Project Narrative

1. PLAN FOR IMPROVING POPULATION HEALTH

Although Iowa generally enjoys high national health rankings, many opportunities exist for improvement in health status. Studies prior to the Medicaid Expansion showed a relatively low percentage (42.9%) of adults that access preventive health services in Iowa, and a low ranking in the category of health equity, an area of increasing focus as Iowa's diversity increases. Health disparities were especially high related to income, race, and ethnicity, with 68.5% of low-income adults unable to access recommended primary care, a rate about 25% higher than the overall state total and a primary driver for Iowa's Medicaid expansion.

Populations that live in rural communities often suffer from poorer health status. This disparity is frequently a result of fewer providers and resources. Currently, "access to services" is one of the most commonly identified categories of need in Iowa counties. Addressing disparities between rural and urban areas is a significant reason for implementing Accountable Care Organizations (ACOs), and the Iowa Medicaid Enterprise (IME) expects that ACOs will naturally facilitate a focus on the areas of greatest need, while capitalizing on local strengths.

Iowans have slightly higher rates of adult obesity (30.4%, compared with 28.1% nationally) and higher rates of adults not meeting physical activity recommendations (82.8%, compared with 79.1% nationally). About one in two youth are not getting the suggested amount of exercise and physical activity. In the Community Health Needs Assessment (CHNA) and Health Improvement Plan (HIP) conducted by the Iowa Department of Public Health (IDPH) in 2011, 3/4 of the counties cited obesity and weight status as a priority need, but only 63 counties said

they were addressing this need.[1] Despite the widely known link between diet, access to nutritious foods, and obesity, only seven counties cited nutrition as a priority, and three counties cited food access. In 2010, 16 of every 100 adults smoked cigarettes. People with lower incomes and less education are also more likely to smoke,[2] thus, many of the individuals with the least access to health care are also those most likely to be smokers. The Medicaid program also covers higher rates of chronic illness than the general population. The top 5% high cost/high risk Medicaid members have an average of 4.2 chronic conditions, receive care from five different physicians, and receive prescriptions from 5.6 prescribers. They account for 90% of all hospital readmissions within 30 days, 75% of total inpatient costs, and 50% of prescription drug costs.[3]

In its 2011 CHNA and HIP, IDPH defined the health needs of Iowans in accordance with Healthy People 2020 categories, outlined 39 critical health needs across nine domains, and identified strategies to positively impact all of them.[4] In addition to the activities of IDPH and local public health agencies (LPHAs), Governor Branstad has implemented The Healthiest State Initiative[5] – a privately led, publically endorsed initiative which requires partnership between the public sector, individuals, families, businesses, faith-based organizations, and not-for-profits to improve healthy behavior within communities. Wellmark Blue Cross and Blue Shield (Wellmark), the State's largest health insurer, sponsors The Blue Zones Project,™[6] a communi-

[1] Iowa Department of Public Health, Understanding Community Health Needs in Iowa, Understanding Community Health Needs Assessment and Health Improvement Plan, 2010-2011.
[2] Iowa Department of Public Health (2011). *Tobacco Use in Iowa: Supplement to the 2009 Iowa Chronic Disease Report*.
[3] Iowa Department of Human Services. Improve Iowans' Health Status. State budget documents. August 2013
[4] http://www.idph.state.ia.us/adper/healthy_iowans_plan.asp.Accessed June 2014.
[5] http://www.iowahealthieststate.com
[6] Additional information is available at http://www.bluezonesproject.com/.

ty-by-community well-being improvement initiative to make healthy choices easier through permanent changes to environment, policy, and social networks.

Because ACOs envisioned in the SIM include all three major payers – Wellmark, Medicaid, and Medicare, covering 86% of Iowans – they also represent a powerful opportunity to improve population health by integrating public health providers with acute care service delivery systems, and leveraging attributes such as value-based incentives, community-driven care, and a culture of accountability.

IDPH has developed specific population health improvement initiatives within six priority areas that target ACOs and local delivery systems, and open opportunities to integrating health care services and public health initiatives. Not every initiative may be applicable to every local delivery system. In some cases, the goal will be to build capacity within the ACO to accomplish population-based interventions; in other cases, the LPHA will provide resources and collaborate with the ACOs through a community health worker/care coordination model. One of the benefits of ACOs is they are organically-derived from local communities and are able to leverage the diversity and strengths of each local delivery system. During the SIM Initiative, IDPH will draw together an expert panel to expand upon the state-wide Heath Improvement Plan to improve population health, and use that to guide SIM activities. Specific initiatives have already been identified (Table 1), along with major efforts to train ACOs in the tools, processes, resources, and culture of public health. IDPH, with assistance from the Iowa Health Collaborative (IHC),[7] will implement these initiatives and monitor their outcomes. Data collection and analysis efforts will focus around existing data such as the Behavioral Risk Factor Surveillance Survey

[7] IHC is a non-profit organization working with the healthcare delivery system on rapid-cycle performance improvement.

(BRFSS), hospital discharge data, and additional data collection efforts when required. Whenever possible, LPHAs will facilitate the connection between ACOs and other community-based health improvement efforts.

Table 1: Population Health Initiatives

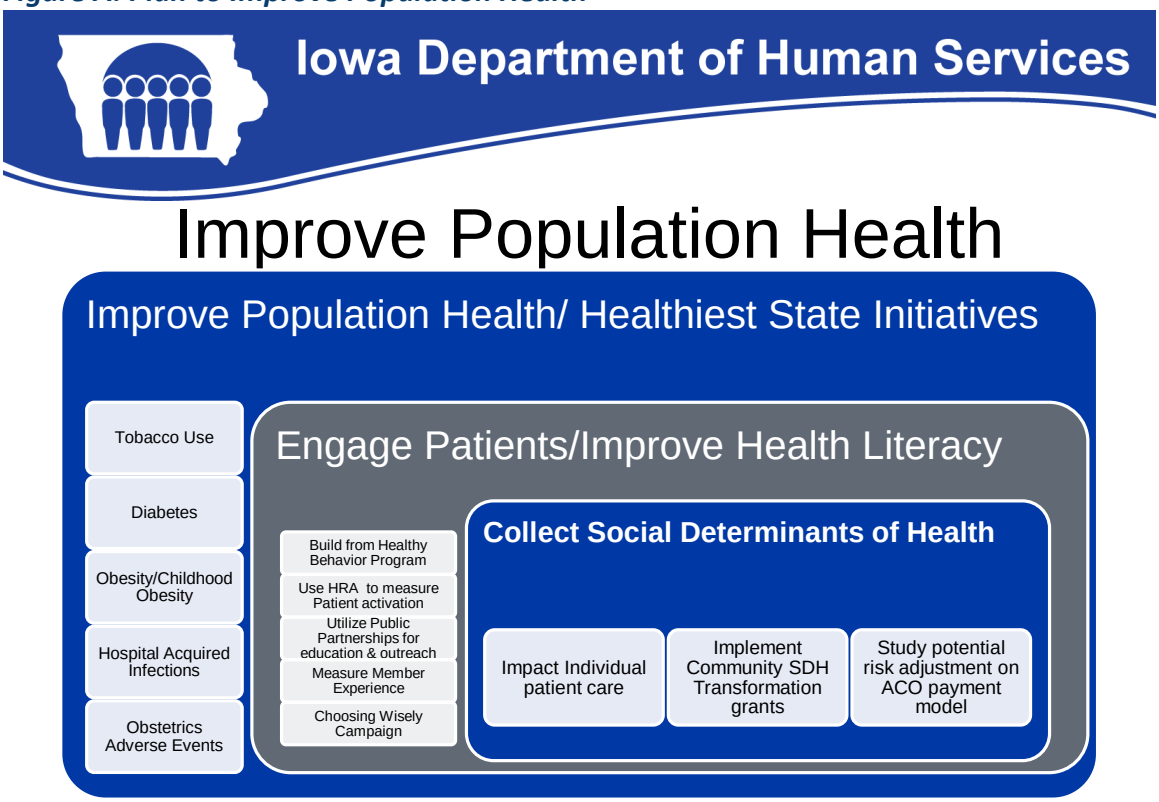
Community Interventions	Measurements
Target Condition: Obesity	
Healthy eating prescriptions and referral program for intensive dietary counseling	Change in average BMI for ACO enrollees
Improve environments that support healthy eating; educate providers on local resources	BRFFS data of adults eating recommended fruits and vegetables
Improve environments for active living; educate providers on local resources to support physical activity	BRFFS data of adults achieving physical activity recommendations
Promote BMI assessment among providers	% of children and adults with BMI assessment
Target Condition: Patient Engagement	
Promote health literacy through community education, equipping patients with "Teach Back," "Ask Me 3," and "Choosing Wisely" tools	NQF measure of health literacy related to patient-centered communication
Prepare physicians to engage and equip patients through implementation of "Choosing Wisely," focusing on implementation of the "Iowa 5"	NQF measure of health literacy related to patient-centered communication
Target Condition: Tobacco Use	
Expand assessment of tobacco habits and promotion of Quitline and nicotine replacement therapy (NRT) through ACOs	BRFFS data for adults who have attempted to quit
Perform tobacco cessation media campaign	BRFFS data/adults who have attempted to quit
Clinical Interventions	**Measurements**
Target Condition: Obstetric Adverse Events	
Reduce early elective deliveries through provider and consumer educational campaign and promotion of early entry into prenatal care	Elective deliveries prior to 39 weeks gestation
Target Condition: Healthcare Associated Infections	
Expand existing programs for hospital and public education with improved coordination with LTCSS through ACO structure	Facility-wide Inpatient Hospital-Onset Clostridium Difficile Infection (CDI) Outcome Measure
Target Condition: Diabetes	
Promote diabetes education, self-management programs, and diabetes prevention programs	Number of patients with diabetes who have completed training. Percent of adults with

	diabetes with optimally managed risk factors
Medication Therapy Management (MTM) with local pharmacists and ACOs.	Percent of adults with diabetes with HbA1C above recommended level

Iowa has expanded Medicaid through the Iowa Health and Wellness Plan (IHAWP), which began on January 1, 2014, and provides comprehensive health care coverage to low-income, uninsured Iowans ages 19 to 64.[8] Part of the IHAWP is the Healthy Behaviors Program, which emerged as a SIM concept during the SIM Design and incentivizes all IHAWP members to work with providers to be healthy and stay healthy. Members who achieve the Healthy Behaviors requirements[9] will not be responsible for a monthly premium. Medicaid has designed payment levers for both the primary care provider and the IHAWP ACOs that align with the member healthy behaviors. Medicaid is using the AssessMyHealth HRA tool[10] developed by Treo Solutions.[11] The tool collects information about members' self-activation, social determinants of health (SDH), and basic clinical risk information that a provider can integrate into an individualized plan of care. Iowa will deploy resources within IME, LPHAs, and community based organizations like United Way and the YMCA, to assist IHAWP members to complete the Healthy Behaviors. The LPHAs will link members to community-based resources and will use the data collected through the HRA to define gaps and provide public health programming. Iowa will use the SIM rapid-cycle evaluation process to further develop the Healthy Behaviors requirements, expand the program to the full Medicaid population, and test the ability to collect, refine, and use SDH data to improve population health.

[8] Additional details regarding the IHAWP can be located at http://dhs.iowa.gov/ime/about/iowa-health-and-wellness-plan
[9] http://dhs.iowa.gov/sites/default/files/Provider%20Healthy%20Behaviors%20Toolkit_05092014_0.pdf
[10] AssessMyHealth.com is based on HowsYourHealth® (HYH), a health risk assessment developed by researchers at Dartmouth College and FNX Corporation.
[11] Treo Solutions is now a wholly owned subsidiary of 3M and a part of 3M Health Information Systems.

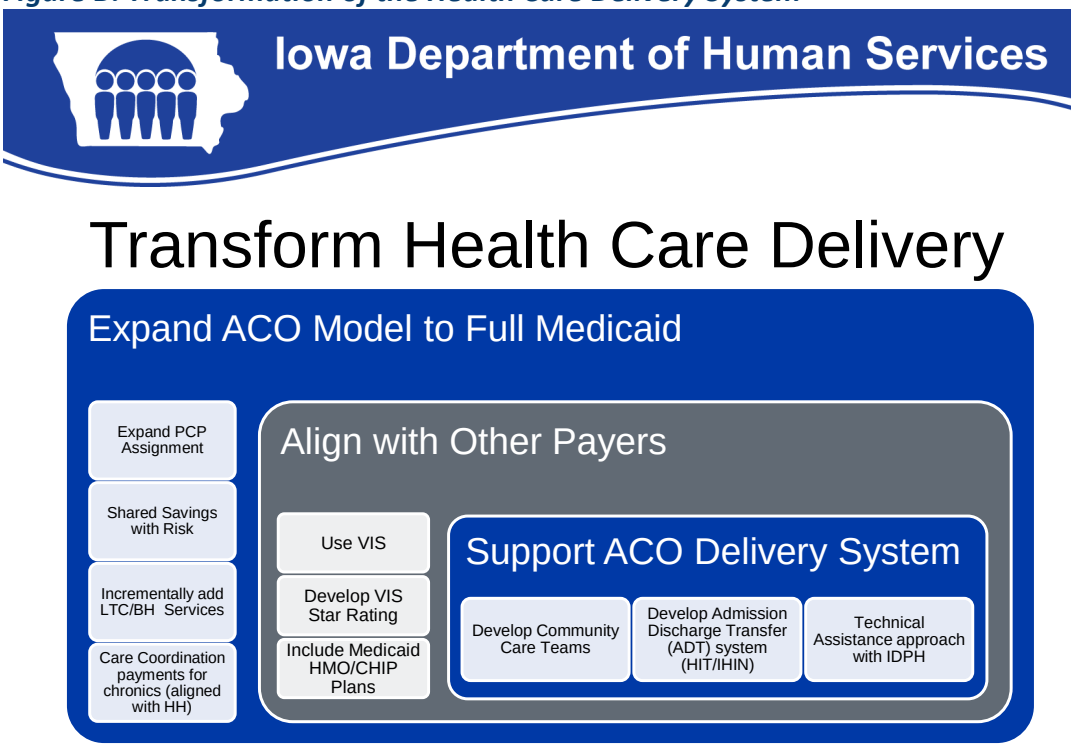
Figure A: Plan to Improve Population Health



2. HEALTH CARE DELIVERY SYSTEM TRANSFORMATION PLAN

Significant transformation has already begun in Iowa through the ACA expansion program, IHAWP. As of June 2014, IME estimates that there are 156,449 Iowans (5% percent of the total population of Iowa) who are eligible; to date, 110,000 have enrolled in IHAWP. Iowa will build on this framework to accelerate transformation to all Iowans through three mechanisms: Expanding the ACO model, aligning with other payers, and supporting the ACO delivery system to integrate with communities and social services to address the social determinants of health.

Figure B: Transformation of the Health Care Delivery System



IME has had three entities sign ACO agreements to serve the IHAWP population and has interest from others, including Federally Qualified Health Centers. The existing ACOs support moving into the Full Medicaid population as part of the SIM Initiative. IME anticipates that ACOs will be more responsive to community needs, address gaps in care, and remedy health disparities often found in lower income and rural areas of the state. The State has already set clear, aligned expectations with ACOs contracted within the IHAWP population. After these ACOs demonstrate their ability to ensure access and engage the IHAWP population in healthy behaviors, the model will be expanded to all Medicaid members. Full Medicaid ACO contracts, using guidance from stakeholders during the SIM model design, will involve partnerships with a broad range of community-based providers moving to a more organized delivery system that includes existing Chronic Condition Health Homes (HH), Integrated Health Homes (IHH), other

behavioral health providers (including both mental health and substance use), providers of long-term care services and supports (LTCSS), including nursing facilities, other facility-based care, and home and community based providers. These partnerships developed at an ACO level are a cornerstone to driving reform in the Medicaid delivery system. Members attributed to the IHAWP ACO have a primary care provider that acts as a medical home. Members are assigned to PCPs through an assignment methodology established and approved through CMS waiver authority. In the Full Medicaid ACO agreement, members will use the PCCM assignment process as well. Through SIM, Iowa will seek a waiver to move Medicaid FFS into the PCCM model of assignment so that all of the Medicaid population is assigned a PCP of their choice.

Initially, ACOs will coordinate care with existing BH and LTCSS; over time, ACOs will assume financial and clinical accountability for BH and LTCSS services. Core sets of ACO quality measures will be expanded in phases and include BH and LTCSS quality of care, access, integration with physical health services, and ratio of community-based vs. institution-based services.

Development of multi-payer ACOs is a key driver of system transformation. This maturing ACO foundation and multi-payer alignment represents a low-risk, high-reward investment of SIM testing dollars. ACOs with similar contracting and quality measurement systems across payers will provide the backbone of the transformation efforts. Together, Wellmark, Medicaid, and Medicare cover 86% of Iowans. Iowa's delivery system is characterized by a relatively small number of large entities that already work together, including several large health systems that deliver the majority of acute care services and employ more than half of the primary care physicians. This multi-payer foundation creates a powerful opportunity to align accountable payment structures to enhance providers' ability to achieve critical mass and catalyze transfor-

mation.

Both Wellmark and Medicare ACOs are operating in Iowa today. Medicaid has adopted Wellmark's approach to measuring performance: The Treo Value Index Score[12] (VIS). The State uses VIS with IHAWP ACOs and will use this for the Full Medicaid ACO program. In addition, IME is working with Wellmark to develop a star rating system based on VIS performance, similar in concept to Medicare, that will enhance transparency and competition. Through SIM, IME aims to partner with other payers involved in Medicaid to implement similar ACO contracts for CHIP and Medicaid HMO populations. Wellmark is one of the two CHIP commercial plans and uses an ACO model and VIS today. IME is already working with the Medicaid HMO, Meridian Health Plan, to implement the ACO model in the IHAWP population. There is potential to engage the plans covering individuals on the Marketplace. Table 2 shows the anticipated development of ACOs across the primary payers and demonstrates the scale that Iowa's delivery system will achieve. Once critical mass is achieved, all Iowans benefit from the transformed system.

Table 2: ACO Diffusion	**2014**	**2015**	**2016 (Yr. 1)**	**2017 (Yr. 2)**	**2018 (Yr. 3)**
Medicaid ACO Enrollment					
Number of Systems in an ACO	7	8	9	10	10
Enrollees	26,000	39,000	200,000	300,000	300,000
Percent of Total Medicaid	4%	5%	21%	42%	42%
Total PCPs Participating	569	600	1200	1300	1300
Commercial ACO Enrollment					
Number of Systems in an ACO	8	10	11	12	12
Enrollees	476,000	483,000	491,000	519,000	519,000
Percent of Total Wellmark	37%	38%	38%	41%	41%
Total PCPs Participating	1584	1625	1625	1650	1650
Medicare ACO Enrollment					

[12] VIS is an aggregated score of seven domains and is explained more fully in Part 7.

Table 2: ACO Diffusion	2014	2015	2016 (Yr. 1)	2017 (Yr. 2)	2018 (Yr. 3)
Projected[13] Enrollment	63,240	68,510	73,780	79,050	89,590
Projected[14] ACO Coverage for Medicare Population	12%	13%	14%	15%	17%
ACO Delivery system Penetration in Iowa					
Percent of Iowa Primary care in an ACO	72%	74%	74%	75%	75%
Total Iowans in ACO	565,240	590,510	764,780	898,050	908,590

Currently, one commercial payer is committed to participating in this payment model, Wellmark, which accounts for 41% of the Iowans who are covered by commercial insurance. Other commercial payers are likely to commit to the model, including United Health Care, which is entering into the ACO model with Iowa provider systems in the fall of 2014. The state is also actively working with Meridian Health Plan of Iowa to enter into a similar payment and quality model for the Medicaid population they serve in Iowa.

Roughly 72% (1584) of the primary care providers are operating in an ACO currently. The state expects that number to grow to 75% (1650) of primary care providers over the next four years.

The numbers identified in the ACO Diffusion Chart are an example of members projected to be attributed to an ACO during the four year grant. In the Project Abstract, the State references that this grant will impact the health of all Iowans, (approximately 3.1 million). Specifically, the state makes this statement based on the adoption of the ACO payment model by over 75% of the primary care providers, and most major hospital based systems in the state. This rate of adoption and the fact that three major payers in the state participate in the ACO model allows providers to get to scale. Getting to scale is the tipping point where provider systems improvements impact every patient and not just patients attributed to the ACO payment model.

The need to support ACOs and hold them accountable for addressing the SDH emerged

[13] Using https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PioneersMSSPCombinedFastFacts.pdf as the starting point for and projecting a5% increase in covered lives over the testing period.
[14] Derived from projected percent of Medicare population in an ACO based on https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PioneersMSSPCombinedFastFacts.pdf.

as an important theme in every workgroup during the model design phase. The SIM Initiative will address the SDH in three ways: first, by developing improved community infrastructure and linkages through community-based transformation activities, as well as integration from public health to support healthy lifestyles (as described in Part 1); second, through practice transformation activities that provide healthcare providers and systems with the knowledge and tools to evaluate the SDH and address them as a routine part of the healthcare encounter; and third, through developing risk adjustment payment structures that provide additional resources for members significantly impacted by the SDH (described further in Part 3).

Iowa has already engaged in significant practice transformation activities around HH (primary care based) and IHH (focused on seriously mentally ill adults and children) models of care. The State views the HH and IHH programs as core building blocks for successful ACOs in the Medicaid population, driving transformation at the primary care level. ACO contracting is a significant lever that drives transformation from the top down. There are already 40 primary care health homes in 29 counties offering health home services in 79 different clinic locations. Patient-Centered Medical Home (PCMH) recognition is a requirement of this program. There are 32 community IHH providers providing coverage statewide. Through engagement in learning collaboratives, webinars, and coaching, both health home programs have begun to substantially reduce ED utilization, and the IHHs are seeing a decrease in psychiatric admissions.

Recognizing this practice transformation effort, the SIM Initiative will provide significant support for ACOs and public health/primary care integration. The IHC is one of the 26 organizations working to implement the Hospital Engagement Networks (HEN), a CMMI-sponsored, nationwide public-private collaboration, which has achieved success in healthcare delivery system

transformation and health outcomes improvement in Iowa. Through its learning collaborative model, IHC has engaged community-based healthcare providers from across Iowa in rapid-cycle improvement opportunities which have resulted in changes in effectiveness for the hospital-based delivery system. Building on this success, the SIM Initiative will expand these quality improvement processes to the entire spectrum of care offered through the ACOs. This process will focus on aligning resources toward a common vision that expands current healthcare delivery into the community setting, developing local champions to serve as faculty of best practice, and aligning measurement strategies to track community progress toward population health initiatives. Onsite technical assistance will be offered to create enhanced processes of care to better serve vulnerable or high needs populations, create pathways for integrating the ACOs with community-based services, promote the use of SDH data for development of community health interventions, and develop learning communities and practice transformation teams. As part of the transformed system, the Medicaid ACOs will be responsible for the training and support of staff and providers to ensure they have the knowledge and skills to operate effectively in the new value-based system. The natural, competitive nature of value-based reimbursement will drive the urgency for the ACO to embrace technical assistance and speed workforce development. The technical assistance offered by IHC and proposed in the SIM will equip the ACOs to take on this responsibility.

The SIM Initiative will test the provision of a shared support system through the development of Community Care Teams. Community Care Teams will act as a platform to connect ACOs to resources available in the community and will ignite the population health strategies outlined in the SIM. In addition, community care Teams provide an opportunity to partner with

hospitals or physician clinics not contracted in an ACO, to ensure smaller providers are able to participate in new care models. Currently, there are two pilots in Iowa legislatively supported in rural communities, which builds the foundation needed to support ACOs and their communities. IME, in partnership with IDPH, will monitor and do a rapid cycle evaluation on the success of these pilots, and through SIM, will test expanding to other areas of the State so that statewide access to a Community Care Team is available.

Successful transformation of the healthcare delivery system requires an adequate and appropriately trained workforce. Growing competition between ACOs should generate new workforce models that utilize lower levels of licensure. Expanding the team to include social workers, pharmacists, community health workers, nurses, and others, will mitigate access to care challenges resulting from medical provider shortages. During early SIM workgroup meetings, ACOs indicated that they have already begun re-training their workforce to engage in team-based care, telehealth, and practices that support a more effective system. IME supports the use of telemedicine and will work to identify levers to expand workforce reach.

IDPH coordinates public and private efforts to develop and maintain an appropriate health care delivery infrastructure and a stable, well-qualified, diverse, and sustainable health care workforce. As the community-based learning collaborative begins their work, IDPH will monitor case studies on the execution of health improvement around the deployment of workforce resources, and share with others to demonstrate cost-effective approaches. IDPH also manages a variety of loan repayment and recruitment and retention programs supporting community delivery systems and will use the case studies to better inform policies.

3. PAYMENT AND/OR SERVICE DELIVERY MODEL

A value-based payment model closely aligned with Wellmark and similar to Medicare is a key strategy in Iowa's SIM. The ACO Payment Model for the Full Medicaid population describes an aligned approach. Through iterative stakeholder engagement venues and data analysis, IME has fully developed a payment approach that details all of these key features.

Key Components of Payment Structure in the Full Medicaid ACO:
PCPs receive a PMPM for all attributed/assigned patients with two or more chronic diseases; the payment will be greater for PCPs working in an accredited PCMH ($27 vs $22). Approximately 30% of the PMPM will be held back as a quality incentive tied to VIS outcomes.
PMPM targets will be set based on a CPI PMPM target and/or a Trend Target PMPM. (CPI will be used when it is higher than Trend.)
There will be set risk/reward levels with limited down-side risk starting in year one in order to advance the ACOs more quickly towards capitation.
Measures are clinically risk-adjusted according to Treo Solution's methodology and used for both Medicaid and Wellmark ACOs.
Industry proven measures are clinically risk-adjusted using 3M HIS tools, used by Treo Solutions for both Medicaid and Wellmark ACOs.
% of shared savings to the ACO based on risk/reward level selected and level of achievement over the savings target. Shared savings will occur if the ACO meets or beats the VIS target.
All ACOs will have a Stop Loss set at $150,000.
Additional quality incentives may be available with incrementally higher percentage of shared savings achieved based on comparison of network VIS and ACO actual VIS.
In addition to VIS, ACOs will be measured on their ability to balance funds to HCBS programs instead of Institutional services. Although ACOs will have LTCSS and BH services excluded from TCOC, IME will calculate a full TCOC for each ACO, so they can see the impact to their programs when those services are phased into the calculation prior to taking on risk for those services.

Through rapid cycle evaluation, the payment methodology will progress so that the ACOs will have more risk and greater accountability for Total Cost of Care and quality measures. The payment reform process within the Medicaid ACOs will proceed in conjunction with alignment of incentives and quality measures being offered by other payers. The State is also open to testing payment reform pilots such as partial and full capitations for ACOs that prove effective at transforming them into a value-based entity. IME has created a rubric of "triggers" that

each ACO will need to achieve before moving to the next level of accountability. Ultimately, the goal is to move to a fully capitated, fully integrated system.

IME will address the process of health care delivery and integration of SDH through transformational support for both providers and communities. Stakeholders also expressed strong support for devising new ways to allocate resources to health systems to address SDH. IME, in conjunction with Wellmark, will work with Treo Solutions to develop, simulate, and test the appropriate and most effective way to embed incentives that will further drive ACOs to invest in the required tools, capability, and capacity to address SDH without increasing risk avoidance. IME has closely followed the development of the NQF[15] brief on *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors* and believes that the SIM Initiative will add critical information for payment reform approaches in an ACO delivery system. IME and the SIM design team agree that this issue requires "thoughtful and nuanced work."[16] To proceed in a way that adds to the knowledge base without compromising care, IME will move through four stages of exploration, with each stage being complemented by carefully designed safeguards.

Stages of Exploration for Risk Adjustment (RA) Incorporating SDH
Stage One: Collection of SDH data and integration into individual care plans. ACOs will implement the use of the AssessMyHealth tool which integrates social determinant data into the member-centered care plan developed by the PCP and informs community interventions.
Stage Two: Selection of metrics and validation for completeness and reliability. Years 1 and 2 will focus on metrics available from public data sets. Years 3 and 4 will focus on metrics derived from the AssessMyHealth tool. Reliability, completeness, and validity will be assessed.
Stage Three: Pilot the use of SDH data to allocate supporting resources for population health initiatives to improve health and reduce disparities created by SDH in communities.
Stage Four: Test use of SDH risk-adjustment in ACO shared savings. Test use of risk- adjusted metrics in the shared savings model for ACOs in a simulated environment.
Safeguards for Ensuring Appropriate SDH Risk Adjustment Methodologies

[15] National Quality Forum
[16] CMS Comments to NQF Brief.

Maintain a workgroup representing disadvantaged patients, caregivers, and advocates.
Maintain an academic, subject matter expert in risk adjustment not affiliated with the contracted vendor to provide unbiased support and input to the SIM team.
IME will not apply these risk adjustments to providers who already receive additional payment for caring for disadvantaged populations.
Explore risk adjustment for individual SDH in stepwise fashion.
RA exploration will proceed in tandem with other efforts to assist providers in addressing SDH.

4. LEVERAGING REGULATORY AUTHORITY

In June 2013, when Governor Branstad signed the IHAWP legislation, Iowa officially set in motion the statutory changes that were required to develop the ACO model. The legislation requires that: DHS develop a mechanism for primary medical providers, medical homes, and participating ACOs to jointly facilitate member care coordination; providers are reimbursed for care coordination services; ACOs incorporate the medical home as a foundation and emphasize whole-person orientation and integration of community and social supports that address SDH; and ACOs develop quality performance standards that are aligned with other payers. In addition, the legislation authorizes the use of payment models that include, but are not limited to, risk sharing – including both shared savings and shared costs – between the State and the participating ACO, and bonus payments for improved quality. Finally, the legislation establishes a framework for exchange of member health information to improve care and reduce costs. DHS is required to provide the health care claims data of attributed members to each ACO. (Every ACO contract contains a HIPAA-compliant business associate agreement to protect patient confidentiality.) The Medicaid environment is a safe place for ACOs to share data and identify efficiencies without the legal concern of collective bargaining for rate setting that can be found with the private market. Embedded in the new law is language that calls for the expansion of medical homes to children, other adults, and Medicare and dually eligible Medicare and Medi-

caid members (if approved by CMS) to the greatest extent possible by January 1, 2015. The legislation requires interagency collaboration to allow State employees to utilize the medical home system with insurers and self-insured companies, if requested, to make the medical home system available to individuals with private health care coverage. This collaboration furthers the multi-payer, incentive-aligned SIM model.

The law also created avenues for continued collaboration and discussions between the Executive and Legislative branches, and the State has established an Advisory Council for the SIM Initiative (Advisory Council) to advise the Integrated Care model development by DHS. Members were appointed to ensure that the SIM process provides ample opportunity for the involvement and participation of a variety of stakeholders. In addition, IDPH will investigate opportunities to align Certificate of Need application questions that would support strategies in this proposal. IDPH staff assigned to the SIM project will educate policy makers on complementary State-level policy, systems, and environmental changes that support healthy behaviors.

For the state-wide Medicaid ACO strategy laid out in this proposal, DHS intends to submit a Payment Methodology State Plan Amendment (SPA) to CMS and move Medicaid into a 1915(b) waiver for choice and PCP assignment. In addition, the State will leverage ACO contracts to expand the ACOs into a community setting with a population health focus.

One important responsibility of Iowa's LPHAs is coordinating the development of community health needs assessments and health improvement plans for their local jurisdictions. While IDPH requires these be developed every five years, adjustments to this schedule are being made to enable LPHAs to coordinate more effectively with local hospital partners, allowing achievement of their IRS requirements to conduct these same local planning efforts on a three-

year basis. Opportunities from this proposal will ensure that community health needs assessments inform local health improvement efforts.

5. HEALTH INFORMATION TECHNOLOGY

The adoption rate of HIT is an example of dedication to change that Iowa providers have embraced. IME is an active participant in Iowa's e-Health efforts, and its strategies and priorities are integrated as part of Iowa's overall HIT and HIE implementation. IME's HIT planning and roadmap centers around four goals central to supporting the health of Medicaid populations and Iowa's overall reform goals. These goals and objectives, as articulated in IME's State Medicaid HIT Plan (SMHP)[17] most recently submitted and approved by CMS, are to: 1) increase provider adoption of electronic health records and health information exchange; 2) improve administrative efficiencies and contain costs; 3) improve quality outcomes for members; and 4) improve member wellness. The SIM will be closely aligned with statewide HIT infrastructure through the Iowa e-Health Advisory Council, which meets on a bi-monthly basis. In addition to the Advisory Council, IME, IDPH, and the Regional Extension Center (REC) meet on a quarterly basis to coordinate efforts regarding HIE, HIT, and the adoption of electronic health records.

Health Information Exchange: Iowa Health Information Network (IHIN): The IHIN utilizes a federated hybrid model that meets the standards of the national "Integrating the Healthcare Enterprise" (IHE), and has a centralized master patient index, record locator service, auditing, Direct Secure Messaging, and translation services, where appropriate. This structure allows for point to point messaging, query/response, and publish/subscribe technology.[18] A blueprint for building the IHIN was described as part of Iowa's revised 2013 Strategic and Oper-

[17] http://dhs.iowa.gov/sites/default/files/2013_Iowa_SMHP_clean_final_0.pdf
[18] Additional information is available at: http://www.iowaehealth.org/provider/overview/what-is-iowa-health/

ational Plan, which also outlined the ten HIE State goals and objectives.[19]

EHR Incentive Program: Iowa was one of the first states to launch its EHR Incentive program, developing capacity to release Medicaid incentive payments in January 2011. Iowa's REC was charged with providing technical assistance to 1,200 primary care providers and 84 critical access/rural hospitals with improving patient care through the adoption and meaningful use of electronic health records.[20] Iowa's REC and Hospital Association worked extensively to assist with the attestation process and will continue to provide support to accelerate adoption as Iowa implements the SIM. Some key facts about HIT adoption in Iowa include:

HIT Adoption[21]
520 IHIN participating sites (represents 85% of all hospitals in Iowa and all four large health systems as well as other community hospitals, clinics, LPHAs, etc.)
All IHAWP ACOs participate in IHIN
1,497 eligible professionals and hospitals participate in Medicaid Incentive program
66% of office-based providers and 61% of hospitals in Iowa have adopted an EHR system (18% and 2% higher than the national average, respectively)
98 out of the State's 118 hospitals have attested and qualified to receive their first year Medicaid EHR Incentive payment, 89% of Iowa's participating hospitals have returned to receive their second year payment, and 38% have received their third and final payment
47% of providers (948) and 89% of hospitals (83) have moved beyond AIU (adopt, implement, upgrade) and have also demonstrated meaningful use

IHIN participation includes Direct secure messaging for all organizations, and Patient Look-Up Service (Query) for approved organization types. Participation using Direct without Patient Look-Up is available to any organization who works with healthcare Protected Health Information. This includes organizations dealing with any part of healthcare such as those dealing with medication or drug use, healthcare legal work, child health, etc. IHIN participation includes all of the core functions which include electronic submission of state reportable

[19] http://dhs.iowa.gov/sites/default/files/2013_Iowa_SMHP_clean_final_0.pdf
[20] http://www.telligenhitrec.org/
[21] Additional HIT/HIE information for Iowa found at: http://dashboard.healthit.gov/quickstats/widget/state-summaries/IA.pdf

labs or immunizations, electronic submission to the State Cancer Registry, and Connectivity to Iowa Medicaid Enterprise programs. More information can be found at:

http://www.iowaehealth.org/provider/get-connected/participation/

lab alerts are generated from any LIMS or EHR across all provider and lab organizations participating. The alerting system can be configured to receive the lab trigger via a multitude of formats including standard HL7 result over any transport connection. Organizations with care coordination processes in place and who are not the provider will pay for an immediate receipt of specific lab results for a subset of their patient population in order to ensure that specific evidence based activities happen as a result of that result. ACOs and many payers have or are building these processes. Providers who are a medical home may also be very interested in being made aware of positive results, for specific tests, for a patient that they are responsible for their care.

Iowa will continue to build basic HIT and HIE capacity among providers not yet implementing EHR systems or hosted functionality, and also support targeted HIE development efforts to enhance information systems required for accountable care. IDPH will ensure alignment of planning activities among the advisory councils established by 2008 legislation.

Iowa's eHealth stakeholders recognize that accountable care systems require more robust capacity for real-time data exchange and data analytics at the point of care. Iowa will implement and test a statewide alert system to support the delivery system by providing real-time or near real-time information about patients and their health care services, accelerating the ability to provide immediate care coordination. One component will be a statewide Admit, Dis-

charge, Transfer (ADT) messaging service. HIEs can become an aggregation service and traffic ADTs between all participating IHIN organizations. Another component is to forward lab results (upon result and delivery back to the ordering provider) to care coordination teams.

To accomplish a statewide ADT and lab notification system, payers will submit eligibility files on a regular basis. When the IHIN gets an ADT or lab transaction, the patient name is cross referenced to the eligibility file and the notification to providers and payers is generated in a secure format. IME and IDPH are already engaged in discussions with several ACOs and will work with the necessary stakeholders to implement and expand this program and provide technical assistance to the IHAWP ACOs, new Medicaid ACOs, and other targeted provider groups throughout the process. The ACO delivery system is the perfect environment to test the alerting innovation; it supports providers, care coordination, and provides needed transparency in data sharing. ACOs are interested in real-time reporting that leads to improved efficiency, better quality, and a lower TCOC.

SIM Investments Aligned with HIE

As stated above, the State is partnering with the IDPH to implement an IHIN Alerting system within the ACO delivery model. The IHIN Alerting model is technology developed by the statewide HIE vendor and uses the IHIN to aggregate ADT data between the ACOs. This Alerting service allows ACOs to use HIT to:

1. Receive timely information from systems outside of their own internal systems;
2. Coordinate transitions of care with entities outside of their own system; and,
3. Improve health outcomes of individual patients that have the potential to both improve overall population health and lower potentially avoidable events.

Additionally, the State is seeking HI-Tech funding through the IAPD to start HIT Technical assistance in 2015 for ACO delivery system to improve their interoperability, understand reports receive from the IHIN and other HIT tools, and implement clinical processes that utilize HIT to the highest potential.

As stated in the Appendix B, the current ACO agreement requires ACOs participation in Direct Messaging, query capabilities and the exchange of ADT information. Future versions of the ACO agreements will have similar requirements in order to expand the availability of HIT throughout Iowa

6. STAKEHOLDER ENGAGEMENT

Stakeholder engagement has been a key driver in Iowa's approach to SIM. During its SIM design process, the State undertook an extensive and comprehensive approach to involving all stakeholders through formal and informal meetings, the creation of workgroups, and the use of the IME website to provide information.[22] The State will work to maintain and expand stakeholder engagement, building on the relationships and processes that are already in place in Iowa, and those that were developed as part of the SIM Design process.

In the Design phase, the State engaged key stakeholders who are representative of the entire State population, including health care providers and systems, commercial payers and purchasers, hospital and medical associations, community-based and long term support providers, and consumer advocacy organizations (See Table 3).

[22] http://dhs.iowa.gov/ime/about/state-innovation-models

Table 3: Key Stakeholders

Category of Stakeholder	Examples of Engaged Stakeholders
Health Care Providers and Systems	Iowa Clinic, Genesis Health System, Des Moines University, Broadlawns Medical Center, University of Iowa Hospitals and Clinics, Mercy Health System, People's Federally Qualified Health Center, Unity Point, Primary Health Care, Henry County Health Center, Trinity/Unity Point, Mercy Sioux City & Community Health Clinics, Child Health Specialty Clinics, Heartland Family Services, Everly Ball
Commercial Payers and Purchasers	Magellan Behavioral Health Services of Iowa, Wellmark Blue Cross & Blue Shield, Medicaid, Medicare, CHIP, Meridian Health Plan
Community-Based and Long Term Support Providers	Evergreen Estates, Western Home Communities, Hawkeye Valley Area on Aging, Orchard Place, Southwest 8 Area Agency on Aging, Iowa Home Care, Child Serve, B&D Services, Hawkeye Care Centers
Consumer Advocacy Organizations	Community Addiction Association, Child & Family Policy Center, Youth & Shelter Services, Iowa Developmental Disabilities Council, Immanuel Pathways, Northeast Iowa Family Education Foundation
Others	Iowa Division of Insurance, Iowa Department of Public Health, Prairie Ridge Addiction, Plains Areas Community Mental Health Center, Iowa Health Care Collaborative, County Social Services, Iowa Department of Inspections and Appeals, Lee CO Public Health

During the SIM design process, the stakeholder engagement process included work groups, a steering committee, formal and informal meetings, public listening sessions, and dissemination of information to stakeholders using a variety of media, including the State's website. The workgroups were built around the key strategies outlined in the original SIM model design grant proposal and included: Metrics and Contracting; Member Engagement; Behavioral Health Integration; and Long-Term Care Supports/Services Integration.

In addition to the four workgroups, a consumer-facing workgroup was created in which IME provided an overview of the project, discussed the workgroup approaches, and shared the recommendations and goals that were presented to the Steering Committee. For individuals not included in the workgroup process, the State created "listening sessions" which gave people an additional opportunity to hear about the SIM process and other interacting initiatives

(e.g., the IHAWP), and to share their thoughts. Additionally, a Steering Committee was engaged to provide feedback on the workgroup recommendations.

During the testing phase, the State will build upon these established stakeholder engagements and expand it to accommodate the type of in-depth input and feedback that will be needed in this round. Stakeholder engagement an important and ongoing strategy that will: 1) ensure all perspectives are heard and considered for incorporation into the SIM Initiative; and 2) help make programmatic improvements throughout the model testing period and beyond. Starting June 30, 2014, the State kicked off SIM Round Two by holding a stakeholder public forum. All workgroup members and stakeholders were invited to provide input to this proposal.

Stakeholder engagement in the Model Test period will include quarterly public forums for the State to share information on progress made, including quality and performance data and project milestones. The State will also develop and convene small work groups to inform the Model Test activities (as described in the operation plan). These may be similar to the work groups utilized during the Design phase, but with a focus on implementation issues. For example, the Metrics and Contracting Work Group may focus on the finalization of new measures during the 12-month pre-implementation phase.

A SIM Leadership Committee will be utilized to help form the work groups, provide support, review, and feedback on recommendations made by each group. Listening sessions will continue to be held throughout the State to gather the feedback from stakeholders about the transformational efforts, to hear concerns, and to answer questions.

Currently, Iowa provides ongoing updates through its SIM website[23] and SIM distribution lists. Attestations of support are included as part of this application.

7. QUALITY MEASURE ALIGNMENT

The State has a solid plan in place to align quality measures across payers in the State. By leveraging measures already in use by the largest commercial payer in the State (Wellmark), including these measures in the implementation of the IHAWP, Iowa has already made significant progress toward this alignment. Through the Model Test, Iowa will continue to build upon this work by implementing these measures within the full Medicaid ACOs. During the 12 month pre-implementation period, the State will work with stakeholders to finalize additional quality measures important to the Medicaid population. These quality measures will be used as part of the payment methodology in an incremental fashion to support the increase of accountability with the incorporation of LTCSS and BH services into the TCOC budget. Additional details about the quality measures for Medicaid and Wellmark are provided below.

One of Iowa's primary strategies, affirmed by the SIM Design, was the implementation of a multi-payer ACO Model adopted and adapted from Wellmark Blue Cross Blue Shield. Iowa's goal is to incorporate Medicaid and CHIP populations across the State into the ACO model through a phased-in approach, and also to build upon lessons learned from the Pioneer and Medicare Shared Savings Plan (MSSP) ACOs operating in the State.

With the transition to ACOs, the level of accountability for quality and improved health has increased. To ensure Iowa providers are working toward the same goals and are focusing on the same measurements regardless of payer, the Medicaid ACOs will use the same quality

[23] http://dhs.iowa.gov/ime/about/state-innovation-models

measures, the Value Index Scores (VIS), ™ in use by Wellmark and the IHAWP ACOs during the Model Test. The VIS is a composite of seven domains (see Table 4) designed to promote the use of medical home concepts and support system transformation that improves quality and lowers cost.

Table 4: VIS Measures

Domain	Measurement Value	Metrics
Member Experience	Assessing and improving patient experience has positive impacts on clinical outcomes.	• AssessMyHealth • Client Specific Patient Surveys
Primary and Secondary Prevention	Increased educating, motivating, immunizing, and screening prevents disease.	• Breast Cancer Screening • Colorectal Cancer Screening • Well Child Visits Birth to 15 Months • Well Child Visits Ages 3-6
Tertiary Prevention	Good access to primary care reduces the incidence of ambulatory care sensitive admissions and ER visits.	• Potentially Preventable Admissions (ACSC Proxy) • Potentially Preventable ER Visits
Population Health Status	Combined impact of good primary care will delay disease progression in chronically ill.	• Chronic Complexity Non-Jumper • Chronic Severity Non-Jumper
Continuity of Care Domain	Consistent patient engagement and coordination of care produces higher rates of adherence, identification of health problems, and patient satisfaction, as well as lower hospitalizations, emergency room use, and total cost of care.	• PCP Visits • Qualified Physician Visits • Continuity of Care Index
Chronic and Follow-Up Care	Follow up care reduces readmissions and a regular source of chronic care improves patient outcomes.	• 30 Day Potentially Preventable Readmissions (Not all cause) • PCP Visit 30 Days Post Discharge • 3 Chronic Care Visits
Efficiency Domain	Efficient use of resources reduces burden on patients and directs health care time and money to more productive patient care.	• Potentially Preventable Service Dollars • Generic Rx Prescribing Rate

Common use of the VIS, dashboard, and tools brings consistency to the provider level. This enables providers to gauge their performance relative to other providers and to identify areas for improvement, bringing alignment in accountability and payment.

A common measure set has the added benefits of further aligning payers across Iowa and measuring performance across many domains, from prevention to healthcare system processes and delivery, to population health outcomes of interest. All VIS measures (with the exception of patient experience of care) are driven from claims data, so for most data, no special collection or processing is needed in addition to claims filing, which is another benefit. Additionally, many measures align with CMMI's priority measures, and with NQF measures.

The VIS composite score represents a comprehensive look at a primary care practice, including measures that can be influenced by changes in provider behavior. The VIS offers an overall score that can be used to rank provider performance and to compare a provider's score to the overall average score for the system or network. The dashboard provides a dynamic reporting and drill-down ability to pinpoint areas that may require more scrutiny for performance improvement. Measures can be aggregated to the ACO level to measure ACO performance, and to the state level to measures statewide healthcare system performance and changes in population health.

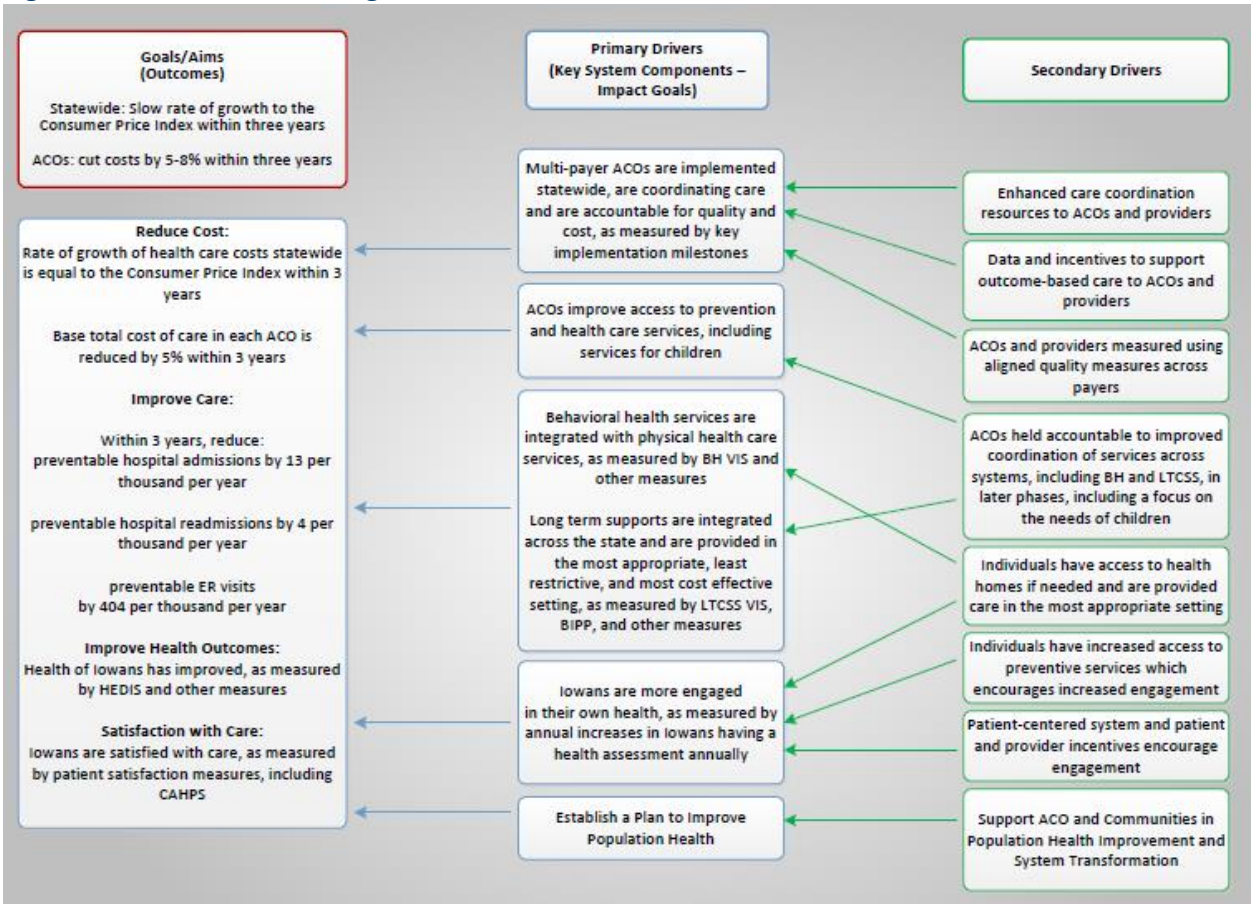
Because individuals receiving coverage through the Medicaid program often have health care needs that differ from commercially insured populations, particularly in terms of needs for LTCSS and BH services, additional performance measures will be added in the second year of implementation, along with financial incentives in these areas. Also added during the second year of implementation are measures that focus on the health care needs of children, particularly children with special needs. Stakeholders will be engaged throughout the first year of implementation to finalize these measures. Finally, IME is working closely with Wellmark to develop a star rating system based on VIS performance, similar in concept to Medicare, that en-

hances transparency to consumers and competition among providers.

8. MONITORING AND EVALUATION PLAN

During the Model Design phase, the State developed a monitoring and self-evaluation plan that includes quantifiable measures for regularly monitoring the impact of the proposed model, including the effectiveness of the policy and regulatory levers applied under the Model Test, on the three key outcomes of (1) strengthening population health; (2) transforming the health care delivery system; and (3) decreasing per capita health care spending. This plan will be utilized in the Model Test phase, and many of the measures that were discussed and developed as part of that plan will be useful to CMS in its evaluation efforts. While these measures are described in detail in Iowa's SHIP. Additionally, a visual of the evaluation plan, drivers of transformation, and process and outcomes measures can be seen in the SHIP. The driver diagram illustrates the conceptual framework, overall goals, approach, and activities of Iowa's Model Test, as well as Iowa's approach to measuring and assessing both the process and outcomes of this work (see Figure 1). The State understands that final measures will be refined in conjunction with CMS during and up to 12 month pre-implementation period.

Figure 1: Current Driver Diagram



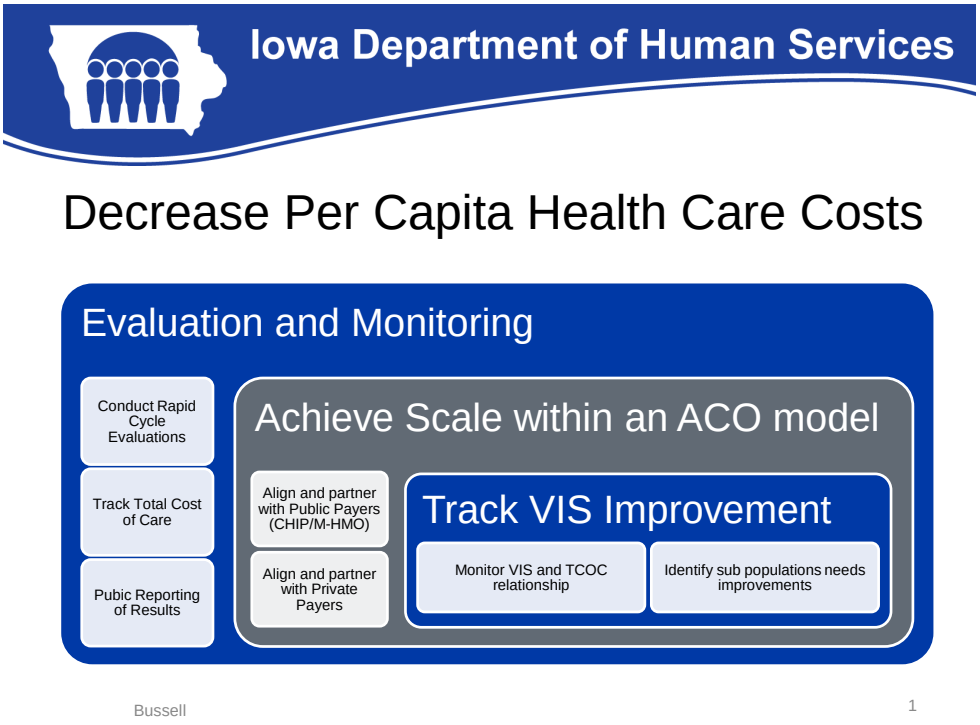
The State's driver diagram, submitted in the SHIP to CMS in December 2013, revised and included illustrates established targets, primary drivers and secondary drivers the State expects to achieve.

Many of the measures described here are part of the VIS that is currently used by the Wellmark and Medicaid's Wellness ACOs in Iowa. Iowa intends to build upon and leverage this existing system of measurement as a core part of its self-evaluation, and as a core part of its measurement of the effectiveness of the ACOs. Using these measures as a core set of measures has the added benefits of further aligning payers across Iowa, and measuring performance across many domains, from prevention to healthcare system processes and delivery, to population health outcomes of interest. All measures (with the exception of patient experience of care) are driven

from claims data, so for most data, no special collection or processing is needed in addition to claims filing, which is another benefit. Additionally, many measures align with CMMI's priority measures.

More detail on the state's goals, primary and secondary driver can be found in the State's SHIP pages 143 through 158.

Figure 2: Activities to support Decrease in Per Capita Health Care Costs



To perform the required evaluation and monitoring functions, the State will contract with an external evaluator, University of Iowa Public Policy Center (PPC), and a data manager, Treo Solutions. The PPC will support self-evaluation and monitoring and will collaborate with the CMS evaluators to provide data, assist with identification of a comparison group, identify appropriate measures and data sources, and finalize the evaluation design and methods. Treo Solutions will continue to collect, analyze, and manage the VIS across both Medicaid and

Wellmark, and will provide data to the State for use in its own rapid cycle evaluation (geared toward program improvement) and reporting to stakeholders as part of the stakeholder engagement work. This data will also be provided to the PPC as part of its self-evaluation and monitoring efforts, and is likely to be part of the data set provided to the CMS evaluators. As part of Iowa's self-evaluation efforts, the State has contracted with Treo Solutions to develop a provider-facing data dashboard for providers and ACOs. IME will manage the data vendor and the external evaluator.

The state is confident that requested data will be available to the federal evaluator. However, the state will require assurances and compliance with State laws to share the data with the selected federal evaluator. Data Use Agreements, Business Associate Agreements and requirements of the Secretary for the State to share the data are all components that will need to be addressed.

Typically, HHS contracts out program evaluation services to professional research services, and the state agency is often asked by such services for direct access to data. In these settings, the state agency normally requests to see that HHS has addressed the privacy, security, and restrictions on redissemination of data in the contract between HHS and the evaluator. As long as HHS has addressed these basic concerns by contract, this state agency customarily will not restrict access to any data under the belief that HHS has the right to evaluate and audit such federally-funded programs. If the basic patient privacy concerns are not addressed, the concerns can be addressed in a number of ways that will not restrict data access. Also, to the extent the evaluator has obtained Institutional Review Board or Privacy Board approval, the state agency would simply ask for a copy of that document to keep in the file to provide additional support should the HHS Office of Civil Rights ever question the data exchange.

The State has already entered into successful data sharing arrangements with vendors like Treo Solutions/3M and the University of Iowa Public Policy Center. In both of these examples, the state sends regular updated data files using secure protocols within the scope of the Business Associate Agreements in place.

The state does not have an all-payer claims database. Wellmark has expressed a willingness to share select claims data (limited fields) with CMS for the purpose of this evaluation within the constraints of State law and their existing provider contracts. Additionally, Wellmark will require the execution of a nondisclosure agreement with the entity selected to perform the evaluation.

Both Wellmark and the State are committed to sharing needed data with the CMS evaluators to evaluate the effectiveness of SIM. As discussed with CMS on October 1, 2014, if Iowa is awarded the SIM Test Grant and if requested by CMS, Wellmark will enter into a written agreement with the state. As noted by Wellmark during the call, Iowa law and federal regulations afford additional protections to substance abuse (42 C.F.R. part 2), mental health (Iowa Code chapters 228, 229), and diagnosis and treatment for HIV/AIDS (Iowa Code section 141A.9).However, Wellmark may release data by either masking these protected categories; or preferably for evaluation purposes, masking all patients with a consistent numerical identifier and releasing all information. Wellmark may need to restrict some cost data to protect its trade secrets. Iowa does not have an APCD in which to draw data for the evaluation.

Limited data sets or the use of de-identified data is not contemplated. As noted, the state agency will not restrict data provided to the evaluator. See answer to question five above for Wellmark's restrictions and potential solutions for evaluation purposes. The state agency is committed to work with the evaluators and Wellmark to ameliorate any problems that may arise from any such data masking, which again are believed to be minor.

The state is confident that once the above assurances and compliance with State laws are worked out, that our data systems can provide a list of Dual Eligible individuals that are participating in Medicaid ACO arrangements. The state has the necessary identifiers in our data to accommodate this request.

State laws that will potentially need be addressed when sharing data:

- Iowa Code § 217.30 (confidentiality of applicants or recipients of services of DHS),
- Iowa Code chapters 228 & 229 (mental health confidentiality in Iowa),
- Iowa Code 141A.9 (HIV/AIDS diagnosis and treatment);

- Iowa Code §§ 125.37, 125.93 (substance abuse treatment and hospitalization).

As noted above, the state agency does not restrict HHS' access to data and makes available data to evaluators to the extent necessary to evaluate HHS-funded programs as long as basic contractual protections are in place to assure the privacy and security of the data and to assure that the information will not be re-disseminated in a way that a patient could be re-identified. If such protections are not in the contract between the HHS evaluator and the federal agency, the state will work with the evaluator to make sure that these basic concerns are addressed so that there will be no restriction on access to data by the evaluator. As to the specific state laws, the only restriction that may be imposed on any data available to the evaluator may come from legal interpretations of counsel for Wellmark, which has instructed Wellmark to mask data elements that identify the treatment received by a patient if the treatment was for HIV/AIDS, substance abuse, or mental health. As noted, the state agency will work with the evaluator to alleviate any problems that might arise through such masking of more restrictive classes of data or to reevaluate the legal advice that has results in data masking.

The State suggests that regular meetings be established between the federal contractor and the States evaluation agent. In addition the State will establish regular meetings with the SIM Project team and the State's evaluation agent to discuss monitoring efforts, confirm project work is moving is following the schedule, and identifying and removing barriers to progress.

Measures that were included in the self-evaluation and monitoring plan (and which will also be provided to CMS as part of their evaluation efforts) include:

- project implementation, including stakeholder engagement, communications, outreach, and measures that track progress toward implementation milestones;
- health care delivery system transformation, such as improved quality of care, strengthened population health, and decreased per capita spending; and
- population health, including the CMS recommended measures of tobacco use, cessation

attempts and interventions; obesity measurement and intervention; and diabetes monitoring and treatment.

Many of the measures included in the Model Test work are aligned with other national data sets, including CMMI priority measures, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, Behavioral Risk Factor Surveillance System (BRFSS) measures, and/or National Quality Forum measures (See Table 39 in the SHIP for additional details).

This data will be used by the State to track progress toward Model Test goals, quality of care of ACOs and providers, and cost savings, to make decisions about program changes and to inform stakeholders about progress.

In the second year of implementation additional measures will be added, including: quality related to BH and LTCSS; the degree of integration of services across systems; and measures of SDH, which may be refined as more is learned about the quality and utility of the measures through the self-evaluation, CMMI's cross-site evaluation, and the work of the ACOs and providers.

Most of the measures that will be collected initially are already being collected via claims data, which will minimize the additional burden on providers. For measures that are not part of claims data, the State will work with the ACOs to develop processes and expectations that meet the needs of the State to monitor and reward quality care, improve health outcomes, and reach appropriate reductions in costs while not overburdening providers or ACOs. Requirements will be determined by the State and clearly articulated in the ACO contracts and, to the degree possible, as part of the application process. Additional data that will be utilized in-

clude measures from CAHPS, HEDIS, and BRFSS.

Quarterly SIM Test Accountability Targets

Accountability targets and thresholds for 2015 based on an October award announcement and January 1, 2015 Grant starting period:

1st Quarter 2015 (January – March)		
Measure	Details	Target
Execute Contracts	Write (or amend) and execute contracts with the following vendors to fulfill SIM activities: • Telligen • IDPH • Milliman • Treo • PPC	5 contracts written or amended and executed by January 31, 2015
Hire Staff	1 ACO Project Manager 1 Quality Director, 1 eHealth Project staff trained 1 IDPH EO2	4 staff hired and Trained by March 31st, 2015
Rapid Cycle Evaluation (Iowa Wellness Plan ACO 2014 data)	Conduct analysis of VIS in 2014 Compile results of Healthy Behavior Program Compile CCT Pilot results	Data compiled by March 31, 2015
Establish SIM Leadership Group and Meeting Schedule	Establish SIM Leadership group, approve charter, and established frequency of meetings	At least one meeting held by March 31, 2015
Conduct Stakeholder Meetings	At least quarterly, hold a SIM public Meeting	At least one meeting held by March 31, 2015
Begin Waiver/SPA Develop-	Meet with contractor, debrief	Meet with Contractor (SVC,

ment	and develop concept paper/outline of waiver and SPA work Develop timeline of requirements for a 1/1/2016 effective date	via Milliman) at least monthly. (NOTE: Initial meeting occurred in August 2014 , next meeting scheduled for November 2014) Timeline established for activities by Feb 28, 2015
Wellmark /IME Collaboration Meeting	Conduct a quarterly meeting with IME and Wellmark to discuss programs, upcoming changes, and areas of collaboration	At least one meeting held by March 31, 2015
Kick-off Call with Iowa Healthcare Collaborative	Conduct a kick off call with Iowa Healthcare Collaborative	Hold by Feb 15, 2015
Kick off Call with eHealth ADT Alerting Project	Conduct a kick-off call with eHealth and the IHIN Vendor to discuss ADT Alerting Project pilot and SIM activities	Hold by March 31, 2015
Kick-off call with PPC	Conduct a kick-off call with PPC and the CMS Evaluation Contractor to discuss data sharing details.	Hold by March 31, 2015

2nd Quarter 2015 (April – June)		
Measure	Details	Target
Hire Staff	Hire second ACO Project Manager 1 PPT and 1 CHC for IDPH	ACO PM hired and trained by May 15, 2015 PPT and CHC hired and trained by June 30, 2014
Draft ACO Agreement for 2016	Develop a draft of the revised ACO Agreement	Internal Draft by April 30, 2015 External Draft for ACOs review by June 30, 2015

Conduct SIM Leadership Meetings	Review 2014 compiled rapid cycle evaluation results, review Implementation plan, ACO draft agreement	At least one meeting by June 30, 2015
Draft Iowa Administrative Code (Rules)	Compose an internal draft of IAC Submit to Rules Committee	Internal Draft by April 30, 2015 Submit to Rules Committee by June 30, 2015
Waiver/SPA Development	Conduct Public Notice and Tribal Notice in preparation of SPA/Waiver submission Continue regular meetings with SCV to prepare for submission	By June 30, 2015
Rapid Cycle Evaluation	Compile results of HRA /SDH data collected to date, Review status of ACO network	June 30, 2015
Establish LTC and SDH Workgroups	Establish workgroup leaders, charters and frequency of meetings	By June 30, 2015
Develop Detailed Implementation Plan	Present Implementation Plan to SIM Leadership,	By June 30, 2015
Conduct Stakeholder Meetings	At least quarterly, hold a SIM public meeting	At least one meeting held by June 30, 2015
Wellmark /IME Collaboration Meeting	Conduct a quarterly meeting with IME and Wellmark to discuss programs, upcoming changes, and areas of collaboration	At least one meeting held by June 30, 2015
Kick-off meeting with IME CORE team	Start the process to update MMIS to track ACO network and member attribution	Kick off meeting by April 15, 2015
Kick-off meetings with IDPH	Conduct monthly meetings	April 30, 2015

	with IDPH on Plan for Improving Population Health, TA	
Conduct Regular Monthly Meetings with contractors	PPC, IDPH and IHC (Combined meetings), eHealth	3 monthly meeting X 3 months = 9 meetings every quarter expected

3rd Quarter 2015 (July – September)		
Measure	Details	Target
Hire Staff	ACO Project Assistant	Hired and Trained by July 31, 2015
Approved ACO Agreement for 2016	Seek ACO Agreement approval from SIM Leadership, CMS, and AGs office	Approved Contract posted on the website by September 30, 2015
Conduct SIM Leadership Meetings	Review 2014 compiled rapid cycle evaluation results, review Implementation plan, ACO draft agreement	At least one meeting by June 30, 2015
Rapid Cycle Evaluations	Review VIS, Healthy Behaviors SDH data, CCTs and Plan for Improving Population Health Metrics	Have data compiled by September 30, 2015
Conduct LTC/SDH Workgroups	Conduct LTC and SDH workgroups with plans to present to SIM Leadership	Recommendations ready to present to leadership by September 30, 2015
Conduct Stakeholder Meetings	At least quarterly, hold a SIM public Meeting	At least one meeting held by September 30, 2015
Continue Waiver/SPA Development	Negotiate SPA/Waiver approval with CMS	Submit Waiver /SPA to CMS for Approval by July 30, 2015
Wellmark /IME Collaboration Meeting	Conduct a quarterly meeting with IME and Wellmark to discuss programs, upcoming changes, and areas of collaboration	At least one meeting held by September 30, 2015

Conduct SIM Risk and Mitigation Planning activities	Present Mitigation plans to SIM Leadership	By August 31, 2015
MMIS ACO Updates Management	Review and approve design of ACO and member attribution within the MMIS	By September 30, 2016
Conduct Regular Monthly Meetings with contractors	PPC, IDPH and IHC (combined meeting), eHealth	3 monthly meetings X 3 months = 9 meetings every quarter expected
ADT Alerting system	ADT Alerting system is ready to accept Users	By September 30, 2015

4th Quarter 2015 (October – December)		
Measure	Details	Target
Execute ACO Agreements with Shared Savings	Execute ACO agreements with a 1/1/2016 Effective date	4 ACO agreements signed by December 31, 2014
Conduct SIM Leadership Meetings	Conduct SIM Leadership meetings	At least once by December 31, 2015
Approved Iowa Administrative Code (Rules)	Rules through process for approval	By December 31, 2015
Rapid Cycle Evaluations	Review VIS, Healthy Behaviors SDH data, CCTs and Plan for Improving Population Health Metrics	Have data compiled by December 31, 2015
Waiver/SPA Approval	Receive approval from CMS on Waiver /SPAs for Full Medicaid ACOs for a 1/1/2016 effective date	By December 1, 2015
Develop and Submit Quarterly Evaluation for 2016 SIM activities to CMS	Based on SIM Leadership approved Operational Plan, develop and submit quarterly evaluation measures to CMS. The 2016 evaluation measures will contain more outcome	By October 15, 2015

	based measures, based on the rapid cycle evaluations collected in 2015.	
Conduct Stakeholder Meetings	At least quarterly, hold a SIM public Meeting	At least one meeting held by December 31, 2015
Wellmark /IME Collaboration Meeting	Conduct a quarterly meeting with IME and Wellmark to discuss programs, upcoming changes, and areas of collaboration	At least one meeting held by December 31, 2015
MMIS ACO Updates	MMIS ACO and Member Attribution updates complete	By December 31, 2015
Conduct Regular Monthly Meetings with contractors	PPC, IDPH and IHC (Combined meetings), eHealth	3 monthly meeting X 3 months = 9 meetings every quarter expected
Learning Community Events	Conduct Learning Community events that focus on Population Health Metrics, health literacy and patient engagement	Conduct at least 5 events across the state by December 31, 2015 involving 5 ACO delivery systems
Community Care Teams	Establish Community Care Teams that integrate LPH and ACO delivery system to address SDH and Social care coordination that improves outcomes	Five established CCT teams across the state by December 31, 2015
ADT Alerting system	At least one user from every ACO signed up and ready to receive ADT Alerts starting early 2016	By December 31, 2015
Updates to Assess My Health	Deploy updates to Assess My Health to incorporate better collection of SHD data for the three SIM purposes	By December 31, 2015

The State will work with CMS to develop a set of quarterly measures for each SIM reporting year. The state will submit those evaluation measures by October 15 each year. The quarterly evaluation measures in 2016, 2017 and 2018 will focus on outcomes of the service delivery as opposed to the more process based measures used in 2015 to evaluate the grant process. Quarterly measures for 2016, 2017 and 2018 will include projected quarterly targets for the number and/or proportion of health care providers, hospitals, and beneficiaries engaged with each model test component.

9. ALIGNMENT WITH STATE AND FEDERAL INNOVATION

Iowa's SIM Initiative builds upon, and aligns with, multiple state and federal innovations that are already in place. This includes building upon a health care system that 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%), and a small number of large integrated health systems deliver the majority of acute care services and employ more than half of the primary care physicians in the State. This environment means fewer pieces need to move to create rapid change, and all pieces have undertaken some aspects of transition, therefore Iowa has potential to quickly realize the results of SIM testing initiatives. The SIM Initiative will build upon this developing infrastructure, aligning measures and payment across Medicaid and Wellmark, and imparting greater transparency and awareness across providers. Specifically, the SIM Initiative will further stimulate innovations in Medicare in Iowa, including the Medicare Pioneer and Medicare Shared Savings ACOs, and on the IHAWP ACOs, by building upon the Medicaid ACO structure, supporting medical homes, health homes,

and encouraging individuals to be active participants in their own health. Other initiatives with which the model test will align include: The Iowa Healthcare Collaborative (IHC), which is part of CMMI's Hospital Engagement Network (HEN) initiative; Meridian Health Plan, which provides managed care to just under 40,000 Medicaid members; Iowa's existing Health Home initiative and Integrated Health Homes for Individuals with Serious and Persistent Mental Illness; Iowa's Balancing Incentives Payment Program; Iowa's existing system to provide behavioral health services via a statewide Behavioral Health Organization (Magellan), and the work of the Mental Health and Disability Redesign initiative; the Healthy Communities initiative; the Healthy Behaviors initiative; and Member Financial Incentives.

Wellmark and Medicaid Value-based Arrangement Alignment

Features of the Wellmark value-based arrangements that will be adopted for Medicaid:

- Quality Measurements system known as VIS.
  - Measures are clinically risk-adjusted according to Treo Solution 3/M's methodology
  - The online VIS Dashboard tool to track VIS progress that includes VIS, Total Cost of Care (TCOC) and Population Health reports to improve patient outcomes
  - The ability to earn additional quality incentives based on comparison of network VIS and ACO actual VIS
  - Medicaid and Wellmark both using the VIS provides alignment and allows providers to utilize a quality measurement methodology that focuses on better care management and delivery system transformation

- Total Cost of Care calculation and Shared Savings methodology
  - PMPM targets will be set based on a CPI PMPM target and/or a Trend Target PMPM. (CPI will be used when it is higher than Trend.)
  - There will be set risk/reward levels with limited down-side risk
  - Includes a Stop Loss consideration for catastrophic events
- Attribution Methodology
  - Although IME will use a PCCM model that assigns members to a PCP, and Wellmark uses attribution method that is based on a plurality of visits to a PCP, both Wellmark and Medicaid will use an attribution methodology that updates attributed member lists every month as opposed to a set attribution list established at the beginning or end of a performance period.

LTC and Behavioral Health Services coordinated in the Medicaid ACO, not anticipated to start until 2017 based on rapid cycle evaluation of the ACO model from 2014 – 2016

- LTC Services
  - Members receiving LTC services will be attributed to ACOs in 2016. ACOs will be accountable for managing the traditional clinical services just as they would for a member not receiving LTC services.
  - LTC services (specific Home and Community Based services and Nursing Facility services) will be excluded from the TCOC in 2016.
  - Care Coordination services for the LTC population will remain the same as the non-LTC population, however the process may be different. For ex-

ample, coordinating a transition out of an inpatient setting for a person of with an intellectual disability will likely involve a case worker and family members.

- Targeted for January 1 2017, ACOs will be measured for the ratio of Home and Community Based service (HCBS) vs. Nursing Facility costs provided to their attributed members. ACO's must achieve 50% of LTC services being administered to HCBS providers (BIP measure).
- The BIP measure will be calculated starting in 2016, but the ACO will not be held accountable for the measure until we bring those services into Total Cost of Care (TCOC) (Page 12 of the project narrative).
- In 2015, the State will form a LTC workgroup to inform additional measures required of ACOs to ensure quality is considered in conjunction of managing costs for the LTC population.

- Behavioral Health (BH) Services
  - Members receiving BH services will be attributed to ACOs in 2016. ACOs will be accountable for managing the traditional clinical services just as they would for a member not receiving BH services.
  - BH services for individuals with a serious and persistent mental illness (SPMI) will be excluded from the TCOC budget in 2016. Those services included, but not limited to:
    - Integrated Health Home Services
    - Habilitation Services

- Children's Mental Health waiver services
- Psychiatric Medical Institution for Children (PMIC)

- Care Coordination services for the BH population will remain the same as the non-BH population, however the process may be different. For example, coordinating a transition out of an inpatient setting for a person with a SPMI will likely involve members from the Integrated Health Home, like a case manager or peer support specialist and family members.
- In 2015, the State will form a BH workgroup to inform additional measures required of ACOs to ensure quality is considered in conjunction of managing costs for the BH population.

Wellmark does not pay for LTC services like long term Nursing Facilities, HBCS, Integrated Health Home, Habilitation, Children's Mental Health and PMIC. Because these services are unique to Medicaid, this is an aspect of the ACO model that only impacts the Medicaid program.

Plan to Address Shortage of Key Medical professionals

Iowa employs a two pronged approach to addressing the shortage of key medical providers in the state. One is the training and education of practitioners and the other is recruitment and retention of practitioners.

Iowa has developed three post graduate training programs to provide specialized training in mental health for Physician Assistants, Nurse Practitioners and Psychologists. Two programs funded by the state and administered through the IDPH involve post graduate training that enable these professions to have a certification in mental health. Practitioners who matriculate through these programs can provide mental health services in a variety of primary and mental health clinical settings. The third program works to provide a post graduate training program for doctoral level psychologists that meets their supervised rotation requirements similar to a residency.

For physicians the state has embarked on a Medical Residency Training State Matching Grants program to provide matching state funding to sponsors of accredited graduate medical education residency programs in this state to establish, expand, or support medical residency training programs. The program focuses on primary care physician and psychiatrist residencies.

Recruitment and retention programs include loan repayment and incentive programs designed to attract clinicians to underserved communities. Underservice is defined by federal Health Professional Shortage Area (HPSA) status or Medically Underserved Area (MUA) or Medically Underserved Population (MUP) designation through the shortage designation process governed by the Health Resources and Services Administration (HRSA) and implemented through Iowa's Primary Care Office.

These programs include PRIMECARRE (Iowa's State Loan Repayment Program), a state program called the Mental Health Professional Shortage Area Program (MHPSAP), the National Health Service Corps (NHSC), and the Conrad 30 J1 Visa Waiver Program. The MHPSAP is specific to

psychiatrist recruitment. The Conrad 30 J1 Visa Waiver Program recruits physicians, and Iowa gives preference to physicians practicing in primary care specialties and psychiatry. PRIMECARRE and National Health Service Corps both include clinicians from a variety of disciplines (primary care, mental health, and dental).

All of the mentioned programs work with the State Universities via their related medical education programs, State Mental Health Institutes, Community Mental Health Centers, Federally Qualified Community Health Centers, hospitals and Rural Health Clinics to coordinate with and administer contracts that address the workforce needs in the state.

In addition, the natural, competitive nature of value-based reimbursement implemented through the SIM Test will drive the urgency for the ACO to embrace technical assistance and speed workforce development. The technical assistance offered by IHC and proposed in the SIM will equip the ACOs to take on the responsibility of training staff and utilizing the two pronged approach the state has developed.

SIM Payment/Service Delivery Aligned with the Plan for Improving Population Health

The state has developed an ACO technical assistance strategy that stretches the scope of the ACO delivery model, which can be considered mostly hospital based organizations centered on the traditional clinical model. The state has entered into one ACO arrangement as of August 1, 2014 that is FQHC based instead of Hospital based. Both types of ACOs represent the payment and service delivery model will be included in the TA offered through SIM.

The ACO TA strategy moves these systems into a community setting that focuses on the goals and measures of the Population Health Improvement Plan. This approach promotes relationship building with community partners, including local public health (LPH), Maternal and Child Health Agencies (MCH) agencies and the newly formed Community Care teams. Presently, LPH/MCH agencies do not have a clear role in the ACO infrastructure. Through this delivery system transformation, LPH/MCH agencies will have the opportunity to be innovative and responsive by aligning with the ACOs and coming together to define what they could offer to the ACO, therefore reducing the number of contractual agreement ACOs would have to make with LPH/MCH agencies. We propose a venue in which the local agencies would actively participate in the development of the integration into primary care and ACOs. One of the venues proposed to create this integration will be the community level learning collaborative that will bring community healthcare leaders together to create community level responses. This will create diverse models to fit the specific needs of a geographical area and encourage a capacity to manage transformational population health changes. In areas where ACO may not be established, LPH/MCH agencies could be incentivized to work with existing healthcare systems. Iowa's Population Health Plan is the framework that local LPH/MCH agencies will utilize to move these efforts on a community level to demonstrated outcomes.

With this new era of health system transformation, the role of local public health agencies is shifting, but they are still essential in establishing successfully population health strategies. Health departments already have infrastructures in place to work with community resources and are well suited to assist in the integration of the population health plan into ACOs and align

incentives to improve the health from population health level. In addition, integrating the other essential public health services into these newly formed systems promotes establishing the shared goal of improving population health. The Population Health Plan will also be used at a statewide level as a benchmark for state-level population health activities. This streamlines existing efforts with newly established strategies such as the CHNA/HIP process, creating patient centered healthcare models and Community Care Teams.

The Community Care teams will vary in their composition but in the pilots seen to date, there have been partnerships established between LPHs and components of an ACO delivery system. The model test proposed in Iowa uses these newly formed Community Care Teams to address social determinants of health by sharing community needs assessment data, and sharing data gathered from the HRA Assess My Health. The State also plans to focus efforts by issuing SDH grants at the community level as a means to accelerate capacity of these teams to address SDH issues specific to their communities. In addition, IDPH has various initiatives, including the Office of Minority of Multicultural Health that already has developed strong relationships with other state departments. These established partnerships will be utilized and evaluated to determine where existing gaps exist in creating effective strategies in reducing the impacts of social determinants of health across state departments.

The State Medicaid Agency will work in partnership with the Department of Public Health in administering the TA approach as the plan to improve population health is fully formed. The TA approach established with the SIM Test will facilitate the operation of the plan.