integration of behavioral health services into the 1,400 primary care practices in CCNC networks across the State. The enhanced payment is used to hire psychiatrists and behavioral health coordinators for each network, to promote integration at the local level. These staff build relationships with providers across systems, identify clients in need of care management, help clients navigate the systems, and support client self-management. They also help primary care providers with care management. As part of this work, IT systems were enhanced to add a behavioral health flags into an existing electronic care management tool to help identify clients who need extra support.

Vermont
Vermont has been working to integrate physical and behavioral health services as part of a statewide multi-payer initiative to transform primary care practices into patient-centered medical homes. Participating PCPs are required to obtain National Committee for Quality Assurance (NCQA) Physician Practice Connections–Patient-Centered Medical Homes recognition, and are paid a PMPM fee by all payers on a sliding scale based on their NCQA score. All payers also share the costs of Community Health Teams (CHTs) made up of nurse care managers, health coaches and other mental health providers.

Relevance for Iowa
This model could work for Iowa as a step toward an ACO model. However, in the absence of ACOs to provide support to PCPs, the state would need to perform the functions that ACOs typically perform.

Option 3: Add Management of Physical Health Care to an Existing BHO
Behavioral health organizations (BHOs) have specialized capacity around managing behavioral health services, particularly for individuals with SPMI. One option for integrating behavioral and physical health care services is to integrate management of physical health services into an existing BHO for clients with SPMI, with the state holding the BHO at full risk for managing all services. Often, existing BHOs have experience coordinating care for clients with SPMI and managing psychotropic medications. Care may be more aligned and seamless, and clients may be more engaged with their providers, making care management more effective. On the other hand, BHOs often have less experience coordinating physical health care services and may not have sufficient provider networks areas available to all clients. To date, no states have done this, but Arizona and Massachusetts are currently pursuing this model.

Example - Arizona
Arizona has begun to implement this model in Maricopa County. Under the model, one "specialty regional behavioral health authority (RBHA)" manages all physical and behavioral health services for Medicaid beneficiaries with SMI in the county, under the single authority of the State's behavioral health agency. This specialty RBHA is closely connected to newly authorized Medicaid health homes for individuals with SMI, enabling coordination and integration of physical and behavioral health care services at the provider level. Given that

approximately 50% of beneficiaries with SMI in this region are dually eligible for Medicaid and Medicare, the State further intends for the new specialty RBHA to be a Medicare Advantage SNP.

Relevance for Iowa

Iowa already has a statewide BHO (Magellan) that manages behavioral health services for all Medicaid clients with behavioral health needs. IME could consider adding management of physical health services to the existing Magellan contract, making it an MCO and at full risk for both physical health care and behavioral health care services for clients with SPMI who enroll with Magellan. However, this would be creating a different system for clients with SPMI, by having their physical health care managed while other clients remain in fee for service for physical health. It may be challenging to administer, and challenging to get CMS approval, and it may not be perceived as an equitable option.

Option 4: Promote Integration via Increased Financial Alignment between Existing Entities

For states that have carved out behavioral health services, want to maintain that carve out, and do not want to (or cannot) pursue the integration options noted above, it is possible to promote greater integration by creating aligned financial incentives across systems, using shared savings models. This model focuses on payment reform within the existing delivery system. This can be accomplished by developing performance measures that all systems are accountable to, and sharing savings with those entities when savings occur. For example, one performance measure might be reducing avoidable hospitalizations. If avoidable hospitalizations are reduced and cost savings result, all entities would share in these savings. An alternative to shared savings is a performance-based incentive program, with one or more incentives tied to activities that promote integration and/or outcomes that indicate successful integration.

Example - Pennsylvania

In 2009, Pennsylvania implemented shared incentive pool for physical health and behavioral health providers, as a two-year pilot in two regions of the state. Providers were eligible to receive incentives based on creating integrated care plans, doing joint risk stratification, coordinating management of medications, and providing real-time notification regarding hospitalizations. Additionally, partners were required to work together to identify clients who could benefit from integrated and better coordinated care.

Relevance for Iowa

Under this option, IME contracts with and performance measures for primary care providers would align with the BHO's performance measures. Payment would be tied to these measures, and shared savings requirements would be part of the contract requirements for both the providers and the BHOs. IME would take on the responsibilities of an ACO.

Option 5: Develop Accountable Care Organizations that Promote Integration

For states that have carved out behavioral health services, want to maintain that carve out, and do not want to (or cannot) pursue any of the above options, but want to provide more support to providers, developing ACOs is a good option. In this model, ACOs are responsible for ensuring care coordination for Medicaid enrollees, sometimes even hiring care coordinators; integrating care across hospitals, specialists, and social services; developing strong networks of providers; ensuring communication across providers; managing incentive

payments; assisting providers with access to and use of data; and supporting management of care across systems. As part of their responsibilities, they are accountable to ensuring that behavioral health services and physical health services are integrated. The ACOs work with primary care providers, BHOs, and behavioral health providers to ensure coordination and integration, and they are held accountable for outcomes.

Relevance for Iowa

Under this option, ACOs would be developed, with contracts that include performance measures that align with the BHO's performance measures. Payment for the ACOs would be tied to these measures, and shared savings requirements would be part of the contract requirements for both the ACO and the BHO. However, it may be important to develop an ACO with specialized experience with and capacity to serve clients with SPMI.

Workgroup Discussion Questions

Goals, Vision and Current State

In terms of behavioral health service delivery and outcomes:

1. What works well in the existing system?
2. What does not work well in the existing system?
3. What should the priorities or goals be for the new system?

Leveraging Existing Structure

4. How should Iowa leverage existing structures and designs of care delivery? How do those structures potentially need to change to meet Iowa's goals?

Statewide or Regional Structure, Providers, and Provider Network

5. If Iowa were to use an ACO model, how would behavioral health services be best integrated into that ACO system?
6. What are the potential challenges to integrating behavioral health services within an ACO model?

Financial and Measurement

7. How should such an ACO work financially?
8. What measures (to measure quality of care and patient experience of care) should be in place?

IT Systems Needs

9. How would health information technology need to change to support integration?

Providers, ACOs, and Work Force Concerns

10. What would be required of the ACO and providers to enhance integration across behavioral health and physical health care services?
11. Are there adequate providers available across the state? What work force needs exist?

Children, Dual Eligible Clients, and Other Special Populations

12. What specific needs or concerns are relevant for children with SED, for dual eligible clients, and for clients with intellectual disabilities?

Workgroup Suggestions

During the third meeting, the workgroup developed a series of suggestions. The SIM team created a table of these suggestions and emailed the documents to the workgroup members; they prioritized the suggestions to support the SIM team in developing the SHIP. As part of the response to the SIM team, workgroup members also provided comments on the suggestions. To ensure each workgroup was aware of the suggestions generated by other workgroups, all four documents were sent to all the workgroup members.

This following table identifies the category of suggestion and comment; a summary of written comments and priorities received between the third and fourth Workgroup meetings, and the number r of members selecting as a priority (members ranked their top 3 suggestion). **In the final column, green boxes mean three or more people indicated as a priority; yellow boxes mean two people indicated as a priority; purple boxes mean one person indicated as a priority; and white boxes mean no member prioritized that suggestion.** It should be noted that not all workgroup members provided an indication of their priorities.

Category	#	Suggestions Captured from Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number Selecting as Priority
Coordination	1	The ACOs should build off the Integrated Health Home model. ACOs should provide support to the IHHs in the areas of, for example, data support, networking, partnerships. The IHHs can provide good care coordination, but additional support from the ACOs would be beneficial	1) The mental health redesign workgroups for children and adults understood that engaging and supporting the chronically mentally ill populations is a specialized skill set that traditional medical providers had not been successful at developing accessible and responsive services for the mentally ill. Knowing this, the State leveraged the ACA health home for special populations to address the need for health homes that would engage and support people with mental illness. The state, Magellan, and private providers have invested in IHH and are in the beginning phases of implementation, with every reason to expect IHH will transform the work and improve the consumers experience and outcomes. The IHH is not just the next fad or next shiny new thing; care coordination is the approach public sector child and adult mental health providers have attempted	

Category	#	Suggestions Captured from Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number Selecting as Priority
			to work for years without reimbursement or formal systems to support it. 2) IHH Model should be the central point but with changes as it evolves. 3) The system should be required of all payers, be patient centered and holistic; with adequate reimbursement for the care coordination function.	
Coordination	2	There should be one primary point of contact for patients since relationships and trust are very important. Care coordination should be provided by the provider with which the client is most comfortable and with whom there is a "natural fit".	Consumers do not have the time or energy to figure out on an issue by issue basis who they should contact; they need one person who will link them to what they need. The need an entity willing to take on this role and the accompanying responsibility for working closely with all services and supports.	
Coordination	3	There needs to be integration/ coordination of services at the county level and local level and social services and medical services are aligned.		
Regulatory	4	The State should permit a safety net ACO to form.	This is a special population with unique needs.	
Regulatory	5	The State should require that some savings be reinvested into the community to support innovation (similar to the current BHO reinvestment strategy)		
Financing	6	The State should include additional non-medical risk factors in the risk-adjustment calculation. These could/should include homelessness status or other social determinants of health. Using measures of social determinants of health for risk adjustment may be something to work		

Category	#	Suggestions Captured from Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number Selecting as Priority
		toward in the future, but it may be possible to utilize these measures more quickly in developing appropriate care coordination plans for individuals.		
Financing	7	There has to be enough money to support the changes being required/requested	There has to be a commitment from the State to fund.	
Measures	8	There should be a Core Set of Measures that all ACOs use. There should be several behavioral health measures included in the Core Set of Measures (these might be focused on outcomes such as housing, employment rate or other quality of life measures).	1) These measures should be tied to provider payment for all payers, inclusive of BH measures, and inclusive of social determinants of health for children, adults, older adults; 2) There should be a patient satisfaction engagement survey.	
Measures	9	The State should require that ACOs conduct a wellness survey, or patient satisfaction/engagement survey		
Provider Support	10	The ACOs should support providers in adapting to the new models and expectations		
Patient Support	11	There should be a Medication Reconciliation program but it should be very patient-centered (with a focus on educating patients about their medications). This should include a focus on ensuring that providers are aware of all medications an individual is taking; using evidence-based practices to ensure the right medications are being prescribed; ensuring patient compliance with medications; and developing, disseminating, and using guidelines for medication regimes. ACOs should be		

Category	#	Suggestions Captured from Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number Selecting as Priority
		required to develop and implement plans to support solid medication management.		
Benefits/ Patient Supports	12	The additional behavioral health services that are currently provided should be retained but there should also be opportunity for assessing whether new benefits are needed with an eye toward using evidence based innovative approaches and expanding existing service types where there is lack of timely access.	1) ACOs need to have standards for access to MH/SA services. Unlike medical specialties where sometimes children and adults can delay seeing a specialist while still receiving care from the PCP, MH/SA issues require timely access or the individual decompensates and the damage done by delaying services is devastating in terms of human and financial cost. 2) Risk factors considered need to reflect how to assess the need for both level of care as well as timeliness of access. If this were required from the outset, the ACOs would need to map the projected need and available services to identify gaps and build their plan of expansion of existing services and development of new services.	
Other/ Partnership Requirements	13	21 (90%) of the 23 Iowa Plan IDPH-funded substance abuse treatment providers must be included in the Medicaid ACO provider network(s) for the 1st three ACO operational years.	(23 contracted providers as of January 1, 2014.)	
Other/ Partnership Requirements	14	At least 90% of the "top" Iowa Plan Medicaid-reimbursed substance abuse treatment providers must be included in the Medicaid ACO provider network(s) for the 1st 3 operational years. "Top" is defined as those providers who, in aggregate, provide 75% of the Iowa Plan substance abuse treatment that is reimbursed by Medicaid, as measured by both a) dollars paid and b) number of enrollees	(Contracted providers as of January 1, 2014; utilization data for the previous 3 Iowa Plan contract years – July10-June11, July11-June12, July12-June13.)	

Category	#	Suggestions Captured from Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number Selecting as Priority
		served.		
Other	15	Establish at least 1 Medicaid Integrated Health Home with an Iowa Plan IDPH-funded substance abuse provider, specific to substance abuse and another chronic condition.		
Other/Benefits	16	Benefits/ continuum of care should span across age, across the span of wellness and should be inclusive of families	1) This opens access to services in a person centered system. 2) For mental health the State should look to the NAMI array of services for adults and children 3) There should be specific measures to assist during key transition periods-child to adult, adult to older adult 4) There should be medical level of services consistently built upon and through other payers	
Other/Provider Support	17	Providers need training, coaching, and education	This involves several things: a pediatric model, an adult model, and an older adult model – all of which include patient and family education and engagement.	

Additional Suggestions Received Outside of Workgroup Meetings (Not Part of Priority Process)
There was support for the idea of a Transformation Center that would help disseminate lessons learned and provide support to providers and ACOs
There was support for the idea of a “Community Reinvestment Fund” that would support innovations using a small percentage of shared savings
Services for people with SPMI should not be carved out of the overall system. However, the ACOs should work with providers to ensure that people with SMI can get care in the most comfortable setting, the setting that is the natural fit. ACOs should provide support to providers as they try to engage people early and intervene early.
There should be IT/HER support for BH providers.
The State should help transition providers into the new system (financially). Small providers may not be able to take financial risk initially.
Services for people with SPMI should not be carved out of the overall system. However, the ACOs should work with providers to ensure that people with SMI can get care in the most comfortable setting, the setting that is the natural fit. ACOs should provide support to providers as they try to engage people early and intervene early.

Sources

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