

# MINUTES

## Medical Home System Advisory Council

Tuesday, May 24, 2011

9:30 am – 12:30 pm

Urbandale Public Library

### Members Present

Chris Atchison  
Melissa Bernhardt  
David Carlyle  
Libby Coyte  
Kevin de Regnier  
Tom Evans  
Carrie Fitzgerald  
Ro Foege  
Jeffery Hoffmann  
Linda Meyers  
CoraLynn Trewet  
Kurt Wood

### Members Absent

Bery Engebretsen  
Rep. Wayne Ford  
Don Klitgaard  
Petra Lamfers  
Mary Larew  
Tom Newton  
Elayne Sexsmith  
Anne Tabor  
Jennifer Vermeer  
Jane Reinhold

### Others Present

Beth Jones  
Angie Doyle-Scar  
Abby McGill  
Leslie Grefe  
Tracy Rodgers  
Nicole Schultz  
Carlene Russell  
Jodi Tomlonovic  
Leah McWilliams  
Lynh Patterson  
John Hostetler  
Brian Kaskie  
Tom Slater  
Jennifer Groos  
Michele Greiner  
Kelly Pennington  
Marni Bussell  
Anita Smith  
Allison Lothe  
Barb Blough  
Janelle Nielsen  
Deb Kazmerzak  
Heidi Goodman  
Linda Goeldner  
Kay Corriere  
Michelle Holst  
Dan Garrett

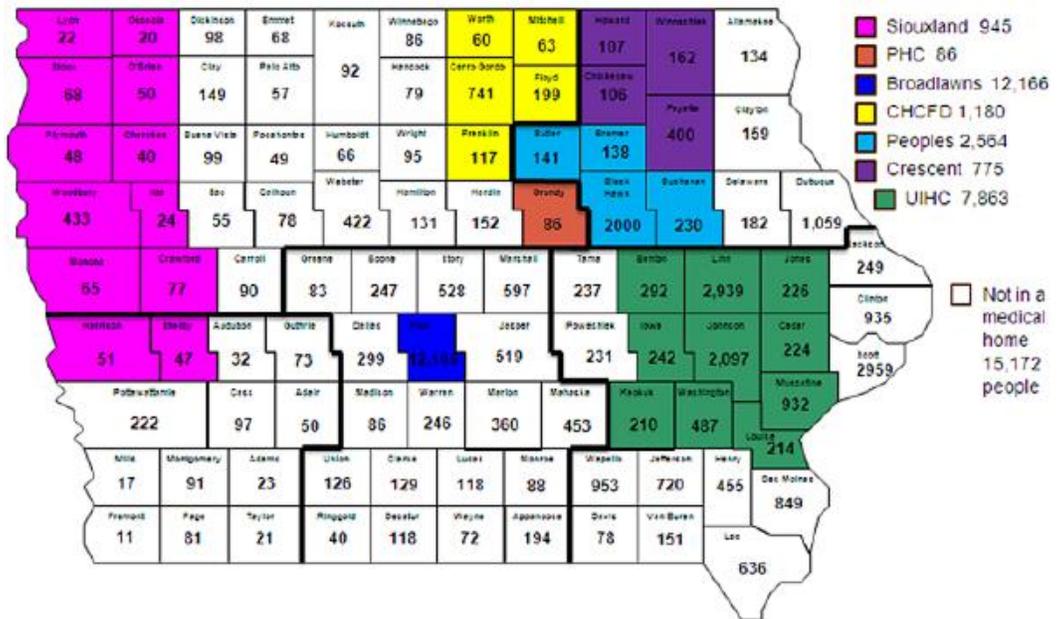
### Meeting Materials

- [Agenda](#) 
- [Behavioral Health and the PCMH- Michele Greiner PPT](#) 
- [eHealth Provider Factsheet](#) 
- [IowaCare Medical Homes and ACA Health Homes- PPT](#) 
- [Specialty Providers and The Medical Home- John Hostetler PPT](#) 
- [The Collaborative Model of Mental Health Care for Older Iowans- Brian Kaskie PPT](#) 
- [Veterans Task Force- Access and Primary Care Integration Handout](#) 

Topic	Discussion
Welcome	<ul style="list-style-type: none"> <li>• Council members and others present introduced themselves.</li> </ul>
<b>Medicaid Health Care Reform Implementation</b> <ul style="list-style-type: none"> <li>• IowaCare Expansion</li> <li>• ACA's Health Homes for Enrollees with Chronic Conditions</li> </ul> <i>Marni Bussell</i> <p><b>PowerPoint:</b> <a href="#">IowaCare Medical Homes and ACA Health Homes- PPT</a></p>	<p><b>IowaCare Expansion</b></p> <ul style="list-style-type: none"> <li>• The Council continues to collaborate with Medicaid in the development the <a href="#">IowaCare Medical Home Model</a> , established in SF 2356. The expansion is phasing in FQHCs to provide primary health care services to the IowaCare population and to comply with certification requirements of a Medical Home. Initially, the FQHC's will be required to meet a set of medical home minimum standards.</li> <li>• On October 1st, FQHC's in Sioux City and Waterloo have begun IowaCare expansion rollout.</li> <li>• Overall, the IowaCare medical homes are managing diabetes patients better than the general Medicaid population.               <ul style="list-style-type: none"> <li>○ 2,351 diabetes patients are in an IowaCare medical home</li> <li>○ 85% of medical home members have had an A1c in the past year, compared to 44% of the general Medicaid population.</li> </ul> </li> <li>• Access has also increased for the IowaCare patients in a medical home. In the past 6 months, over 18,000 same day visits and about 50,000 patient encounters have occurred.</li> <li>• As of March 31<sup>st</sup>, 2011, there are 28,539 members in a medial home- a 3,814 increase since October 2010.</li> <li>• Some overall lessons learned from the IowaCare medical home pilot are:</li> </ul>

- More work needs to be done to ready a practice for an assigned mass of members needing care on the same day.
- Attention is needed to understand the higher medical needs of this population before rolling out to other practices.
- Referral protocols and communication lines should be pre-established and understood.
- Three new FQHCs are joining the pilot July 1<sup>st</sup> to redistributing existing counties currently assigned the People’s clinic in Waterloo:
- Grundy county to Marshalltown (86 members)
- Worth, Mitchell, Floyd, Cerro Gordo, Franklin counties to Fort Dodge (1,180 members)
- Howard, Chickasaw, Winneshiek, Fayette counties to Dubuque (775 members)

### IowaCare Medical Home Coverage Proposed Redistribution for 7/1/11



- Webster County (Fort Dodge) patients will still need to go to the University of Iowa for care.
  - Discussion and concern was raised regarding this.
  - We need to keep in mind that there is still a timeline and plans to have every single county allocated to a medical home. The goal of the July 1<sup>st</sup> rollout is to alleviate Peoples in Waterloo of the overbearing burden they experienced in the initial rollout.
- The phasing in of FQHC’s is making the IowaCare program better, but not fixing the underlying issue.
- Chris Atchison raised the notion that the pilot is set up to be “county centered” vs. “patient centered”. Individuals are designated to medical homes in terms of what county that person lives in.

### ACA’s Health Homes for Enrollees with Chronic Conditions

- Starting in early 2010, IME is forming a Chronic Condition Health Home program for all Medicaid members.
  - The program is limited to practices with at least one MD/DO or ARNP
- May include, not limited to entities enrolled as:
  - Physician Clinic
  - Community Mental Health Centers
  - Federally Qualified Health Centers
  - Rural Health Centers
- Health Homes will have to meet the standards specified in IDPH rules. Those rules will likely require NCQA or other national accreditation. Until those rules are finalized, providers may enroll as a health home by:
  - Completing a TransforMED self-assessment (if not already recognized)

	<ul style="list-style-type: none"> <li>○ Achieve NCQA or other national accreditation within first year of operation</li> <li>○ Sign Contract delineating responsibilities of a health home</li> <li>● Payment Methodology for the program will be per-member-per-month (PMPM) care coordination health home payment: <ul style="list-style-type: none"> <li>○ Targeted only for persons with defined chronic disease</li> <li>○ PMPM Tiered payment Levels 0 to 4</li> <li>○ Depending on the acuity/risk of the enrollee the PMPM increases by the tier assignment.</li> </ul> </li> <li>● Individuals eligible for the program include those diagnosed with at least one serious and persistent mental health condition, has at least two chronic conditions or has one chronic condition and is at risk for a second chronic condition from the following list of categories: <ul style="list-style-type: none"> <li>○ Mental Health Condition</li> <li>○ Substance Use Disorder</li> <li>○ Asthma</li> <li>○ Diabetes</li> <li>○ Heart Disease</li> <li>○ Obesity (overweight, as evidenced by a BMI over 25)</li> <li>○ Hypertension</li> </ul> </li> <li>● Individuals will opt in to the program through the engagement of the provider.</li> </ul>
<p><b>Integrating Health Homes and Mental Illness</b>  <i>Kelly Pennington-  Magellan Behavioral Health</i></p>	<ul style="list-style-type: none"> <li>● Magellan Behavioral Health is collaborating with IME on a piece of the ACA's Health Homes for Enrollees with Chronic Conditions Model. They are focusing on the piece related to members with a serious mental illness.</li> <li>● Pilot projects are being conducted with funding from community reinvestment dollars focusing on an integrated health home with chronic mental health conditions model. A primary care provider is placed into the community mental health center setting. An RFP was released a few months ago, and four pilot sites were selected. Each pilot has integrates with FQHCs. <ul style="list-style-type: none"> <li>○ Cedar Rapids</li> <li>○ Des Moines</li> <li>○ Council Bluffs</li> <li>○ Sioux City</li> </ul> </li> <li>● At the hub of the integrated health home model is the behavioral health clinic (ex. local community mental health center) with a unique set of skills and expertise. At this hub is a physical health component- someone that can conduct basic physical health assessments and read labs results etc. This physical health component does not exist in the normal behavioral health clinic.</li> <li>● All of the pilot projects will have the basic medical component in-house. A health coordination team will be responsible for coordinating the care of the patients. The teams will include peer specialists (people who have had the same experience for peer guidance).</li> <li>● The patient populations of the pilot projects are very unique and have serious health needs, which is why it is carved out as a specialty population. Many of the patients have coexisting conditions, and alcohol and drug is related 40-70 percent of the time.</li> <li>● Significant use of emergency rooms exists with this population. Chronic disease management/education is not adequately addressed during visits due to the need for treatment of the mental illness. People with mental illnesses die on average 25 years earlier.</li> <li>● The Health Information Technology initiative will allow data to be shared from the Community Health Center to the FQHC (continuity of care document). The health coordination team will make sure the patients information gets transferred from one organization to another.</li> <li>● Health Risk Assessments will be a requirement for initial enrollment into the program</li> </ul>

	<p>since this is an opt-in program.</p> <ul style="list-style-type: none"> <li>• Outcomes will be tracked throughout the entire project. Process changes will also be monitored such as medical homeness, care coordination, increasing rate of clinical measures, improving evidence based medical adherence, referrals, etc. These process changes should aim to reduce hospital admissions and improve the longevity of people’s lives.</li> <li>• The adult population is the main focus of the program because they often have more chronic conditions and not as much family support. However, children will not be turned away from the program.</li> <li>• A number of Council members voiced concern that the project is underestimating the need for primary care with this complex population. It is not adequate enough for a nurse to be the liaison from mental health to primary care- there needs to be a primary care doctor involved at all times.</li> <li>• The idea is that somebody takes responsibility of coordinating the care of the patient, whether at the medical or mental health provider location.</li> <li>• It was mentioned that this seems to be a “disease management program on steroids,” not a medical home. The national definition of medical home focuses on a high degree of physician integration. “Who” within the medical care team would be responsible for care coordination with primary care doctor?</li> <li>• Further discussion took place about the wall that exists between medical home and mental health. Part of the medical home is to utilize all of the community resources available to the patient. This pilot is an opportunity to chip away at the wall by forming relationships with mental health and medical providers.</li> </ul>
<p><b>Primary Care/ Mental Health Integration Discussion</b></p> <ul style="list-style-type: none"> <li>• <b>Michele Greiner</b> <i>Iowa Psychological Association &amp; Greiner Psychological Services</i> <b>PowerPoint:</b> <a href="#">Behavioral Health and the PCMH- Michele Greiner PPT</a></li> <li>• <b>Tom Slater</b> <i>State Public Policy Group</i> <b>Handout:</b> <a href="#">Veterans Task Force- Access and Primary Care Integration Handout</a></li> <li>• <b>John Hostetler</b> <i>Community and Family Resources- Fort Dodge</i> <b>PowerPoint:</b> <a href="#">Specialty Providers and The Medical Home- John Hostetler PPT</a></li> </ul>	<p><b>Michele Greiner- Approach to integrating clinical care with behavioral/mental health and primary care</b></p> <ul style="list-style-type: none"> <li>• This presentation was centered on six main reasons behavioral health should be an integral part of the patient-centered medical home practice. They are: <ol style="list-style-type: none"> <li>1. Prevalence of Behavioral Health Problems in Primary Care</li> <li>2. Unmet Behavioral Health Needs in Primary Care</li> <li>3. Cost of Unmet Behavioral Health Needs</li> <li>4. Lower Cost When Behavioral Health Needs are Met</li> <li>5. Better Health Outcomes</li> <li>6. Improved Satisfaction</li> </ol> </li> </ul> <p>A number of statistics were shared and can be found in the PowerPoint presentation.</p> <ul style="list-style-type: none"> <li>• 40 percent of the reason people die is due to behavioral issues.</li> <li>• Stigma is a huge issue when talking about mental health. Co-location is one strategy to remove that stigma. People living in a small town in rural Iowa are going to be very apprehensive to visit a mental health clinic, for fear that friends and neighbors will see their car parked outside.</li> <li>• Annual medical expenses (chronic medical &amp; behavioral health conditions combined) cost 46% more than those with only a chronic medical condition.</li> <li>• The top five conditions driving overall health cost (work related productivity + medical + pharmacy cost) are: <ol style="list-style-type: none"> <li>1. Depression</li> <li>2. Obesity</li> <li>3. Arthritis</li> <li>4. Back/Neck Pain</li> <li>5. Anxiety</li> </ol> </li> <li>• Two examples of integrated care systems utilizing psychologists were described from Cherokee Health System and University of Nebraska, Munroe-Meyer Institute.</li> <li>• A suggestion was given that as we look at the educational component, a training model which includes doctoral psychologists should be considered.</li> <li>• It was encouraged to have a mental health provider sit on the MHSAC who is a practicing provider.</li> </ul>

- **Brian Kaskie**  
*Associate Professor-  
Health Management  
and Policy, UI College  
of Public Health*  
**PowerPoint:**  
[The Collaborative  
Model of Mental  
Health Care for Older  
Iowans- Brian Kaskie  
PPT](#)

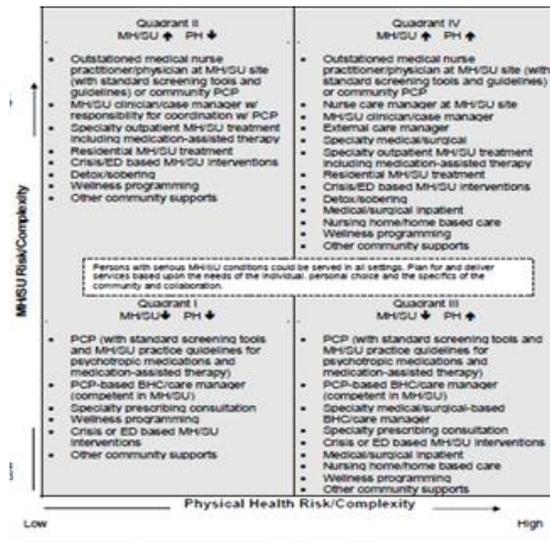
### **Tom Slater- Aligning primary care and behavioral health services for returning veterans**

- An introduction was given about some of the mental illness soldiers coming home from war are experiencing.
  - 20 percent of them are coming home with serious post traumatic stress disorder or other mental illness.
- In order to address this, work is being done in partnership with the Iowa Commission of Veterans Affairs to expand access to mental health services for Iowa veterans through partnerships and coordination with non-VA primary and behavioral health care providers.
- The complexities of readjustment to family and community life and trauma experienced by veterans necessitate provider coordination and broader access to behavioral health services. Veterans may seek services through the VA, a local primary care provider, or other provider of choice. Regardless of point of entry for services, the goal is to ensure that all veterans have access to quality behavioral health services. The following strategies are recommended:
  - Utilize the existing network of Community Health Centers and Community Mental Health Centers to expand veterans' access to behavioral health services.
  - Integrate behavioral health services with primary care.
  - Provide tools to primary care providers to better serve and refer veterans.
  - Educate and train family members and natural support networks of veterans.
- In 2008, the Iowa General Assembly required a study of existing veterans benefits and deficiencies. A stakeholder Task Force comprised of veterans, county services officers, commission members, VA representatives, and others recommended more in-depth work on mental health issues, leading to the development of the following recommendations. State Public Policy Group (SPPG) is working with the Iowa Commission and Department of Veterans Affairs to develop plans to implement these recommendations.
- The Iowa Veterans Mental Health Task Force made the following nine recommendations to improve mental health services available to veterans in Iowa.
  1. Provide mental health first aid training to county veterans service officers, veterans service organizations, the state Family Readiness Group, first responders, and other veterans stakeholders.
  2. Enhance the veterans database by capturing veterans' information through existing state data collection systems.
  3. Develop a social marketing and outreach strategy for veterans' behavioral health issues.
  4. Advise the law enforcement academy to integrate crisis intervention team training with an emphasis on veterans' issues.
  5. Create community-based peer support pilot programs for veterans and their families.
  6. Initiate a process to create a jail diversion program for veterans in Iowa.
  7. Support efforts to secure a mobile outreach vehicle to serve veterans in Iowa.
  8. Establish a state fee basis program for mental health services to serve veterans in their local communities.
  9. Develop a veterans screening process that will enable non-VA providers to screen and refer patients as appropriate for military service, substance abuse, mental health issues, traumatic brain injury, and post-traumatic stress disorder.

### **John Hostetler- What specialty providers can bring to the table that fits into the concept of cross integration and community utility**

- Two agencies (Addiction Treatment & Prevention Services and the Richmond Center) are dedicated to proactively assisting individuals, families, and communities achieve healthy behavior and lifestyle through advocacy, treatment, and prevention of substance abuse, problem gambling and mental illness.
- The counties served by these agencies include: Boone, Calhoun, Carroll, Greene, Hamilton, Hardin, Humboldt, Pocahontas, Story, Webster & Wright Counties.

- Persons with serious mental illnesses die on average between the ages 53-56.
- A Kaiser study on the impact on healthcare costs in North Carolina was discussed.
- Iowa substance abuse providers served 46,808 clients in SFY 2010, and completed 39,267 assessments.
- The Four Quadrant Clinical Integration Model was introduced as a great tool to determine the needs of the population and target services.



### **Brian Kaskie- Integrated models currently underway in three clinic locations**

- A variety of graphs/statics was given and can be found in the PowerPoint presentation.
- Depression, followed by anxiety and altered states, are the top primary mental health disorders.
- The Presidents New Freedom Commission on Mental Health states “The Federal Government should add evidence-based collaborative care services for psychiatric disorders to the list of covered services through the Medicare National Coverage Process”.
- Clinical procedures for mental health were described. They are:
  - Screening
  - Referral
  - Diagnosis
  - Treatment Plan
  - Multi-Arm treatment
  - Evaluation
- Examples of screening tools that are currently being used were shared with the Council.
- Treatment procedures were described. They are:
  - Prescription Therapy
  - Psychotherapy
  - Supportive Services
  - Six-Month Course
- Two different staffing models were described. The first model is a co-location model where a patient with a mental health problem can have a formal diagnostic assessment in the same office. The second model is a referral model where the patient with the mental health problem has to be referred to a specialty mental health clinic for a formal diagnosis.
- Three clinics in Iowa were given an Agency for Healthcare Research and Quality (AHRQ) award:
  1. Covenant Clinic in Waverly
  2. Myrtue Medical Center in Harlan
  3. West Iowa Community Mental Health in Denison

**Discussion**

- It was suggested to bring together leadership from each healthcare area to flesh out how to bridge the gap between primary and mental healthcare.
- There is no standard approach to screening in Iowa- that should be the first step.
  - Libby Coyte replied that there is a disincentive to doing screenings because of the workforce issue. She does 5-7 referrals a week, and when you screen, something needs to be done if follow-up is needed. It is a workforce issue when there is nobody to refer to.
  - One solution is to provide incentives to doing screenings/referrals. There might be the workforce out there that we are not adequately utilized.
- Another major issue in reimbursement is that Medicaid will cover some screenings, but other private insurances won't cover the same screenings. Providers aren't able to treat/screen all patients the same way.
- Dr. Carlyle, family medicine, suggested that the problem with the system is the fee-for-service payment. That is why screenings and co-location is not being done.
- Brian Kaskie described how much providers could get reimbursed for providing screening services. Many providers may be unaware of how to reimburse for providing certain services.
  - Reports from the three pilot projects mentioned will be disseminated and one main message will be to teach how to charge for reimbursement of certain services.
- Access was an issue that was discussed. Depression and anxiety could be treated by the primary care office, and patients with more serious and uncommon conditions could be treated in the specialized mental health clinic.
- Care coordination is also an important first step. Our reimbursement creates many silos and we are incentivized not to work together. The MHSAC will work to remove these silos and coordinate care for patients.
- If the mental health person isn't in the primary care office, the services most likely won't be received.
- Ro Foegen mentioned the stigma associated with labeling somebody a "mental health" worker. If the person is known by name, say in a smaller town, it would be better to refer a patient to the person by their name.
  - CoraLynn replied with a similar message- if she goes to meet and visit with the patient in the same room as the primary care doctor, the patient will likely go to her for diabetes education.

**Iowa eHealth**  
*Leslie Grefe*

**Handout:**  
[eHealth Provider Factsheet](#)

- Health care providers have an opportunity to improve health care through the use and exchange of electronic health information. This includes implementing and using electronic health records in every provider setting, and a statewide health information exchange. Two key definitions/initiatives to be aware of are:
  - **Electronic Health Records (EHRs)** are used to collect and store relevant patient health information, including patient history, diagnoses, medications, allergies, clinician visits, and laboratory tests.
  - **Health Information Exchange (HIE)** allows EHR data to be securely shared among health care providers (e.g., clinics, hospitals, pharmacies, etc). A statewide HIE allows providers to access vital patient information where and when it's needed.
- The HIE will include a secure messaging service to help the exchange of information between provider settings. This is the first step to be completely electronic communication and removes faxing papers, sending hard copies, etc.
- The continuity of care document is a great tool to support care coordination and the medical home initiative. The tool consolidates information at various provider settings and has all of the patient information in one view.
- Pharmacies are a key stakeholder in this planning process. They hear on a regular basis from patients on how things are going and are another checkpoint for the patient. The HIE will be incredibly valuable when working with older adults and their medication lists.

	<ul style="list-style-type: none"> <li>• Population health is a focus of the HIE to reduce the provider burden of submitting information to IDPH, such as to IRIS (immunization registry). This will be streamlined in interoperable so that the information will automatically be submitted to IRIS through the EHR.</li> <li>• The first step in implementing Iowa eHealth is for providers to get an EHR up and running. The second step is the HIE and making it available to other people. Long-term goals for Iowa eHealth are to incorporate advanced services such as alerts and quality reporting. Click <a href="#">here</a> to view a demonstration of the tool and the potential of what the HIE will be able to do in Iowa.</li> <li>• The next Electronic Health Information Advisory Council meeting will be held on June 24<sup>th</sup> from 10:00 – 2:00 at Mercy Hospital downtown (East Tower, Level A). At this meeting, the Council will approve their Financial Sustainability Plan. For more information, visit the Iowa eHealth website at: <a href="http://www.iowahealth.org">http://www.iowahealth.org</a></li> </ul>
<p><b>Other Discussion Items</b></p> <p>Legislative Update</p> <p>Iowa Health Benefits Exchange</p> <p>Prevention and Chronic Care Management Advisory Council</p> <p><a href="#">MHSAC Progress Report #3</a></p> <p>Next Issue Briefs- Social Determinants of Health</p> <p>Community Utility</p>	<p><b><u>Legislative Update</u></b></p> <ul style="list-style-type: none"> <li>• The state budget has yet to be finalized. At this point, the Prevention and Chronic Care Management and Medical Home System Advisory Council’s will be combined into one council.</li> <li>• Membership, structure etc. will need to be looked at. IDPH staffing will stay the same.</li> <li>• For current Iowa Legislature information, visit: <a href="http://www.legis.iowa.gov/index.aspx">http://www.legis.iowa.gov/index.aspx</a></li> </ul> <p><b><u>Iowa Health Benefit Exchange</u></b></p> <ul style="list-style-type: none"> <li>• The Health Benefit Exchange website with resources and meeting information can be found here: <a href="http://www.idph.state.ia.us/hcr_committees/health_benefit_exchange.asp">http://www.idph.state.ia.us/hcr_committees/health_benefit_exchange.asp</a></li> <li>• IDPH has been awarded a one-year grant to plan for the Health Benefits Exchange (HBE). An Interagency Workgroup has been formed with IDPH, Iowa Medicaid Enterprise, Iowa Insurance Division, and the Iowa Department of Revenue to begin the initial planning.</li> <li>• <u>Background of Insurance Exchanges-</u> Beginning in 2014, tens of millions of Americans will have access to health coverage through newly established Exchanges in each State. Individuals and small businesses can use the Exchanges to purchase affordable health insurance from a choice of products offered by qualified health plans. Exchanges will ensure that participating health plans meet certain standards and facilitate competition and choices by rating health plans’ quality. Individuals and families purchasing health insurance through Exchanges may qualify for premium tax credits and reduced cost-sharing if their household income is between 133 percent and 400 percent of the Federal poverty level. The Exchanges will coordinate eligibility and enrollment with State Medicaid and Children’s Health Insurance Programs to ensure all Americans have affordable health coverage.</li> <li>• <u>Regional Meetings and Focus Groups-</u> The Interagency Workgroup held a series of regional meetings and focus groups across Iowa to ensure considerable stakeholder involvement throughout the planning of the HBE. <ul style="list-style-type: none"> <li>○ Joel Ario, Director of the U.S. Health and Human Services Center of Health Insurance Exchange, attended the first of five regional meetings in Des Moines on December 13th. They gained consumer buy-in and created transparency. Community stakeholder groups were given a chance to voice concerns and solicit ideas and expectations from what Iowans want out of an HBE.</li> <li>○ Information that was collected included such items as what benefits should be incorporated in the benefits packages, how should information be delivered and what tools should be available to access services. The information gathered from the meetings will be shared with stakeholders and policymakers as part of the planning process. A Stakeholder Advisory Council will also be formed to lead this effort.</li> <li>○ The information gathered from the meetings will be shared with stakeholders and policymakers as part of the planning process. A <a href="#">Preliminary Summary of HBE Regional Meetings-Focus Groups</a> is available, and a full report will be finalized soon.</li> <li>○ Video presentations from the regional meetings can be viewed <a href="#">here</a>.</li> </ul> </li> </ul>

- Educational whitepapers that were created by the Interagency Workgroup and distributed at the regional meetings and focus groups can be viewed here:
  - [HBE Overview](#)
  - [HBE Consumer Overview](#)
  - [HBE Whitepaper- Key Decisions and Activities Table](#)
  - [HBE Whitepaper- Difference Between Exchanges](#)
  - [HBE Whitepaper- Medicaid Expansion Under the ACA](#)
- Legislation- Three pieces of legislation were introduced during the 2011 Iowa legislative session creating a HBE in the state. The bills were [Senate File 348](#) and two companion bills, [Senate File 391](#) and [House File 559](#). None of these bills made it through the second funnel and are dead for the 2011 legislative session. This places Iowa in an interesting position for the 2014 health care reform push, making the 2012 legislative session even more important for Iowa HBE legislation to be passed.
- Interagency Workgroup Activities- As previously stated, IDPH is collaborating with the Iowa Insurance Division (IID), Iowa Department of Human Services (DHS) and the Iowa Department of Revenue (IDR) as part of an Interagency Planning Workgroup to assess the support of, need for, and creation of the HBE. The workgroup will issue final recommendations to the Governor, policymakers, and the public for the establishment of a HBE.
  - **DHS** received \$445,727 and is identifying IT requirements for program interoperability and seamless enrollment into coverage plans. DHS is also evaluating business processes and IT solutions that will integrate Medicaid and CHIP eligibility determination, enrollment and covered services into the HBE, and new eligibility procedures for tax credits.
    - DHS has contracted with FOX: A Cognosante Company (FOX)
      - To date, FOX has delivered, to the DHS, work breakdown structure, communication plan, risk management plan, quality management plan, and staffing management plan. FOX is on schedule to produce a RFI in the spring of 2011.
      - FOX is analyzing the current eligibility IT systems and infrastructure for Medicaid. FOX will be conducting an “as-is” and “to-be” analysis. Specifically, FOX will analyze the Medicaid eligibility determination business “As Is” processes and develop a “To Be” roadmap as it relates to field operations, state Medicaid eligibility policy and the Iowa Automated Benefit Calculations (IABC) system to determine the impact on a new Medicaid eligibility determination processes and system as well as the impacts to the HBE to achieve a defined business outcome.
      - Additionally, FOX is working on a strategic plan to identify business processes and IT solutions to integrate Medicaid, CHIP and tax credits eligibility determinations and enrollment. FOX will examine Medicaid eligibility determination system options that support and align with health care reform, create innovative business processes and utilize the most advanced technologies.
    - They are also in the process of identifying needs for Medicaid program interoperability with the HBE. FOX is looking to tie Medicaid eligibility in the Iowa HBE by analyzing interfaces with other systems.
  - **IID** received \$232,523 and is taking the lead in developing insurance market assessments, assessing integration to the current insurance information exchange call center, reviewing filings for premium rates, and surveying carriers benefit designs and survey carrier and provider market competitiveness.
  - **IDR** received \$23,424 and is providing leadership for financial modeling, developing specifications for accounting and financial systems, determining budget impacts, working to ensure that a system is in place to issue appropriate tax credits and subsidies to eligible individuals, and developing a system that can be easily audited and understood by the taxpayers.
- Establishment Grant- Iowa has submitted a letter of intent to apply for the Level One of the

Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges by December 31<sup>st</sup>, 2011. The letter of intent can be viewed [here](#).

- **National Meetings-** Three members of the Interagency Workgroup attended the *Center for Consumer Information and Insurance Oversight (CCIIO) State Exchange Grantee Meeting* in Denver, Colorado on May 5<sup>th</sup> and 6<sup>th</sup>. Topics covered during this meeting include experiences from the seven early innovator states, other states legislation/governance structures, and IT guidance. Interagency Workgroup members also attended the Utah Health Exchange Invitational meeting held on May 12<sup>th</sup> and 13<sup>th</sup> in Salt Lake City, Utah to learn about Utah's experience in implementing their HBE.
- **New National Website/Resource-** A new website called State Refor(u)m has been launched- <http://www.statereforum.org>- as a resource to assist state health officials and the broader state health policy community as they tackle the implementation challenges and opportunities created by the federal law. State Refor(u)m provides tools, information and resources to aid states in meeting the ACA's requirements. The goals of the website are to: 1) foster online peer learning, 2) highlight states' implementation progress and 3) share states' successes with others nationwide that may benefit.

### **Prevention and Chronic Care Management Advisory Council**

The **Chronic Disease Management Subgroup** is focusing on [SF 2356](#) to develop a plan to coordinate care for individuals with diabetes who receive care through safety net providers. As a first step, IA/NEPCA conducted focus groups in the Federally Qualified Health Centers (FQHC) to determine the barriers that people with diabetes face. IA/NEPCA produced a report for the Council summarizing the results of the focus groups. The report can be found [here](#). PCCM Staff have been meeting with members of the Iowa Collaborative Safety Net Provider Network, including the free clinics, community health centers, family planning clinics, and rural health clinics to discuss this legislative charge and begin collaboration for the diabetes care coordination plan.

The Subgroup has finalized an [Iowa Diabetes Issue Brief](#) which will include initial recommendations concerning issues that have quickly become high priority while working on the diabetes care plan. The recommendations are:

1. Coordinate with existing programs to ensure that test-strips are made available for underinsured and uninsured people with diabetes in Iowa.
2. Ensure that certified diabetes education is available statewide and that outreach is conducted to patients to ensure awareness of this critical service.
3. Ensure the utilization of educational tools, resources, and programs to promote the engagement of people with diabetes and self-management of both obesity and its complications, including diabetes and metabolic syndrome.

The **Prevention Subgroup** is focusing on [HF 2144](#) to develop recommendations by December 15, 2011 on strategies to collect and provide statistically accurate data concerning chronic disease in multicultural groups of racial and ethnic diversity in the state. Following implementation of the strategies and collection of data, the council shall also make evidence-based recommendations to the director to address and reduce identified disparities. The subgroup will submit the recommendations to the full Council, then the Council will submit them to the Director of IDPH. An agreement has been made that the subgroup and IDPH's Office of Multicultural and Minority Health Advisory Council will collaborate closely in the work of this legislative charge. An environmental scan has been conducted on the multicultural data currently being collected in Iowa.

The PCCM Advisory Council continues to collaborate with the Iowa Collaborative Safety Net Provider Network and the Health and Long-Term Care Access Advisory Council to develop their strategic plans.

Affordable Care Act (ACA) Grant Opportunities- PCCM Advisory Council staff has collaborated in applying for two grants:

*Medicaid Incentives for Prevention of Chronic Diseases- ACA Section 4108:* This grant

opportunity allows states to offer incentives to Medicaid enrollees who adopt healthy behaviors. An effective way to encourage healthy lifestyle changes is to offer incentives to those who reach goals. States will adopt such strategies as rewarding Medicaid enrollees who meet goals established for them such as weight loss, smoking cessation or diabetes prevention/control. Click [here](#) for more information.

*Childhood Obesity Research Demonstration:* IDPH's Bureau of Nutrition and Health Promotion was the lead in coordinating and writing this grant. This grant opportunity will determine whether an integrated model of primary care and public health approaches in the community can improve underserved children's risk factors for obesity. These approaches may include policy, systems, and environmental supports that encourage nutrition and physical activity for underserved children and their families. Grantees will develop, implement, and evaluate multiple settings (childcare, school, community, health care), multiple levels (child, family, organization, community, policy) intervention demonstration projects for underserved children ages 2-12 years and their families. To view the Funding Opportunity Announcement, click [here](#).

### **MHSAC Progress Report #3**

The MHSAC Progress Report #3 has been finalized and is available [here](#). The report includes six priority areas with recommendations to focus on in 2011. The recommendations are:

1. Support state and federal efforts to reverse the decline in primary care workforce and access to dental services in Iowa by addressing the utilization of alternative staffing models including mid-levels.
2. Continue to monitor and discuss the federal direction of the Accountable Care Organization model and determine implications for Iowa.
3. Support additional resources to advance the IowaCare Medical Home Pilot Project to sustain continued rollout of the Federally Qualified Health Centers.
4. Continue to develop and sustain the Medical Home Multipayer Collaborative Workgroup to advance the development of a multipayer pilot in Iowa.
5. Collaborate with the Prevention and Chronic Care Management Advisory Council to improve incentives for prevention and chronic disease management by providing support for care through payment systems, organization and delivery of care, and care coordination through a patient-centered medical home.
6. Support the implementation of the statewide Health Information Exchange in Iowa.

The next meeting of the Medical Home System Advisory Council will be held  
**Wednesday, September 14<sup>th</sup>, 9:30 – 12:30 at the Urbandale Public Library.**