



State Innovation Model (SIM)

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SIM Steering Committee Executive Summary Report

The State has prepared a SIM "Report to the Steering Committee" to support drafting of the State Healthcare Innovation Plan (SHIP), the multi-year plan that ensures the State achieves its goals of lowering health care costs and improving the quality of care for Iowans.

The report has the following sections and has been posted to the SIM Website for Steering Committee members and other interested stakeholders.

- The **Background and Overview** provides a summary of the SIM Design Award and the four key strategies. Also in this section are the organizing principles for the new health care system and an overview of health status of Iowans
- The "**As Is**" **State/Existing Efforts** section provides a brief overview of initiatives underway with a discussion of how they will support the SIM project and serve as a foundation to the evolution to a value-based system.
- The **SIM Process and Stakeholder Involvement** section provides an overview of the stakeholder meetings and communications.

Additional reports summarize the discussions of each workgroup, the background reading provided and the comments, concerns and recommendations articulated during the 16 workgroup meetings (four for each of the four workgroups) held from late July to early September of 2013.

This Executive Summary Report synthesizes the key recommendations for ACO models that are supported by workgroup efforts to-date and represents the current direction of the SIM design work. These reports and recommendations reflect the work of the stakeholder process (including Workgroups and listening sessions) and may not reflect the position of the Governor's Office and the Department of Human Services.

1. Accountable Care Organization (ACO) contracting and regions

- The Iowa Medicaid Enterprise (IME) should use a competitive procurement process to award ACOs based on geographic regions. Data analysis of existing referral patterns identified six naturally-occurring regions. The State is taking a regional approach because it:
 - Brings transformation to the community and enforces a person centered approach;
 - Ensures sufficient volume and scale for an ACO to effectively provide population management and accept risk for the population; and
 - Ensures accountability state-wide for both rural and urban areas.
- The State will require that the ACO be accountable for care; they should have a culture that encourages innovation and competition.

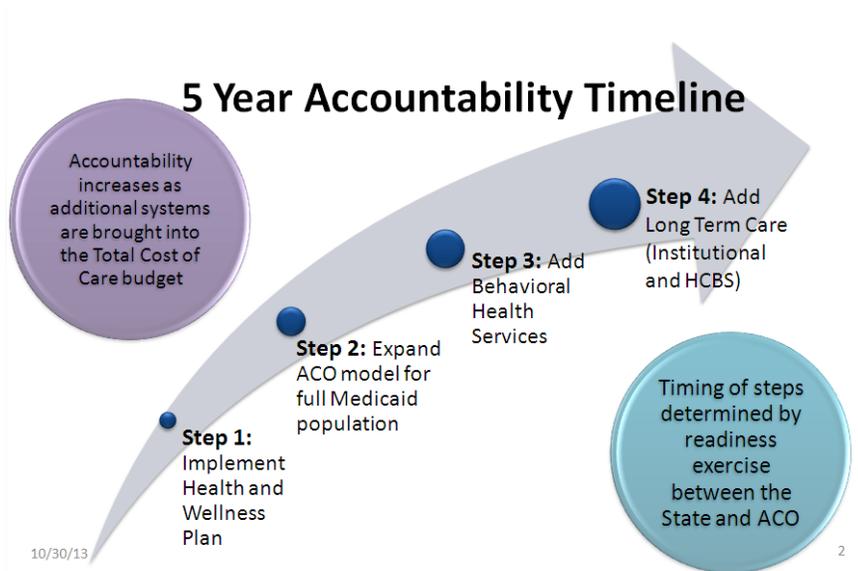
- ACOs will be expected to have an understanding of the needs of the Medicaid population and be prepared to implement innovative designs to impact member engagement and system change that is designed for Medicaid populations.
- The State should be open to contracting with any organizational/business structure including managed care organizations and collaborations between, for example, provider groups.
 - The State welcomes innovative partnerships and recognizes that providers and entities not operating currently as an ACO will be interested in the program.

2. ACO provider relationships

- The State should expect and require that the ACOs develop strong relationships and collaborate with quality partners in their region and communities to **enhance care coordination, reduce costs, ensure access** and change the overall health care system to one focused on outcomes.
 - ACO partnerships should include groups and organizations that have demonstrated expertise in serving low-income individuals and those with intellectual and other disabilities, and individuals with serious mental illness.
 - ACOs should draw strength and expertise from existing local community agencies like Public Health, Department on Aging and the Mental Health Regions as well as safety net providers, health homes and Integrated Health Homes.
- The ACO will be held accountable for outcomes, but these partnerships will support them through collaboration and direct service provision.

3. Ensuring accountability and alignment with other payers

- The State will use the Value Index Scores (VIS), currently used by Wellmark and proposed in the Wellness Plan, as a standard measure of quality across all payers. The State should require these same measures be used for all other markets and payers because:
 - Providers are familiar with the measures; and
 - Consistent measures will ensure practice change, as driven by performance, occurs across payers.
- In phases, the State should augment this core set of measures for physical health with additional measures for individuals and services, including behavioral health and long-term care supports and services based on input from the Mental Health and Disability Redesign [Outcomes and Performance Measures Workgroup](#).
- The long-term goal is to also include other payers, for example CHIP and Marketplace Choice health plans.



4. **Increased transparency**

- The State should develop a solution to share data with ACOs in a manner that is timely and transparent across all payers. This transparency is necessary to improve the quality of healthcare and reduce costs.
 - This will ensure access to standard metrics and patient level data for ACOs and their providers.
 - The standard metrics, adjusted for risk, provide a means to track performance, establish accountability, and fairly distribute incentive payments linked to performance.
 - Risk stratification allows care management resources to be targeted.

5. **Reimbursement approach**

- The State should hold the ACOs accountable for the total cost of care as the cornerstone to a shared savings methodology. Methodologies should be risk adjusted and transparent with sufficient analytics and reporting. The State should explore the feasibility of using social determinants of health (e.g., homelessness status, formerly incarcerated, etc.) in the risk adjustment methodology.
- In subsequent years, reimbursement should evolve such that the ACOs have more risk and greater accountability for Total Cost of Care (TCOC). There should be triggers and target dates for these adjustments. Within five years the ACOs will bear full-risk.
- Reimbursement should also include additional metrics to measure performance related to the provision of Long Term Care Supports and Services (LTCSS) and Behavioral Health (BH) services.

Proposed Triggers and Timing for Increasing Total Cost of Care (TCOC) Accountability			
Step 1 – Wellness Plan ACOs Start 1/1/2014	Step 2 – Regional Medicaid ACOs Start Early 2016	Step 3 – Add in BH Services to TCOC Start Early 2017	Step 4 – Add in LTCSS to TCOC Start Early 2018
Proposed readiness requirements for ACO receiving increased shared savings			
<ul style="list-style-type: none"> Wellness Plan members have access to primary care Member outreach and engagement strategies Incentives align with members' health behaviors Incentives for system improvement through Value Index Score (VIS) quality measurements No shared savings or downside risk initially (will be added in subsequent years) 	<ul style="list-style-type: none"> Well defined care coordination program Community relationships with traditional and non-traditional providers established <p>ACO PAYMENT STRUCTURE</p> <ul style="list-style-type: none"> Shared savings triggered by VIS and TCOC outcomes ACOs choice: 3 risk levels Up and down side risk Some BH and some LTCSS expenditures not included in TCOC calculation 	<ul style="list-style-type: none"> Established IHH capacity to serve Serious & Persistent Mental Ill (SPMI) population Established formal relationships with IHH providers Refined care coordination program to account for complexities of population with high Behavioral Health needs 	<ul style="list-style-type: none"> Established formal relationships with all Long Term Care (LTC) provider types, including but not limited to those serving individuals with ID Demonstrates data sharing capabilities with LTC providers Demonstrated Balancing Incentive Payment Program (BIPP) with increased percentage of home and community based (HCBS) spending Refined care coordination program to account for complexities of populations



* ACO potential shared savings increases with each step



* Disincentives may apply to ACOs that do not advance by target date

6. Approach to integrating behavioral health care services

- The State should phase in behavioral health services into the ACO responsibilities. Once phased in, the State should incorporate metrics that both evaluate and reward ACOs for integrated care delivery.
 - All services to all populations, including those with serious and persistent mental illness and substance use disorders should be included in an integrated accountable care structure.
 - This will move the State to greater integration of these services.
 - Care Coordination should address the recovery needs of the whole person and should foster the use of intensive community support services, evidence based practices, and peer supports.
 - This will demonstrate achievement of the outcomes reflected in the MHDS Redesign Workgroup and substance use disorder outcomes workgroup.
 - Recognize the value and contributions of the existing behavioral health system.

7. Approach to integrating long-term care supports and services

- The State should phase in long-term care supports and services into the ACO responsibilities. Once phased in, the State should incorporate metrics that evaluate and reward the use of Home and Community Based Services (HCBS) and incentivize the transition from serving individuals in institutions to serving them in home and community based settings. Incentives for behavioral health should build off the MHDS Redesign Outcomes Workgroup.
 - This will move the State to greater integration of these services since the ACO would be responsible for all services to all populations including those with long term care needs.
 - This will demonstrate achieving outcomes reflected in the HCBS waiver and MHDS Redesign outcomes workgroups.

8. Member engagement and approach to encouraging healthy behaviors

- The State should monitor the effectiveness of the Iowa Health and Wellness Plan and incorporate any best practices or strategies from that program into the statewide ACO model.
- The State should align the incentives and the metrics for ACOs with incentives for members who actively participate in becoming, and staying, healthy. Aligning the incentives will increase the effectiveness of member engagement activities.
- The State should consider implementing healthy behavior accounts or other funds to reward individuals for participating in specific health-related activities.
- The ACO should be held accountable for innovative, in-depth member education and outreach to ensure members have the tools and information to be better consumers.

9. Provider support and ensuring sufficient and appropriate workforce

- ACOs should provide technical assistance, training, and support to staff and providers to ensure they can operate effectively in the new, value-based delivery system.
- The ACOs should use a variety of partners, such as community health workers to serve these populations.
- The State should continue to support and build on the multiple initiatives already underway to address workforce challenges.

10. Creation of a reinvestment fund

- The State should consider financial approaches that will support longer-term investments in improved healthcare delivery, for example, ensuring the health and proper development of children.
 - The reinvestment fund should support innovation in an ACO delivery system.
 - Realized shared savings funds from both the State and the ACOs should support the reinvestment fund activities.

Acronym List

ACO: Accountable Care Organization
BIPP: Balancing Incentive Payment Program
BH: Behavioral Health
HCBS: Home and Community Based Services
IHH: Integrated Health Home
LTC: Long Term Care
LTCSS: Long Term Care Services and Supports
MHDS: Mental Health and Disability Services
SIM: State Innovation Model
SHIP: State Healthcare Innovation Plan
SPMI: Serious and Persistent Mental Illness
TCOC: Total Cost of Care
VIS: Value Index Score